The role of stigma, threat, and trust on support seeking among young people dealing with their own or a friend's symptoms of mental illness

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This thesis is the result of the author's original research. It has been composed by the author and has not been previously submitted for examination which has led to the award of a degree.

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For both publications, Sofia Milheiro Pimenta carried out the literature search and review, designed the study, and collected the data. Additionally, Sofia also completed data analysis and interpretation, and drafting of the manuscript. Simon Hunter was involved in providing guidance for the design of the study, data analysis and interpretation, and critical revision of the manuscript. Susan Rasmussen provided support with the design of the study and the critical revision of the manuscript.

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Abstract

This thesis applied psychological theory to examine how young people seek support for their own or a friend's symptoms of mental illness. Research has provided insight into the coping process when adolescents are dealing with mostly their own symptoms of mental illness. How a young person copes with a friend's disclosure of mental illness is still somewhat unknown. In this thesis, one qualitative and two quantitative studies were carried out to explore the differences in young people coping when dealing with their own or with a friend's symptoms of mental illness. A qualitative study with 11 young people aged 12 to 15 years old, examined the applicability of the Transactional Theory of Coping (TTC). An interview schedule was developed to capture the core concepts of the TTC: cognitive appraisals and coping strategies. Through the use of Thematic Analysis, results revealed that young people would employ different strategies when dealing with their own or with a friend's symptoms. This study showed stigma, trust, and severity of symptoms as key factors when seeking support.

Study 2 extended these findings by examining the influence of stigma, threat, and trust on support seeking. With a sample of 250 participants, this study used a multi-group path analysis and results confirmed differences in coping concerning one's own, compared to a friend's, symptoms. Threat, trust, and self-stigma were relevant when young people were seeking support for their own symptoms, while public-stigma played a significant role in support seeking for a friend's symptoms. Finally, Study 3 built on the findings from the previous two studies by exploring lived-experiences of young people seeking support for their own or a friend's symptoms of mental illness and aimed to investigate the role of perceived severity of symptoms on support seeking. Despite the limitations introduced by COVID-19 (e.g., a total sample size of 76), this survey-based study showed support for the influence of perceived severity of symptoms when young people dealt with a friend's symptoms.

This thesis suggests that different variables influence young people’s support seeking for their own or a friend’s symptoms of mental illness. Exploring a topic where research has been scarce (i.e., support seeking following a friend’s disclosure), allows for adjustments to the current services that support young people to be made accordingly. Thus, implications for research, theory, and practice are discussed in the thesis aiming to offer suggestions to improve support to young people.

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Introduction and Thesis Overview

Young people start to experience symptoms of mental illness as early as 11 years old (Patalay & Fitzsimons, 2018). Also, more than half of all psychological disorders, in adult life, start to develop before the age of 15 (Kim-Cohen et al., 2003). Despite the high prevalence, most young people do not seek support for their symptoms (Rickwood et al., 2007), avoiding disclosing to others, and cope with symptoms alone. The underlying stress involved in the exposure of symptoms of mental illness has been shown to impact on how young people cope with this situation. Most young people would define experiencing symptoms of mental illness as stressful (Auerbach et al., 2011; Galaif et al., 2003; Moksnes et al., 2010). Adolescents are likely to experience higher levels of stress if, for example, they lack the skills to deal with the symptoms (Byrne et al., 2015) or due to social pressures (Heary et al., 2017). Thus, using a framework that provides an understanding on how an individual responds to stressful situations, can be helpful to comprehend young people support seeking behaviours. As such, this thesis will be underpinned by the Transactional Theory of Coping (TTC) of Lazarus and Folkman (1984).

When it comes to coping with symptoms of mental illness, research has shown that young people tend to ask for support from friends (i.e., informal sources) more often than from professional sources (i.e., formal sources) (Rickwood et al., 2007). Keeping this in mind, this thesis will use the Ecological System Theory (Bronfenbrenner, 1979) as a framework to better understand the young person within the wider context they operate in. Thus, research such as the one presented earlier, reports on the preference by young people to resort to relationships in their existing microsystems and be less reliant on external systems such as the exosystem or macrosystem.

Young people report feeling more comfortable disclosing to informal sources due to higher levels of trust (e.g., Burke et al., 2022; Rowe et al., 2014) and higher level of intimacy with the individuals in question. When it comes to formal sources, young people feel discomfort when talking to someone they do not know and hold negative beliefs about professionals (Corry & Leavey, 2017), which could make them reject this type of support. However, it is also possible that disclosure of symptoms might be influenced by the severity of the symptoms being experienced by the individual. This is the case especially when it comes to the use of professional sources where, for example, young people are more likely to seek support from a professional if they perceive their symptoms to be more severe (Hinson & Swanson, 1993).

Adolescents are encouraged by adults, through different means (e.g., campaigns, school, etc.), to disclose their symptoms to others when coping (Griffiths et al., 2011). Often, as highlighted before, they chose to disclose to friends as they feel more comfortable and trust their friends most (Camara et al., 2017; Rickwood et al., 2007). However, this leads to the corollary proposition that young people need to be able to, and need to know how to, respond when a friend discloses to them. Despite this, literature is still scarce on how young people deal with a peer disclosure of symptoms of mental illness. When comparing help-seeking behaviours, young people are more willing to refer a friend to professional help than to self-refer, even if they are experiencing similar symptoms (Raviv et al., 2000). This shows that there are some differences when coping with their own versus a friend’s symptoms. Nevertheless, it is still unclear how the coping process develops, since there is little information about their evaluation of the situation, what resources they value and use, and their preferred coping strategies. Thus, the aim of this thesis is to use psychological theory to support investigation of young people’s coping strategies in the context of symptoms of mental illness. Within this, the thesis focusses on the differences between dealing with their own symptoms of mental illness and dealing with a peer disclosure of symptoms of mental illness.

The thesis starts with a review of the literature. Chapter 1 reviews evidence on young people social, emotional, and mental development, and establishes the link between the different stages and symptoms of mental illness. Literature shows that young people struggle most commonly with symptoms of depression and anxiety (Sadler et al., 2018). As such, this chapter will also explore these two conditions in more detail. While both gender and age are not key variables explored in this thesis, their role within the support seeking literature and differences between genders and ages will be explored throughout the thesis. Thus, it will be argued in this chapter that gender and age differences play a significant role when it comes to knowledge, recognition of symptoms, and support seeking behaviours.

Chapter 2 discusses the relevance of the TTC (Lazarus & Folkman, 1984) used in this thesis. It is argued that the TTC is a useful theory that aids to understand the support seeking process when dealing with symptoms of mental illness. The development of the theory, concepts, strengths, and weakness are discussed. Each stage of the coping process (i.e., cognitive appraisals and coping strategies) will be detailed to clarify how they influence each other, and how the TTC has been applied in previous relevant literature. This chapter will also explore the links between TTC and Ecological Systems Theory of Bronfenbrenner (1979). This will support the understanding of how young people evaluate the resources available to them and who they choose who to disclose symptoms of mental illness to.

Chapter 3 describes the general methodology applied to all three studies of this thesis. Thus, Chapter 3 will detail the open science practices used in this thesis as well as the relevance of these in Psychology more generally. This chapter will also consider the ethical issues and protocols put in place for the three studies. Finally, this chapter will explore the positionality and reflexivity of the researcher in light of the mixed methods nature of the thesis.

Chapter 4 will provide further detail on the methodology used in Study 1. This will complement Chapter 5 which is itself a copy of a manuscript that has been published in the *Journal of Adolescence Research*. Chapter 6 is a bridge between Study 1 and Study 2 and details the key results from Study 1. This chapter also explores the barriers and facilitators relating to young peoples' support seeking, thus covering topics including stigma, trust, and their relationship to support seeking when dealing with mental illness. Additionally, these different factors will be integrated within the TTC framework. Relevant literature about how these are thought to influence young people's support seeking when a friend is experiencing symptoms, together with the model being tested in both quantitative studies, will be presented. Furthermore, in this chapter there will be a change in terminology and the reasons why will be explored. Mainly, as a result of the findings from Study 1, instead of referring to 'mental health problems', from this chapter on, the term used will be 'mental illness'. Similarly, Study 2 and 3 will focus on exploring support seeking as a form of coping, instead of looking specifically into both emotion- and problem-focused forms of coping strategies.

Chapter 7 is the last methodological chapter and covers Study 2. As in Chapter 4, this will provide further insight into methodological aspects not covered in the paper published in the *Child and Youth Care Forum* (Chapter 8). This will explore in more depth the survey used, factor analysis of the trust measure created, and description of the procedure for recruitment. Chapter 9 will present the third and final study of this thesis. It will cover how the model tested in Study 2 performs in a sample of young people with lived-experiences of symptoms of mental illness, and will investigate how perceived severity of symptoms influences young people's support seeking.

Due to the nature of the work presented in this thesis being publication based, throughout the thesis there will be moments of repetition of literature review (particularly in Chapters 5 and 8 where a copy of the published papers is presented). Finally, Chapter 10 is a general discussion which will involve extended consideration of the aims and findings of the thesis. Furthermore, implications for practice, research, and theory will be presented as well as suggestions for future directions. Reflections will be presented in the form of strengths and limitations, and personal reflections about the PhD process as a whole. This will bring to light the literature discussed in Chapter 3 and personal considerations about research, professional development, and a student's mental health throughout the PhD will be explored.

Chapter 1- Mental Illness and Young People

Adolescent psychology entails exploring four overarching elements: the perspectives and theories that frame development itself, the processes through which adolescents actually develop (e.g., physical and cognitive changes), the contexts in which said changes occur, and finally the social and emotional maturation that is characteristic of this stage of human development and that could result in mental health difficulties (Coleman, 2011; Newman & Newman, 2020). This chapter will look into each of these elements. Adolescence will be presented as a transitional period, and the focus will be on presenting an overall look at some of the existing developmental theories. Furthermore, the rationale for the importance of focusing on a friend's disclosure will be presented by explaining that friendship and peer relationships are of particular relevance during this period of development. Finally, this chapter will explore the link between adolescence and mental illness, by presenting evidence on the prevalence of mental health difficulties during adolescence and how these can influence their development and function in many different contexts.

1.1. Adolescence

Adolescence is a continuous process of physical, cognitive, emotional, and social change. This time is characterized by a continuous development of personality, identity, and physical transformation, and has attached to it a highly meaningful social and peer approval (Arnett, 2014; Coleman, 2011). Overall, adolescence is a stage of transition between childhood and adulthood which constitutes an important mark in human development (Coleman, 2011; Jackson & Goossens, 2006; Sullivan, 1953). However, defining age limits for this developmental stage can be challenging (Arnett & Taber, 1994; Sawyer et al., 2018). This a result of the impact of factors like cultural-specific elements, and biological and social patterns that have changed throughout the years.

Sawyer et al. (2018) suggested to consider two main elements in defining boundaries: physical changes and social transition. Physical changes, most notably puberty, usually marks the start of adolescence (Gluckman & Hanson, 2006; Patton & Vinner, 2007). Commonly, a social transition will occur at the end of this developmental stage (e.g., marriage, employment) (Arnett, 2014; Crone & Dahl, 2012). In developed Western countries, such as the United Kingdom, the social transition that marks the end of adolescence has been delayed in recent decades (Jackson & Goossens, 2006). This is a result of a longer financial dependency on parents/carers which delays the transition into adulthood (Arnett, 2000, 2014).

The United Nations Conventions (1989) defined children as any individual under the age of 18 years old. On the other hand, the World Health Organisation (WHO, 2021a), defines adolescence between the ages of 10 and 19 years old. Others go even further and suggest that adolescence can be extended until the twenties (i.e., 24 years old) (Sawyer et al., 2018). This is justified by the social transition characteristic of this stage, where a young person's development is not viewed as fully complete until they reach their twenties. The existence of different models can pose a challenge when developing policies to address challenges during this developmental stage. At the same time, research can also be influenced by this lack of clear definition. This could happen by difficulties in developing relevant age-related measurements and, consequently, problems in interpretation of data.

Notwithstanding the difficulty to present age boundaries to adolescence, most authors and theories propose similar changes and stages which young people go through during this time of human development. In addition to characteristics of these theories already stated previously (e.g., physical changes, and social transitions), others are also established during this period. For example, self-esteem and identity are developed at this stage as a result of the interaction with others (e.g., Erikson, 1983). Additionally, interaction with other systems where the young person acts gain more relevance. For example, if parent-child was the predominant relationship during childhood, during adolescence friendships and peers gain a more predominant role in the individual's life (e.g., Bronfenbrenner, 1987; Sullivan, 1953) and contribute to mutual development.

For the purposes of this thesis, adolescence will be defined in line with authors that suggest this time to be comprised between 10 to 19 years old. However, the studies in this thesis will only focus on a subset of this range. Mainly, the focus of the studies in this thesis will be between 11 and 15 years old.

1.1.1. Theories of Development

Despite some disparity in stage names and age limits, theories of development tend to share the idea that there are three stages (i.e., early adolescence, adolescence, and later adolescence), with each being associated with specific psychosocial difficulties and crisis (Hashmi, 2013). Developmental theories can be classified as biological, psychological, or societal (Newman & Newman, 2020); these provide the opportunity to attribute meaning to different developmental changes and allow for hypotheses about development to be tested, leading to a better understanding of human development (Miller, 2002).

Biological theories, such as Hall's Genetic Psychology Theory (1904), explore the concept of 'storm and stress' believed to be characteristic of adolescence. These theories clarify what physical changes occur throughout this stage, and to what extent these changes influence young people's overall development. Psychological theories include Freud's Psychosexual Stages of Development (Freud et al., 1991), Erikson's Theory of Identity Development (1983), and Piaget's Theory of Cognitive Development (1948). Psychological theories explore the development of psychological concepts such as self-concept, identity, or abstract thinking. These theories view the adolescent as a constant changing living organism adapting to its surroundings. Finally, societal theories explore the role that social and cultural factors have in human development during adolescence. Bronfenbrenner's Ecological Systems Theory (1977) is one such societal theory and is described in detail in the next chapter (see section 2.4) given the importance that it holds for young people's development and when considering what sources of support young people have at their disposal when dealing with symptoms of mental illness.

1.1.2. Contexts of Development: Relevance of the Peer Group

Though the primary contexts of development when considering adolescents are peer group, family, and school (Coleman, 2011; Newman & Newman, 2020), a focal point of this thesis is to assess differences in support seeking by a young person experiencing symptoms of mental illness and when a friend discloses these. Thus, focusing on the relevance of the peer group at this stage of development is of importance when framing the overall aim and possible implications of this research.

A prominent and well-established feature of adolescence is the development of close relationships with peers and the creation of meaningful friendships (Furman & Rose, 2015; Roach, 2019; Sullivan, 1953). Associated with the development of these relationships are questions regarding status, sense of belonging, and peer rejection for young people who are trying to establish and find their place in society (Rubin et al., 2015; Sullivan, 1953). Theoretical perspectives analysing interpersonal relationships established at this stage of development can provide a good framework to better understand the relevance of the former factors in the development of concepts (e.g., identity or personality traits), particularly given that young people tend to associate themselves with peers perceived to possess the same levels of knowledge and social rank (Hartup, 1983).

Sullivan (1953) proposed that adolescents develop meaningful connections that can be considered personal and of a close nature. These are mostly with same-sex peers, and are commonly referred to as ‘best friends’. These relationships play an important role in the construction of the meaning of intimacy and the roles that each individual plays in a society (Brown & Larson, 2009; Collins & Steinberg, 2006; Rose & Rudolph, 2006). These friendships are characterised by reciprocity and commitment, often leading to the learning of shared attitudes and values (Beckmeyer & Weybright, 2016; Rossetti, 2011). Additionally, there is the opportunity of shared social needs to be fulfilled (Sullivan, 1953) while exploration of power dynamics takes place (Buhrmester, 1996). During this stage of development, sharing of personal thoughts and feelings often takes place and allows young people to explore their understanding of the world surrounding them (Rubin et al., 2009). This is of particular importance when considering young people’s disclosure of symptoms of mental illness to their friends.

An inability to develop these close bonds, and furthermore, not adhere to socially imposed norms that dictate language used or even dress code, can lead to a sense of interpersonal loneliness (Schwartz-Mette et al., 2020). Similarly, there is an inherent peer pressure that is present during this stage which can be attributed to a need for belonging which is characteristic of this stage of development (Brown et al., 2008). However, Brown et al. (2008) propose that the pressure exerted by young people’s peers might not be of coercive nature, but rather of a shaping and adaptation nature.

One possible outcome of an inability to develop friendships is peer rejection (Pedersen et al., 2007). Peer rejection and lack of ability to develop peer relationships have been linked with high levels of anxiety (Pedersen et al., 2007; Sullivan, 1953) and depression (Schwartz-Mette & Rose, 2016; Rudolph et al., 2000). Pelkonen et al. (2003) concluded that a lack of friendships at the age of 16 predicted symptoms of depression at the age of 22. Additionally, the lack of friendships has been associated with peer victimisation (Ladd & Troop-Gordon, 2003) and bullying (Tipton-Fisler et al., 2018). These are two of the most prevalent disorders young people report experiencing and will be explored in more depth later on in this chapter (see section 1.2.2).

1.2. Definition of Concepts: Mental Health and Mental Illness

Discussions in the mental health field have raised many questions and different interpretations. This is particularly the case when it comes to the distinction between mental health and mental illness. These are all different concepts but at times seem to be merge into one confusing and overlapping definition (Payton, 2009; Westerhof & Keyes, 2010). This overlapping is partly because some of these concepts have been shown to be associated with each other (Iasiello & Van Agteren, 2020). To this end, prior to moving on, it is necessary to try to bring some clarity about each of these concepts in order to better understand their impact in adolescence.

Mental health has been defined as a state of psychological balance and wellbeing that allows individuals to function in their environment (Bhugra et al., 2013; Galderisi et al., 2015; Keyes, 2005; Westerhof & Keyes, 2010). On the other hand, mental illness has been defined as a psychological discomfort (Horwitz, 2002) that manifests as social, emotional, behavioural, and cognitive distress (Manderscheid et al., 2010). Furthermore, speaking to the overlapping nature of these concepts, there are two main approaches in the literature when it comes to the conceptualisation of mental health and mental illness. The first approach proposes exploring mental health and mental illness as a dichotomy, where an individual is either mentally healthy or mentally ill. To this extent, some authors define mental health by the absence of mental illness (Bhugra et al., 2013).

The second approach puts mental health and mental illness in a spectrum. This means that an individual, throughout their life, fluctuates between these two opposites (i.e., mental illness versus mental health). At any given time, the individual can be attributed with a degree of health or illness depending on where they are in this spectrum (Keyes, 2005; Westerhof & Keyes, 2010). Although this approach suggests that the relationship between mental illness and mental health is better placed on a spectrum, authors have also suggested that lower levels of mental health do not necessarily equates to high levels of mental illness (Iasiello & Van Agteren, 2020; Manwell et al., 2015).

For the purpose of this thesis, there will be different conceptualisations used. In the first instance, poor mental health will be used in Study 1 (further details provided in Chapter 4 section 4.1.2 and Chapter 5 under the Methods). This is due to the exploratory nature of this study and the aim to assess young people's coping strategies when experiencing symptoms related with higher levels of distress. Further ahead, the focus in the two later studies in this thesis will change to mental illness given the introduction of stigma related to mental illness as a variable (see Chapter 6). However, for the purpose of the literature review and presentation of rationale between studies, the thesis will refer to mental illness to provide harmonisation throughout the entire thesis.

1.2.1. Mental Illness During Adolescence

Adolescence is a time when symptoms of mental illness start to develop and symptoms which emerge at this stage can be maintained throughout the life course (Colman et al., 2009; Kessler et al., 2012). Given the important milestones and constant changes reported earlier in this chapter at an emotional, social, and physical level, adolescence is a stage that is prone for the development of a mental health disorder (Blakemore, 2019). Furthermore, the appearance of symptoms of mental illness can hinder young people's development by, for example, negatively affecting the formation of interpersonal relationships like friendships (which the importance for development has been highlighted in the previous section) (Schwartz-Mette et al., 2020). Similarly, experiencing symptoms of mental illness during adolescence is associated with life-long difficulties including reduced financial stability and difficulties finding and keeping jobs (Fletcher, 2010, 2013; Patel et al., 2007; Roza et al., 2003).

Research has shown that mental illness has a significant impact in several areas of a young person's life. Alluding to the social environment a young person is part of, high levels of anxiety have been shown to be associated with adolescents' reports of higher peer rejection (de Lijster et al., 2018; Ranta et al., 2013) and more problems with social relationships (Ladd et al., 2011; Tillfors et al., 2012). Research has also showed that the presence of supportive experiences is associated with lower depression symptoms (Pelkonen et al., 2003), and higher self-esteem (Rubin et al., 2009). This shows that experiencing mental illness during adolescence can result in difficulties in social functioning (Arseneault et al., 2010).

Mental illness is also often associated with factors such as adverse childhood experiences in the family context (Blakemore, 2019). Experiencing symptoms of a mental illness can hinder an adolescent's relationships with family, and consequently, their overall development and growth (Lee et al., 2008). In school, the development of symptoms of mental illness, has been shown to negatively affect young people's school performance (Rahman et al., 2016) and increased academic pressure to perform (Collishaw, 2015). Young people with mental illness are at an increased risk of facing challenges in school, such as low performance or exclusion from learning (Schulte-Körne, 2016).

Further to all of the discussed literature in this section, it is also relevant to highlight that the association between mental illness and the different contexts where the young person develops and acts can be bidirectional (Forbes et al., 2019; Zhang & Mersky, 2022). This means that, for example, difficulties in different systems and areas can also lead to the development of symptoms of mental illness (Lundh et al., 2011; Pardini et al., 2008; Shen et al., 2022). It is not only the case that mental illness will affect the behaviour and interaction of the young person with and within the systems. Thus, this is a highly complex interaction, and this complexity should be carefully considered when evaluating the existing evidence and when researching the impact of mental illness on young people's behaviour and overall function.

Thus, due to the impact of mental illness in the different contexts of action of young people, it is of relevance to explore the ways in which adolescents seek support when dealing with symptoms of mental illness. This will be discussed further ahead when the different sources of support from the various contexts of development of the young person are presented in more detail (see section 6.1. in Chapter 6).

1.2.2. Prevalence of Adolescent Mental Illness in the United Kingdom

WHO (2021b) reports that one in seven adolescents between the ages of 10 to 19 years old experience mental illness. Specifically in England, 17.6% of 11 to 16 years old have been shown to be likely to develop a mental illness (Newlove-Delgado et al., 2021). Furthermore, for adolescents in the same age range, the prevalence of anxiety disorders accounted for between 4% to 5% and depression disorders between 1% and 3% in adolescents (WHO, 2021b). This contrast with previous research showing that worldwide, the prevalence of mental illness in children and adolescents (6 to 18 years old) was 13%, with depression and anxiety disorders reaching 7% and 3% respectively (Polanczyk et al., 2015).

Research indicates that at least 50% of all adult mental illness starts developing during adolescence (Belfer, 2008), with half of individuals that report having a mental illness in adulthood, also reporting experiencing their first symptoms when aged approximately 14 years old (Kessler et al., 2005). By the age of 24, this increases to three quarters of individuals reporting experiencing a mental illness in their lifetime (Kessler et al., 2005). A recent meta-analysis explored the global epidemiological estimates of age at onset for mental illness, concluding that 35% of individuals develop symptoms before the age of 14 (Solmi et al., 2021). The prevalence of onset of mental illness increases with age (18 years old = 48% and 25 years old = 63%), providing further evidence of the need to explore the role of adolescence in mental illness.

In the UK, Green et al. (2005) reported that one in five young people aged 5–16 experience a mental illness. Prevalence rates of mental illness in young people have been increasing for the past several decades (Collishaw et al., 2010; Fink et al., 2015). A recent NHS digital wave looking at mental health of children and young people in England (Newlove-Delgado et al., 2021), concluded that 17.4% of 6 to 16 years old were likely to develop a mental health disorder. Furthermore, 39.2% within this age range, experienced a decline in their mental health when compared to the previous wave in 2017.

Patalay and Gage (2019) used two longitudinal datasets to assess prevalence of mental illness at the age of 14 years old, concluding that there was an increase of 6% of young people reporting mental illness, between 2005 and 2015. In Scotland, there was an increase in odds of young people having a long-standing mental illness between 2003 and 2014 (4-12 years old = 5%, 13-15 years old = 7%, and 16-24 years old = 8%) (Pitchforth et al., 2019).

Inchley et al. (2020) compared data from 1990 and 2018, concluding that 37% of Scottish pupils (11 to 15 years old) reported having low wellbeing highlighting age and gender differences. Scottish girls reported higher levels of low mood (i.e., low wellbeing) (41% versus 33% for boys), with older adolescents (boys and girls) reporting higher levels of depressive moods (i.e., mental illness symptoms) (for boys, an increase from 14% to 29%, and girls, an increase from 14% to 31%). Similarly, older Scottish girls reported the highest increase in perceived stress from 11 to 15 years old (M = 5.5 to M = 7.8, compared to M = 5.7 to M = 6.7 for boys).

Given the age focus of this thesis and the adolescence definition provided earlier in this chapter, it is of use to discuss in more depth the most prevalent disorders in the targeted age range (i.e., 10 to 19 years old, with particular attention given to 11 to 15 years old which end up being the focus on the three studies of this thesis). The most prevalent disorders during adolescence are anxiety and mood related disorders (specifically depression) (Frydenberg, 2019). Solmi et al. (2021) showed that up to 45% of individuals reported experiencing their first anxiety symptoms at the onset age of 14. For the first depression symptoms at this age, the percentage was lower (10 %), but by the age of 18, over a quarter of the individuals (26%) reported their first depression symptoms (Solmi et al., 2021).

When it comes to equality characteristics, such as gender and age, these seem to play a concurrent role in disorder development. Longitudinal data shows that mental illness in boys is most often identified prior to adolescence (Gutman et al., 2015). Boys between the ages of 11- and 12-years old experience higher level of behavioural difficulties when compared with girls (Yoon et al., 2022). However, this prevalence changes as they get older and there is a shift with adolescent girls higher levels of symptomology (Wolpert et al., 2020). Girls are more likely to experience emotional problems like depression (Fink et al., 2015) as well as higher levels of anxiety than boys (Blakemore, 2019) during adolescence. Research has even concluded that the changes during adolescence could be seen as a risk factor for adolescent girls when it comes to developing anxiety-related symptoms (Blakemore, 2019). This difference between girls and boys with regards to maturation might not be due to a lower likelihood of boys experiencing symptoms of mental illness, but due to boys being uncomfortable with, and unable to, disclose as they get older (Chandra & Minkovitz, 2006; Vogel et al., 2011).

Research has also explored the effect of these disorders in young people's development. Adolescents reporting high levels of anxiety are more prone to deviant behaviour, have lower school performance (e.g., Stoep et al., 2002), report higher rejection rates by peers, and lower self-esteem (e.g., Ialongo et al., 1998; Kupersmidt & Coie, 1990; Prinstein & La Greca, 2004). Furthermore, anxiety and depression are disorders that often present as comorbid. Adolescents that experience symptoms of anxiety, have been reported to be more likely to develop depressive disorders (Beesdo-Baunm & Knapee, 2012; Wehry et al., 2015). Comorbidity rates of 31% have been found between anxiety and depression for young people between the ages of 11 and 17 years old (González-Tejera et al., 2005). Studies looking at specific forms of depression and anxiety have reported that 13 to 17 years-old with obsessive-compulsive disorder reported a comorbidity of around 21% with generalized anxiety and 12% with social anxiety disorder (Jones et al., 2018). This suggests that young people are likely to experience multiple mental illness at the same time (Balestrieri et al., 2010).

In conclusion, adolescence is a time when symptoms of mental illness start to develop, particularly depression and anxiety. As such, focusing on how to provide support to young people when experiencing symptoms of this nature during this time of development, could reveal itself to be beneficial to young people's holistic development.

1.2.3. Young People's Understanding and Conceptualisation of Mental Illness

As a result of the increase in prevalence of mental illness in young people previously presented, there has also been an increase in the demand for help from Child and Adolescent Mental Health Services (CAMHS) around the UK (e.g., Crenna-Jennings

& Hutchinson, 2020; Department of Education, 2020; Hagell et al., 2015). Despite the high prevalence of mental illness and increased pressure on CAMHS, children and adolescents report low access rates to these services (McGorry et al., 2013; Reardon, et al., 2017). A recent study in the UK reported that out of 66% of young people (5-19 years old) expressing concerns about mental illness that were in contact with mental health services, only 25% were doing so through a mental health professional (Sadler et al., 2018), with most adolescents resorting to teachers to seek help from a professional (49%).

Not reporting or not recognising, mental illness is one of most prevalent barriers to support seeking (Gulliver et al., 2010). Research exploring how children and young people conceptualise and understand mental illness can aid support seeking and in reducing stigma around help-seeking (Hennessy et al., 2008). The difficulties that adolescents perceive to arise from symptoms of mental illness have also been noted as predictors of access to professional mental health services (Pandiani et al., 2005; Reardon et al., 2017). Adding to this, young people's understanding of what constitutes mental illness (i.e., mental health literacy) also plays a role in reporting and/or recognising mental illness (Hart et al., 2018; Jorm, 2012).

Most young people between 11-12 years old are able to recognise symptoms of depression when presented with a vignette depicting said symptoms (Georgakakou-Koutsonikou et al., 2019). Further evidence shows that when comparing depression and anxiety vignettes, young people perform better in recognising symptoms of depression (82.2% versus 41.4%) (Coles & Coleman, 2010). The ability to recognise symptoms evolves across late childhood: Georgakakou-Koutsonikou et al. (2019) concluded that 11-12 years old are more likely to recognise depression than participants aged 8 and 9 years old.

Mental health literacy can have a direct impact on seeking support (Coles et al., 2016; Georgakakou-Koutsonikou et al., 2019). For example, in their vignette study, Mason et al. (2015) found that young people (14 to 17 years old) were more likely to seek help from an adult for depression than for social phobia. Girls seem to have better levels of mental health literacy than boys (Byrne et al., 2015; Chambers & Murphy, 2011; Coles et al., 2016), and seem more mindful of the pros and cons of each source when assessing the possibilities in providing help to others (Leighton, 2010). Furthermore, having previous experience with mental illness seems to influence their evaluation of the situation and usefulness of the sources (Georgakakou-Koutsonikou et al., 2017), which also shows a higher level of mental health literacy (Leighton, 2010).

1.3. Summary

In conclusion, in this thesis adolescence is defined as the period between 10 and 19 years old when many changes at a social, emotional, and physical level occur. As a transition period, adolescence is also a time when the first symptoms of mental illness start to develop. Both depression and anxiety related symptoms have high prevalence in young people, making these two disorders of particular relevance when exploring support seeking behaviours.

When dealing with symptoms of mental illness, young people have been encouraged to talk about their symptoms with others (Griffiths et al., 2011). This can happen as a result of anti-stigma campaigns (e.g., *See Me* in Scotland) or as a method of starting conversations in their close circle of friends (Griffiths et al., 2011). Similarly, as reported in this chapter, adolescence is a period when friendships gain importance and tend to work as replacements for the parent-child relationship characteristic from the earlier stage of development. Usually, adolescents will choose to talk with their friends or peers when they have concerns about their mental health (Camara et al., 2017; Griffiths et al., 2011) since, as detailed earlier, this is a time marked by growing independence and a disconnection from parents/carers while the importance of friendships is increasing.

Thus, given the detailed high prevalence of mental illness in young people (particularly in the form of depression and anxiety), it is worth exploring how young people respond to their own symptoms of mental illness and when friend discloses symptoms of mental illness to them. The next chapter will delve into the theoretical framework chosen to guide this research and will explore how, through the use of a coping process theory, it is possible to have a better understanding about young people's support seeking behaviours.

Chapter 2- Coping with Mental Illness

To frame the studies in this thesis, different theories were considered. During early stages of the design of the research, specific theories focused on help-seeking process (e.g., Stiffman's et al. (2004) gateway-provider model, Srebnik's et al. (1996) mental health help-seeking pathways) and media-based theories (e.g., Galloway and Meek's (1981) uses and gratifications expectancy theory) were considered and explored as possible frameworks. However, these did not reveal themselves to be suitable to explore all the necessary elements. For example, some of these theories initially explored lacked flexibility for integration of evaluation of sources of support (e.g., trust as a buffer to support seeking). Also, due to the exploratory nature of the first study in this thesis, there was a need to use a theory that allowed for a flexible and complex approach to dealing with symptoms of mental illness.

So, a more complex and flexible theoretical approach to dealing with symptoms of mental illness seemed to be more appropriate as it would provide a better outlook into how young people deal with symptoms of mental illness, particularly when after a disclosure from a friend. Due to the already established application to the mental health context and following this initial scope of existing theorical approaches, the Transactional Theory of Coping seemed to offer the flexibility needed to explore the topic whereas different elements that potentially could influence young people's support seeking to be included in the model.

Adolescents report that experiencing symptoms of mental illness is stressful (Galaif et al., 2003), with higher levels of stress being linked to higher levels of anxiety and depression in young people (Cole et al., 2006; Hankin, 2008; Schmeelk-Cone & Zimmerman, 2003). Thus, it is appropriate that the TTC and its concepts be used as a framework for this thesis since this theory explores the link between stress and coping.

This chapter will explore the theoretical framework used in thesis by describing Lazarus and Folkman's (1984) TTC and demonstrating its applicability to the ways in which young people deal with mental illness. Bronfenbrenner's (1977) Ecological Systems Theory will also be explored to provide a better insight on the resources available to young people when asking for support. Finally, these two theories will be considered together to frame support seeking behaviours of young people dealing with their own, or with a friend's, symptoms of mental illness.

2.1. What is Stress?

The TTC explores how an individual deals with stressful demands (Lazarus & Folkman, 1984). Thus, initially it is relevant to understand what can constitute stress in a young person's life and how this perception of stress impacts their overall support seeking when dealing with either their own, or with a friend's, symptoms of mental illness. Since its inception, the term stress has been applied to different subjects and has been given different definitions. Authors started by using it in engineering and physical sciences and included concepts like load, strain, and stress, to describe how a structure could withstand usage and the demands of the environment (Lazarus, 1999; Lazarus & Folkman, 1984).

In the early 1950's, Selye (1950, cited in Lazarus & Folkman, 1984) started to include the term stress within the psychological sciences. Mason (1975) provided further insight into what constitutes stress and how psychology defines this concept by highlighting that the term stress can be used in three different ways: strain, stressor, and transaction. By thinking of stress as a strain, the emphasis is on physiological and emotional responses to adverse encounters faced by the individual (Pearlin & Schooler, 1978). For example, sympathetic nervous system reactions that lead the individual to be in high alert (Aldwin, 2007). As a stressor, stress can be attributed to issues related to what types of stress individuals are exposed to (e.g., daily hassles, symptoms of mental illness, academic performance) or even about the duration of these events (Aldwin, 2007; Mason, 1975). Research has concluded that prolonged exposed to a specific stressor can lead to higher perceived stress (Lazarus & Folkman, 1984). Finally, as a transaction, stress is defined as the combination of cognitive efforts and the intensity that the individual perceives to be upon the stressful event (Aldwin, 2007; Lazarus & Folkman, 1984; Mason, 1975). This transactional form of stress is the one being explored in this thesis.

Historically, psychology has defined stress as being a stimulus that enlists a response from the individual (Lazarus & Folkman, 1984) and the stimulus can arise within the person or the environment. Lazarus and Folkman (1984) provided a clear definition of psychological stress stating that this is "*a particular relationship between person and environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being*" (p.19). In other words, stress is a consequence of a perceived imbalance between the demands of the environment and a person's capability to cope with the situation. This definition is in line with the proposition, central to many stress models, that environmental factors play a significant role in people's mental health. At the same time, individual characteristics (e.g., gender, age), circumstances (e.g., socio-economic status), and experiences (e.g., traumatic events) are also important to understand how stress unfolds (Aldwin, 2007).

2.2. What is Coping?

Linked to stress is the way individuals deal with it, that is, their use of coping strategies. Thus, exploring what coping is, and how it is defined within the psychological literature, is relevant to better understand its relationship to support seeking. Scholars have stated that there is a need to go beyond stress and its effects, and also focus on coping and the capability one holds to adapt to a situation by responding to the stress (e.g., Cheng et al., 2014; Lazarus & Folkman, 1984). Lazarus and Folkman (1984) concluded that the way individuals cope and respond to stress can have a great impact in their overall wellbeing.

The term coping originated from research with animals by initially exploring how these survived elements in their environment that were considered harmful (Lazarus & Folkman, 1984). As theorists expanded their knowledge about stress and coping, so did its applications, with Lazarus (1993) defining coping as a response to *"ongoing cognitive and behavioural efforts to manage specific external and/ or internal demands that are appraised as taxing or exceeding the resources of the person"* (p. 237). Looking into this definition closely, there are different elements that stand out. Firstly, coping is process-oriented, with Lazarus (1993) and Folkman et al. (1986) framing it as situation-specific and relating to the person's assessment of what is the best option at that moment. Secondly, coping can also be contextual and dependent on a person's appraisal of their environment and what is available to aid with overcoming the stressful event, suggesting a level of variability between individuals that is important to consider (Folkman et al., 1986). As a result, coping strategies that are effective for some individuals might not be for others since coping strategies and outcomes are two separate elements of the coping process, allowing for individual differences to manifest (Lazarus & Folkman, 1984). Finally, this definition does not make any assessments about the outcome of the coping; irrespective of being successful or not, the act of engaging in efforts to manage stress is considered coping (Folkman et al., 1986).

Lazarus and Folkman (1984) stated that coping actions can be learned and are flexible, implying a level of adjustment and adaptability to the circumstances. Coping strategies used by people can change according to their own experience and their assessment of helpfulness in any given moment. Specifically for adolescents, and due to maturation and development, different strategies and knowledge about their own coping capacities and efforts might lead them to improve their coping competencies for specific problems for previously deemed difficult or impossible situations (Hampel & Petermann, 2005, 2006; Horwitz et al., 2011; Seiffge-Krenke, 2000). As a result, a person’s portfolio increases, and so do their capabilities to respond to stress (Bohanno & Burton, 2013; Cheng et al., 2014). Figure 2.1 describes four main theoretical approaches to coping and these approaches highlight the evolution of coping as a concept and its connection to the person and environment (Aldwin, 2007).

Figure 2.1

Theoretical approaches to Coping.

Figure 1a: Person-based approach

Figure 1b: Situation-based approach

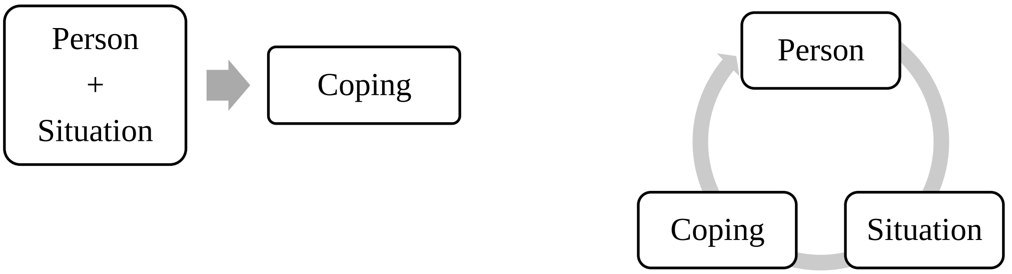


Figure 1c: Interactionist approach

Figure 1d: Transactional approach

Figure 2.1a focuses on the Person-based approach, a unidirectional relationship from the person to the coping strategy premised on personality being the key component that influences coping behaviours (Aldwin, 2007). The Situation-based approach (Figure 2.1b) proposes that the environment where the stressful event occurs determines the strategy used to cope. For example, strategies used by a young person dealing with stress from their own symptoms of mental illness may vary from how they deal with stress caused by school-related activities (e.g., class test).

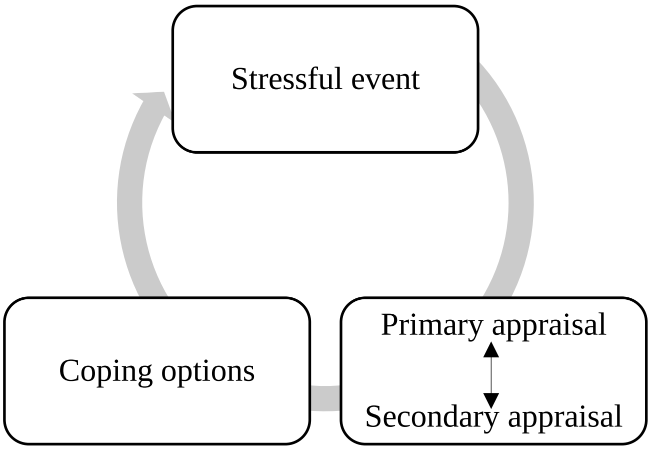
Figure 2.1c starts to show the evolution of the coping approaches where it was assumed that there was some sort of interaction between person and situation and this would lead to a choice of coping. Interactionist approaches can also be referred to as cognitive approaches where an appraisal of the situation is key to the coping process to develop, while at the same time accounting for each individuals' singularity (Aldwin, 2007). Cognitive theories are the foundation for the type of approach used in this thesis: the Transactional approach (Figure 2.1d). This approach is the one that has been most widely accepted within the psychology literature, where person, situation, and coping mutually-influence each other, making this a complex and dynamic process. In this approach, coping responses are impacted by many different factors such as social interactions, personality traits, cultural context, and personal experiences (Compas, 2009; Skinner & Zimmer-Gembeck, 2009; Zimmer-Gembeck & Skinner, 2010).

2.3. Theory of Transactional Coping (TTC; Lazarus & Folkman, 1984)

The TTC proposes that multiple factors play a role during coping, making it a highly dynamic and complex process, with coping constantly changing over time, and being both situation and person specific (Lazarus & Folkman, 1984). As stated earlier, this is a cyclical process where the different components influence each other. Figure 2.2 illustrates a simplified diagram of the theory proposed by Lazarus and Folkman (1984), depicting both cognitive appraisals and coping options.

Figure 2.2

Theory of Transactional Coping (Lazarus & Folkman, 1984).



2.3.1. Cognitive Appraisals

Lazarus and Folkman (1984) defined cognitive appraisals as a person’s evaluation of if and how a particular encounter with the environment is relevant to their wellbeing. Lazarus and Launier (1978) define appraisals as constantly changing and resulting from the implications a particular event has for the person’s wellbeing, with primary and secondary being the main types of cognitive appraisals.

Primary Appraisals.

Lazarus and Launier (1978) proposed three categories. The first category is ‘irrelevant’ which pertains to a person not considering that an event will have any impact on their own wellbeing. Secondly, ‘benign-positive’ refers to the assessment people make when an event has an anticipated positive outcome. Thirdly, ‘harmful’ or, more commonly, referred to as stress appraisals. This last category itself encompasses three appraisals: harm/loss, threat, and challenge (Lazarus & Folkman, 1984)

A harm/loss appraisal entails injury or damage occurring as a result of the stressful situation; an appraisal of threat corresponds to when there is potential for physical or emotional harm to occur; and finally, an event is perceived as challenging where there is space for growth and mastery (Folkman, 1984; Lazarus & Folkman, 1984; Lazarus &

Launier, 1978). These appraisals are not mutually exclusive (Lazarus, 1999). For example, when considering the temporal aspect of appraisals, a harm/loss appraisal is associated with damage or injury that happened in the past. Thus, this is likely to have been preceded by an appraisal of threat, which often relates to future outcomes of a stressful event. On the other hand, appraisals can vary and depend on the individual, manifesting differently when responding to the same stressful situation (Lazarus & Launier, 1978). For example, when a young person is experiencing symptoms of depression, they might feel threatened, but, as a result of personal experiences, an appraisal of challenge might be reported by a different adolescent experiencing similar symptoms (Hunter & Boyle, 2004). As for threat, challenge is also linked with future expectations.

The association between stress and emotion (Lazarus, 1999), and particularly, its link to appraisals of threat and challenge, has also been explored as stressful events generate emotions (Lazarus, 1999; Lazarus & Folkman, 1984). Threat appraisals are reported to be mainly associated with negative emotions (e.g., sadness), and challenge is associated with positive feelings (e.g., mastery) (Lazarus, 1999; Lazarus & Folkman, 1984). These links will be explored later. In a later subsection (see section 2.5.), evidence concerning the ways in which symptoms of mental illness are often related to negative emotions (e.g., Fosco & Lydon-Staley, 2019; Gidron, 2013) will also be presented.

Lazarus (1991, 1999) suggested three components of primary appraisals. First is goal relevance, which entails an assessment by the individual on the extent to which an event is affects their personal goals and what it is personally at stake. There is a clear link between goal relevance and emotion: if there is no goal relevance the individual will not experience any emotion resulting from the stressful event. Second is goal congruence, which is defined by the perception that a stressful transaction between person and environment will aid an individual achieve their goals. Congruency is often associated with positive emotions, since the individual believes their personal aspirations will be upheld. In contrast, incongruency is often linked to negative emotions due to the threat to one's goals. The third and final component is type of ego involvement and relates to the perception of how stressful events threaten the person's ego identity, such as their self-esteem, or another person's wellbeing. This component is related to both positive and negative emotions because it depends on the perception of what is at stake for the individual and their goal congruency or incongruency.

Research with young people has associated negative primary appraisals (i.e., threat and harm/loss) with negative life events (Fosco & Lydon-Staley, 2019; Lengua & Long, 2002) and specifically with symptoms of mental illness (Cole et al., 2019; Ellis et al., 2009). For example, higher levels of depression were associated with higher threat levels (Folkman & Lazarus, 1986; Mak et al., 2004). Similar patterns have been found in research with adolescents with anxiety (i.e., higher levels of anxiety are associated with higher levels of threat) (e.g., Gidron, 2013; Vallance & Garralda, 2008).

Attribution of appraisals can be affected by gender and age. Girls are more likely than boys to report a situation as threatening (Felton et al., 2017; Mak et al., 2004; Zimmer-Gembeck et al., 2009) and are more likely to perceive a situation as stressful and severe (Felton et al., 2017; Merikangas et al., 2010; Frydenberg & Lewis, 1994; Raviv et al., 2009). An individual's levels of perceived stress associated with specific situations increase with age (i.e., older adolescents reporting higher levels of perceived stress) (Felton et al., 2017). On the other hand, Sillars and Davis (2018) examined appraisals across four age groups. They concluded that young adults (17 to 26 years old) were more likely to make challenge appraisals when compared with the other three age groups (i.e., 3–5 years, 6–8 years, and 9–11 years). Likewise, threat appraisals have been shown to decrease from childhood to adolescence (Richmond & Stocker, 2007).

Secondary Appraisals.

Secondary appraisals are an individual's evaluations of the resources available to them and to what extent these can be used to deal with a stressful event (Lazarus & Folkman, 1984). Despite their names, primary and secondary appraisals can occur simultaneously and are likely to influence each other (Frydenberg, 2019; Lazarus, 1999). For example, a young person is more likely to find an event threatening if they do not identify any available resource to help them. Overall, the appraisal process is where differences in coping may start to emerge. As part of this process, an individual assesses the stressful situation, their skills, and their resources in order to achieve an optimal outcome (i.e., to overcome the stressful situation).

Lazarus (1991a, 1999) proposed that secondary appraisals involve three main components: blame or credit, coping potential, and future expectations. Blame or credit involve attributions of responsibility for the stressful event. Coping potential represents the assessment a person makes on their ability to manage the strain from the environment. This differs from actual coping behaviours and is instead the perception they have of their capability to change (or not change) their current relationship with the environment. Finally, future expectancy refers to the beliefs that people might hold about their goals changing. This is closely related to goal congruency where changes in psychological development can be associated with less goal congruency.

Here we begin to see how primary and secondary appraisals interact with each other during the coping process. This relationship can be characterised as interdependent (Lazarus, 1999; Lazarus & Folkman, 1984). If a young person experiencing symptoms of mental illness perceives that they have the support necessary to deal with their symptoms, it is likely that appraisals of threat will not occur. In this scenario, it is more likely that perhaps an appraisal of challenge would be present as a result. Finally, when thinking about the interdependency of primary and secondary appraisals, the direction of the primary appraisal could also have an effect on secondary appraisals (Lazarus, 1991a, 1999). Specifically, due to the cyclical nature of the coping process, even though harm/loss appraisals relate to past experiences, these can still impact present coping attempts. This is due to the future expectancy component of secondary appraisals described previously. For example, a person that had a previous experience that was appraised as harm/loss, if faced with it again in the present or future, will more likely appraise it as threatening as a consequence of the previous experience.

Coping is complex and situation-oriented, as such, variability is likely to occur. One element shown to play a role in young people's selection of coping strategies is self-efficacy (Bandura, 1997). A person's perception of their ability to deal with the stressful situation can impact their choice of strategy or even their assessment of need of help (Lazarus, 1991b). Considering the TTC, self-efficacy levels can be seen as a secondary appraisal. If a young person believes that they are well equipped to deal with symptoms of mental illness, then they are less likely to ask for support and more likely to try to cope independently. Existent gender differences for example, might help explain this influence. Adolescent boys report higher levels of perceived competence in general, which in turn is related to a greater self-confidence when seeking support from different sources of help (Raviv et al., 2000). Also, as a result of this greater perceived competence, boys might consider themselves more able to deal with issues on their own than girls.

Also important in the coping process is resource availability during a stressful situation. The assessment of resources' availability and ways of seeking support are examples of secondary appraisals (Lazarus & Folkman, 1984). During secondary appraisal, young people will consider the resources available to them and will evaluate how helpful they believe those to be (Fortune et al., 2008; Mak et al., 2004; Thompson et al., 2014; Rowe et al., 2014). There is a clear distinction between formal (e.g., mental health professionals) and informal (e.g., parents/carers, friends) sources when considering mental health support seeking behaviours, and young people more often disclose their symptoms to parents/carers and friends than to professionals (Camara et al., 2017; Rickwood et al., 2007). Adolescent's report feeling that they can trust informal sources more than formal sources, and the possibility that confidentiality will be breached in a professional setting is one of the main reported barriers when considering professional help (Leavey et al., 2011). However, the possible effect of resources in support seeking will be discussed later in this thesis when literature pertaining to the effects of trust is presented (see Chapter 6 section 6.2.3).

2.3.2. Coping Options

Lazarus and Folkman (1984) started by proposing two overarching coping categories within the TTC: problem-focused (i.e., efforts directed to solving the stressful situation), and emotion-focused (i.e., efforts linked with regulating the emotional outcomes resulting from the distress). Different distinctions between coping strategies have been proposed over the years (Compas et al., 2001; Folkman & Moskowitz, 2004; Skinner et al., 2003), with these multiple categorisations emerging from empirical work and criticism posed to the initial problem- and emotion-focused dichotomy. For example, to cope with a stressful event, people might cope using strategies associated with both categories (Folkman & Moskowitz, 2004), and not all coping strategies can be included in these two categories with multiple strategies also fitting in both types (Carver & Vargas, 2011). An example of this is social support, where support is sought from others to either ease the emotional effects of the distress or to help to solve the situation.

Other potential overarching categories were proposed attempting to better encompass coping options. Skinner et al. (2003) stated that given the multilevel and multidimensional nature of coping, lower-order coping efforts are nested within higher-order coping categories. Table 2.1 provides a brief summary of some of the proposed higher-order categories of coping explored throughout the years in the literature, with definitions of each of the categories, examples of proposed coping efforts associated with each of them. A main take-home message here is that the same coping efforts can be included in more than one categorisation.

Table 2.1

Non-exhaustive summary of higher-order categories of coping.

Categorisation	Definition	Example of coping efforts
1. Problem-focused vs 2. Emotion-focused	Problem-focused are efforts that deal directly with the cause of the stress. Emotion-focused coping entails on regulating the emotion resulting from the distress (Lazarus & Folkman, 1984)	1. Seeking information, generate solutions. 2. Seeking emotional support, relaxation, wishful thinking.
1. Approach vs 2. Avoidant	Efforts that are directed toward (i.e., approach) or away from the threat (i.e., avoidant) (Roth & Cohen, 1986).	1. Seek understanding, problem solving. 2. Withdrawal, denial.
1. Productive vs 2. Non-productive	Strategies that aid in the reduction of stress versus strategies that might not change or increase the stress level (Frydenberg & Lewis, 1994)	1. Solving a problem, relaxation, physical recreation. 2. Worry, wishful thinking, self-blame.
1. Maladaptive vs 2. Adaptative	Maladaptive strategies are efforts that increase stress. Adaptative strategies are efforts that reduce stress (Garnefski et al., 2009)	1. Anger, aggression, disruptive behaviours, acting out, rumination 2. Problem solving, social support.

Consideration should also be given to the level of efficacy and frequency with the use of any given strategy (Aldwin, 2007; Frydenberg & Lewis, 2009a, 2009b). A young person might choose a particular strategy multiple times, however its level of efficacy may vary according to the problem experienced. As such, coping options tend to vary throughout life as a result of, for example, experience and maturation. Furthermore, distinctions between ‘good’ versus ‘bad’ coping have been reported in the literature (Aldwin, 2007). Research has considered how young people perceive strategies they used and their helpfulness (Dewa et al., 2021; Frydenberg et al., 2009; Higgins et al., 2005). However, this debate has faced some criticism mainly because most definitions of coping include efforts to manage stressful demands, regardless of the outcome. This means that no single strategy is considered inherently better than any other. The efficacy of one strategy is determined only by its effects in each encounter and its long-term effects (Lazarus & Folkman, 1984). For example, to deal with the stress caused by an argument, it might be a suitable strategy to avoid and walk away from the situation. However, avoidance might not be suitable if a person is dealing with a life-threating illness.

Mainly the dichotomy initially suggested by Lazarus and Folkman (1984), is of relevance given that evidence suggests that adolescents use a variety of strategies to deal with mental illness that can be associated with either problem- or emotion-focused coping (Compas et al., 1988). When comparing to emotion-focused coping, research has highlighted the beneficial role that problem-focused coping strategies (such as, solving the problem) has on a young person’s life (Rabenu et al., 2017). Overall, evidence points to the positive effect of the use of problem-focused strategies being related to better academic performance (Meneghel et al., 2019), wellbeing (Chen, 2016), and less emotional-related problems (such as the development of symptoms of mental illness) (Breton et al., 2015).

Overall, problem-focused strategies have been related with lower internalisation issues and higher externalisation outcomes (Compas et al., 1988; Penley et al., 2002). For depression in adolescents, higher levels of symptomology have been associated with more use of emotion-focused strategies (Breton et al., 2015; Cairns et al., 2014; Evans et al., 2015), and the use of problem-focused strategies has been associated with lower levels of symptoms of depression (Cong et al., 2019; Li et al., 2006; Horwitz et al., 2018). Similar patterns have been reported for adolescents experiencing symptoms related to anxiety. For example, a recent study exploring the effects of the pandemic related school closures and lockdown on young people anxiety and depression levels, showed a positive correlation between anxiety symptoms and emotion-focused coping strategies used by the adolescents, and a negative correlation between anxiety symptoms and problem-focused coping (Duan et al., 2020).

As stated earlier, a combination of different types of coping strategies is likely to occur when acting to reduce stress. Combining strategies is more likely to happen in older adolescents as a result of maturation and previous experiences (Compas et al., 1988; Renk & Creasey, 2003). For example, older adolescents might simultaneously confide in a friend to deal with the emotional distress caused by their symptoms (i.e., emotion-focused coping) and search for information on how to deal with the symptoms they are experiencing (i.e., problem-focused coping). Emotion-focused coping gains more prevalence as adolescents grow older (Compas et al., 1988). As they mature, young people learn new skills and strategies that help them to overcome stressful events, which in turn broadens the range of strategies that they have to choose from (Galaif et al., 2003). Gender differences when selecting coping strategies to deal with mental illness have also been studied (Frydenberg, 2017), indicating that girls use more emotional support to deal with the distress caused by symptoms of mental illness (Frydenberg & Lewis, 2000; Frydenberg, 2019). Brytek-Matera (2007) concluded that this is possibly due to their higher level of maturity when it comes to managing their emotions.

It has also been shown that boys report distress less frequently (Seiffge-Krenke et al., 2009) and this could be due to a gender difference when it comes to coping strategies being used. Research has concluded that boys are more likely to use strategies such as avoidance, ignoring the distress, or physical activity (Plenty et al., 2014; Seiffge-Krenke, 2000). This contrasts with what was reported before where girls are more likely to use social support from friends and family (Frydenberg, 2019).

2.4. Ecological Systems Theory (Bronfenbrenner, 1979)

In order to better understand human development, scholars have explored how an ecology of systems might explain how people develop and interact with their context and surrounding environment. Thus, it has been proposed that both the Ecological Systems Theory (Bronfenbrenner, 1979) and TTC (Lazarus & Folkman, 1984) could be used together in order to better understand coping in general (Frydenberg, 2017). This is because, as described previously, coping seldom happens in a vacuum. As context matters, the Ecological Systems Theory (Bronfenbrenner, 1979) provides a relevant explanation regarding human development in line with context and surrounding systems.

Rosa and Tudge (2013) offered a three-phase timeline for the development of Bronfenbrenner’s thinking on human development. Phase 1 (1973-1979) focused on the ecological approach, where Bronfenbrenner (1979) proposed the existence of four ecological systems: 1. Microsystem; 2. Mesosystem; 3. Exosystem; and 4. Macrosystem. Bronfenbrenner (1979) proposed that the environment should be looked at as more than just the behaviours of an individual but instead as the result of the interaction between the different systems. Definitions for each of these systems are presented next.

Phase 2 (1980-1993) explored the addition of biological and time components to the model (Rosa & Tudge, 2013). Human development is a result of the interaction between the environment and the individual’s biological and psychological characteristics (Bronfenbrenner

& Ceci, 1994). During the introduction of biological influences in this human development model, Bronfenbrenner focused most of his attention on the outcomes of reciprocal face-to-face interactions with others within the different systems (also known as proximal processes). Rosa and Tudge (2013) stated that proximal processes like interactions between parent/carer and child (e.g., reading to the child) are one of the strongest predictors of human development. The introduction of time as a relevant element for human development permitted Bronfenbrenner to also consider maturational differences that occur as young people grow (Bronfenbrenner, 1986). At the same time, these changes occur in the environment and systems themselves. This addition was designated as chronosystem by Bronfenbrenner (1986).

In the third and final phase (1994-2006), Bronfenbrenner (2005) further developed his understanding of the proximal process by proposing the ‘Process-Person-Context-Time’ (PPCT) model. As with the TTC, Bronfenbrenner (1979) saw the relationship between individuals and their environments as reciprocal and bidirectional in that individuals are both influenced by, and influence, their environment. In this later model, ‘Process’ corresponds to the recurrent interaction between a person, their environment, and others. ‘Person’ relates to the role that individual characteristics play in proximal processes. The ecological systems the person is part of are refer to as ‘Context’. These are interrelated and mutually influenced. Finally, ‘Time’ is the effect of the passage of time on each of the systems, and therefore, the impact on a person’s development.

2.4.1. From the microsystem to the macrosystem

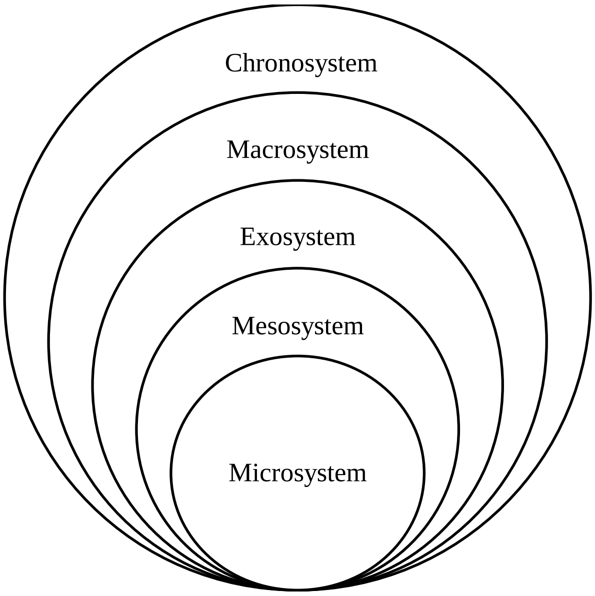
Figure 2.3 shows the five systems that are part of the Ecological Systems Theory, representing the notion that each system encompasses another which result from the interaction between all the active elements within these systems. Next, a detailed exposition of each of these systems is provided.

Microsystem.

The microsystem is the immediate setting where the young person interacts and develops. This includes their home, school, and other environments where interactions of a social nature take place on a regular basis and the young person develops as a result of this (Bronfenbrenner, 1979). The microsystem contains both settings and roles, with settings being physical spaces where the interactions occur, and roles are what is attributed to each element that composes a setting (Bronfenbrenner, 1977, 1979). For example, at school (i.e., setting) a young person interacts and establishes relationships with their peer and friends (i.e., roles). Also, in the home environment (i.e., setting) the young person interacts with parents/carers, siblings, etc. (i.e., roles).

Figure 2.3

Ecological Systems Theory (Bronfenbrenner, 1986).



Mesosystem.

The mesosystem is defined by the relationships between the different microsystem settings (Bronfenbrenner, 1979). For example, a young person’s mesosystem will be composed by the interactions between family and school, or their family and their peer group. Bronfenbrenner (1979) has further defined the mesosystem as “a system of microsystems” (pp. 25).

Exosystem.

As displayed in Figure 2.3, the exosystem encompasses both the micro and mesosystems. This system is composed of different settings in which the young person is not directly involved in, but which can nonetheless affect their development (Bronfenbrenner, 1979). For example, a parent/carer's place of work could result in a change of mood in a parent/carer, in turn impacting the parent-child relationship.

Macrosystem.

Finally, the macrosystem is considered to be the overarching system that has within it all the other three systems. This particular system is associated with elements like cultural beliefs and values held by society, political systems, for example (Bronfenbrenner, 1979). While the other three systems can be linked to specific settings and roles, the macrosystem mainly informs on the implicit and explicit effects that the societal structures have on human development. This means that ideology, cultural beliefs, and even for example socioeconomic characteristics are considered to play a role in human development (Bronfenbrenner, 1978).

Chronosystem.

For the purposes of this thesis, the chronosystem is not as relevant as the other four, however it is still of relevance to define and explain its importance in a person's development. Chronosystem refers to the effect that time has on human development (Bronfenbrenner, 2005). The passage of time can be of a personal nature, if one considers physical and psychological maturation characteristic of development. Moreover, time can result in changes in the environment itself (Bronfenbrenner, 2005). For example, a parent/carer's change in employment status can lead to a need to readjust to a new normal by the child.

2.5. Transactional Theory of Coping and Ecological Systems Theory as a Framework for Understanding How Adolescents Deal with Their Own, or a Friend's, Symptoms of Mental Illness

It is proposed in this thesis that young people exposed to symptoms of mental illness, whether their own or those of a friend, will perceived this as a stressful situation (Galaif et al., 2003). As a result, they will need to, conscious or unconsciously, assess if their wellbeing is at stake (i.e., make a primary appraisal) and whether or not they have the resources they need to overcome this stressful encounter (i.e., make a secondary appraisal) (Lazarus & Folkman, 1984). These appraisals will than influence the coping response (Lazarus, 1991a; Lazarus & Folkman, 1984). By considering each of the first four systems proposed by Bronfenbrenner, in conjunction with the TTC, a nuanced understanding of the coping process might be possible. As both these theories propose that there is a recurrent bidirectional relationship between the person and the environment, different individual circumstances as suggested in the Ecological System Theory can lead to differences in choice of coping strategies.

Bronfenbrenner's (1978) model provides a good framework in understanding what factors can positively or negatively influence the development of symptoms of mental illness (e.g., Aston 2014; Pilgrim & Blum 2012), and in understanding how young people select their resources when coping. The model posits that the young person exists in both social and individual domains and, as such, each of these domains could possibly contain relevant resources and attributes that can aid or hinder young people's coping strategies. Eriksson et al. (2018) explored how the different concepts of Bronfenbrenner's theory were applied to mental health research. They concluded that existing research is mostly divided into either studies that focus on interaction between systems or research that does not consider the effects of this interaction. One strength of the former is the ability to specifically highlight risk and protective factors in the development of mental illness for each of the systems.

In this thesis, the focus is on four out of the five ecological systems. The microsystem level resources explored in this thesis are parents/carers, friends, teachers, and online interactions. The reasons for this will be detailed in the subsequent paragraphs (e.g., preference for disclosure to friends). Similarly, research has also highlighted the parental role in supporting adolescents experiencing symptoms of mental illness (Sears, 2020), though this association changes with age and as young people start to develop their own sense of autonomy (Boulter & Rickwood, 2013; Sears, 2020). Despite being in one of the most immediate settings of a young person's life, teachers and school staff are often not considered by young people when dealing with symptoms of mental illness (Berger, 2015; Jobe & Gorin, 2013) for different reasons (e.g., lack of trust, confidentiality). Finally, online interactions are also included as a representation of the microsystem since evidence indicates that online interactions are now central in adolescents' everyday life (Horgan & Sweeney, 2010; Houghton et al., 2015).

The TTC and the Ecological Systems Theory converge in the secondary appraisals being directly affected by the mesosystem. If we consider the mesosystem a result of the interaction between microsystem settings, and a secondary appraisal an assessment by the young person on how to cope with a stressful situation, this implies that a secondary appraisal is influenced by the interactions between microsystem settings. For example, young people might think that they cannot trust their teachers to keep their symptoms private if they believe that school professionals report back to parents/carers about the wellbeing of their child. If this were true, children might be less likely to disclose any symptoms of mental illness to teachers or school staff.

One additional relevant source of support is professional support seeking. Considering the ecological systems, professionals are likely to be included in the exosystem since it encompasses settings which young people might not be in direct contact with but which nonetheless affect them (Bronfenbrenner, 1978). Reasons for the lack of engagement with support seeking from professionals by young people will be discussed further ahead in this thesis. Lack of mental health literacy to understand the severity of the symptoms (Kelly & Jorm, 2006), lack of confidentiality, and consequently, lack of trust (Leavey et al., 2011; Verhaeghe & Bracke, 2011), will be some of the elements discussed. Finally, the macrosystem is included not as a resource per se, but as result of what societal beliefs about mental illness are. In this, the role of mental illness stigma as a deterrent from seeking professional support, for example, has been studied (Klineberg et al., 2013). Thus, the macrosystem is considered in this thesis as a way to have a better overall understanding of how each of the four contexts affect young people's support seeking behaviours.

After the appraisal process is complete, young people select what coping strategy (or strategies) to use based on what they believe will bring them the best results (Lazarus & Launier, 1978). In this thesis, the focus will be on two overarching forms of coping: dealing with the problem (i.e., problem-focused) and seeking to change the negative emotions resulting from the exposure to the stressful event (i.e., emotion-focused). So, forms of problem-focused coping can include young people searching for information about their symptoms, with emotion-focused coping including seeking emotional support in order to vent one's feelings. Although there is no current literature consensus on how to define each of these activities, one must create a distinction between them, since there is evidence that suggests that adolescents may gravitate towards one type of content to the detriment of the other (Rickwood et al., 2015).

When considering Bronfenbrenner's (1978) model, research has concluded that young people are more likely to disclose and talk about their symptoms within their microsystem, mainly with their friends and as a result of high trust levels (e.g., Camara et al., 2017). At the same time, young people are encouraged by adults to talk with someone about symptoms of mental illness in order to cope with, and ultimately overcome, any such difficulties (Griffiths et al., 2011). Likewise, mental health campaigns reinforce the idea that disclosure to others is important, helpful and appropriate. For example, several UK-based organisations provide online guidance for young people which advises them to talk about their symptoms with a friend (Mental Health Foundation, 2021; Mind, 2017; Young Minds, 2021a). This is part of a larger investment in stigma reduction. Nonetheless, this raises the question: how do young people cope with a friend's disclosure and what type of coping strategies do they use in order to deal with this potentially stressful event?

Considering the TTC, primary appraisal could be the moment where differences between chosen strategies for oneself and the ones that are chosen to help others start to appear (Folkman et al., 1986). It is possible that young people might apply different coping strategies when they are the ones experiencing symptoms from when it is a friend experiencing those symptoms (Raviv et al., 2000). Research has supported this by showing that young people are more likely to seek professional support for a friend than for themselves, even if they experiencing the same symptoms (Raviv et al., 2009; Rickwood et al., 2005). The reasons why are still unclear, however factors like the ones mentioned before (i.e., self-efficacy, support network, availability of resources) are thought to play a role in these decisions (Salaheddin & Mason, 2016; Wilson & Deane, 2001).

2.6. Summary

In sum, this chapter has shown how both the TTC and Ecological Systems Theory can be used to better understand the coping process in seeking support for mental illness, and it is argued that combining both of theories will aid in a more rounded understanding of this process. Thus, this thesis aims to use both these theories to achieve this goal and applies them in two different contexts: first, when the young person experiences symptoms of mental illness and, second, when a friend discloses symptoms of mental illness. Most of the research regarding coping with mental illness has looked into it from the perspective of young people experiencing the symptoms themselves. However, there is an argument to be made that when young people are encouraged to disclose and talk about their symptoms, attention needs to be paid to the outcomes of these disclosures and the effects on the young person who receives these disclosures. Research in this area is scarce (Cogan et al., 2005), and this thesis aims to address some of these questions.

Moreover, the overall premise for the self versus friend symptoms investigation in this thesis relates to the inherent variability of the coping process (Frydenberg & Lewis, 1994). Young people respond differently in their own daily lives to stresses and stimuli due to differences in-person and situational characteristics. The same thought process can be applied when thinking about young people dealing with a friend’s disclosure of symptoms of mental illness. It is plausible to think that there might be differences across both situations. Young people might not make the same appraisals with regards to a friend’s disclosure of symptomatology that they do for their own symptoms. Similarly, it is still unclear what coping strategies young people select when dealing with a friend’s symptoms of mental illness. Thus, through a qualitative methodology, Study 1 aims to explore how applicable the TTC concepts are to experiencing stress through a friend’s disclosure, while also exploring existing differences and similarities in appraisals and coping strategies selected for both situations.

Chapter 3- General Methodology

As this thesis is publication based, there will not be an overall methodology chapter. Instead, the methodology is communicated in three discrete sections within the thesis. This organisation was chosen to better emphasise the progression and influence that each study had on the next one. The current chapter will explore the general elements common to the three studies in this thesis, discussing the open science practices adopted before addressing the use of a mixed methods approach alongside the advantages and disadvantages of this and how the researchers' positionality affected the entire research process. Lastly, the ethical elements at play when conducting research with young people and the recruitment strategy used will be detailed.

The present thesis comprises three studies using different methodologies: one qualitative (i.e., Study 1), and two quantitative (i.e., Study 2 and 3). Table 3.1 provides a brief overview of each of the studies.

There will be two further chapters that will describe specific methodological questions and elements that pertain to each of the studies conducted as part of this thesis. Specifically, Chapter 4 will consider additional specifics of the qualitative study conducted in this thesis, while the methodology used in Study 2 will be described on Chapter 7. Finally, Study's 3 methodology will be presented in Chapter 9, alongside the report of that study, since that study is *not* reported in the format of a manuscript for submission to a peer-reviewed journal.

Table 3.1

General overview of studies within the thesis.

Chapter	Study	Description	Analytical approach	Sample
5	Study 1: Qualitative study (interviews)	Aimed to understand how young people cope with their own or a friend's symptoms of poor mental health.	Thematic Analysis	11 young people aged 13 to 15
8	Study 2: Quantitative cross-sectional study	Explored the role of stigma, trust, and threat appraisals in adolescents' support seeking when exposed to their own, or to a friend's, symptoms of mental illness.	Exploratory factor analysis, validity and reliability testing, multi-group path analysis.	250 young people aged 11 to 15
9	Study 3: Quantitative cross-sectional study	Explored the mediating role of perceived severity of symptoms on the proposed model in Study 2.	Comparative analysis, descriptive statistics, inferential statistics	76 young people aged 12 to 15

3.1. Open Science Practices

Researchers have suggested in recent years that there is a replication crisis (Baker, 2016; Shrout & Rodgers, 2018). This crisis refers to the recurrent difficulty in replicating results in different fields (psychology included), with more than 70% of researchers unable to replicate existing findings (Baker, 2016). This difficulty has been attributed to qualitative and quantitative problematic practices (John et al., 2012; Munafò et al., 2017) and occasional academic misconduct (Nelson, et al., 2018). The replication crisis has implications to research results' trustworthiness, lack of transparency, and credibility of research results (Cook et al., 2018). While not a complete list of questionable practices, the following constitute some of the most prevalent issues that can be addressed by using open science practices in both qualitative and quantitative methods.

For quantitative research, inappropriate statistical conduct and faults with hypothesis testing are key factors contributing to this crisis (Ioannidis, 2005), which include p-hacking (i.e., re-analysing data to achieve a significant result) (Raj et al., 2018), HARKing (i.e., generating hypotheses after results are known), having low statistical power, and misinterpreting p-values (Chambers et al., 2014). Most of these can be attributed to a lack of understanding of how to interpret statistical results (Sijtsma, 2016).

P-hacking involves the analysis of data until significant results are achieved, this contributes to bias in reporting and publication of unreliably significant results (Friese & Frankenbach, 2019). This practice is also questionable due to its focus on data and not on a theoretically sound approach. Examples of p-hacking include deletion of specific outliers, recoding of variables, and reporting only significant results from a suite of analyses (Simonsohn et al., 2014). P-hacking is linked with HARKing, where researchers change their initial hypothesis after analysis has been conducted to fit with the results found (Rubin, 2017). This type of practice is particularly detrimental to the development of theories as hypothesis are never negated. In order to address both these questionable practices, pre-registration of a study can be helpful. Pre-registration is a way for researchers to specify the details of their research on an openly available website for consultation by others (Haven & Van Grootel, 2019), defining a priori the study’s hypothesis and methodology. By pre-registering studies prior to data analysis, opportunities for both HARKing and p-hacking are greatly reduced.

For qualitative research, open science practices primarily relate to data credibility and validity. In qualitative research, the debate around subjectivity has been prevalent, highlighting the need to pay close attention to its impact on data interpretation (Berger, 2015; Haven & Van Grootel, 2019). Connected to subjectivity issues, the possibility of data interpretation bias has been highlighted as needing to be addressed when writing up results (Berger, 2015). This could be addressed by stating positionality and addressing issues of reflexivity from the perspective of the researcher, for example. Also, qualitative researchers should consider their stopping criteria when collecting data (Hennink et al., 2017).

Open science can be a vehicle against some of the questionable research practices highlighted earlier. Several strategies can be implemented to help transparency, reproducibility, and openness within research. For the current thesis, the main strategies were pre-registering the research in an online repository (i.e., the Open Science Framework: OSF) and openly sharing materials and data collected throughout the research. For Study 1, there was a pre-registration of the analysis plan focusing on detailing the research questions, design, and the analysis plan that was conceptualised in advance. Pre-registration of qualitative studies is relatively recent (Kern & Gleditsch, 2017; Piñeiro & Rosenblatt, 2016) with most templates available to pre-register studies being focused on quantitative data analysis plans, and are not adapted to the particularities of qualitative research. At the time of pre-registration, there were two templates available. For this study, Haven and Van Grootel's (2019) qualitative template was used when pre-registering the analytic plan in the OSF. The pre-registration and all the materials used in Study 1 can be found here: www.osf.io/wshfn.

In qualitative research, more often than not, the approach is not a hypothesis-testing one; rather, it is exploratory and deductive. Haven and Grootel's (2019) template provided an opportunity for studies to be pre-registered by using a table of contents that they adapted from the quantitative version of pre-registration. More recently, their template has been added to the OSF as one of the options to pre-register qualitative studies. Openly available materials, scripts, and data is encouraged as it can help with both replication and also with data re-analysis by future researchers (Munafò et al., 2017). For qualitative research, openly sharing data poses specific challenges (Bishop, 2009; McLeod & O'Connor, 2020). For example, when using interviews that ask about a person's experiences, researchers need to be careful and have to consider if publicly sharing these will break anonymity in any way. Additionally, participants in the research must give their consent for their data to be publicly available in this way. In Study 1, the use of interviews revealed an added challenge when pre-registering the study. Although the interviews conducted were previously prepared (e.g., questions and probes were thought through), there were still the possibility that other elements not captured during the design and piloting phases could arise. As such, flexibility for the interview schedule used and the data collected need to be included in the pre-registration process.

For Study 2, the open science practices consisted of openly sharing all the materials used during data collection, data, and dataset used for analysis (available in the following link: https://osf.io/et28h/). Given that Study 1 used a qualitative approach, openly sharing data was not possible since this could lead to identification of participants through the interview transcripts. Study 2 on the other hand, uses a quantitative methodology (i.e., a survey), and as such data was openly shared on the OSF given that anonymity was accounted for during data collection. This was done by not collecting any personal identifiable data from the participants. Finally, since Study 3 is presented in this thesis as a pilot study, pre-registration and openly sharing of materials was not possible.

3.2. Rational for a Mixed Methods Design

Mixed methods research is defined by combining both qualitative and quantitative methodologies into one research project (Mertens, 2010). In this thesis, Study 1 used a qualitative methodology (semi-structured interviews) while Studies 2 and 3 employed a quantitative approach (questionnaires). When thinking of mixed methods research, one should explore relevant philosophical and epistemological assumptions that drive the research. This is pertinent to frame how biases, worldviews, and previous experiences could be influencing the research process (e.g., Creswell & Poth, 2017; Schoonenboom et al., 2017). Some philosophical assumptions refer to the nature of the reality and participants’ perspective of reality (i.e., ontology), how the researcher’s own biases and perspectives influence decisions (i.e., epistemology), the role of insider or outsider to the field of study (i.e., axiology), and what methods are chosen to explore the research questions (Creswell & Tashakkori, 2007; Creswell & Poth, 2017). Epistemology and axiology assumptions are particularly relevant and are closely related with a next section later in this thesis where the researcher positionality and reflexivity are explored.

3.2.1. Ontology and Epistemology

Philosophical assumptions pertaining to a research approach are linked and have a direct influence in how research is conducted (Creswell & Tashakkori, 2007; Creswell & Poth, 2017). Philosophical assumptions are seen as paradigms and assumed to be worldviews the researcher brings when conducting a study, which can be thought of as beliefs, worldviews, or perceptions about the topic being explored, and the world as a whole (Creswell & Plano Clark, 2011). Overall, several paradigms, such as postpositivism, social constructivism (e.g., Creamer & Reeping, 2020), participatory (Creswell & Tashakkori, 2007; Creswell & Poth, 2017), and pragmatism (e.g., Heyvaert et al., 2013) have been explored in the literature. These propose that research should have a foundation in theory and be bound by theorical limits (i.e., postpositivism), explore the subjective meaning of reality to each of the participants without assuming that reality is the same for all (i.e., social constructivism), and that the participant should be included in the research process from the start, giving the participant a voice (i.e., participatory). Different paradigms are associated with the use of different methodologies in order to better answer research questions. For example, postpositivism has been linked mostly with quantitative methodology (Creamer & Reeping, 2020), while social constructivism has been explored through the lenses of qualitative methods (Creswell & Plano Clark, 2013).

Some theorists believe that these paradigms should be merged, and debates over what have been called the ‘incompatibility thesis’ have emerged (Howe, 1992). The ‘incompatibility thesis’ emphasise that quantitative and qualitative methodologies should not be combined, and that assumptions that guide these methodologies should be kept separated. Support for the creation of a new paradigm has emerged where assumptions are considered in a spectrum, moving from concrete ideas and theoretical boundaries, to more subjective and fluid forms of research (Johnson & Onwuegbuzie, 2004). Theorists suggested that research should explore the role of multiple worldviews and assumptions, and how these can aid when answering research questions in any particular topic (Green & Caracelli, 1997; Creswell & Poth, 2017).

This paradigm has been called pragmatism and is the one paradigm used in this thesis. Different authors have elaborated on the benefits of conducting qualitative and quantitative research together (e.g., Feilzer, 2010; Heyvaert et al., 2013; Johnson & Onwuegbuzie, 2004; Morgan, 1998). One of the recurrent reasons for using this paradigm is the fact that using both these methodologies enables a more in-depth understanding of the world and of the topic being studied (Feilzer, 2010), and aids adjusting the methodology to the research questions (Heyvaert et al., 2013). Meaning that, a researcher using a pragmatic approach tends to focus more on the research questions and then chooses which methodology is best suited to answer them.

3.2.2. Mixed Methods

Mertens (2010) has provided an overview of the existing types of mixed methods research. According to Mertens (2010), the research in this thesis can be considered a sequential mixed methods design. This means that there was an initial data collection that led to further data collection using another method. In this case, Study 1 used interviews to collect data (i.e., qualitative) about young people’s perceptions and understanding about seeking support when dealing with their own or a friend’s symptoms of mental illness. Then, two survey-based studies (i.e., quantitative) were conducted and these looked in more depth at how each of the variables highlighted by the participants in the initial qualitative study could explain young people's support seeking.

The purpose for the use of mixed methods can be interpreted according to different categorisations such as follow-up, comparison, and development (Greene et al., 1989; Schoonenboom, et al., 2018). In this thesis, the first qualitative study aimed to better understand how to design the following two quantitative studies. This was done due to the scarce research referent to young people's support seeking when dealing with a friend's symptoms of mental illness. Thus, in an initial phase the qualitative study allowed for *exploration* of the topic by the researcher's access to participants' perceptions and understandings, and this helped to further develop theoretical understanding to guide the research. Schoonenboom et al. (2018) suggest that exploration as a purpose can be helpful in the development of ideas as well as concepts and theorical approaches. For the current thesis, all of these were at play during the first study. Furthermore, exploration supports identification of the elements and variables, from the young people's point of view, that might be playing a significant role (Green et al., 1989). The second phase of the research involved the design of the quantitative studies focused on *explaining* the results found in the initial qualitative study. The explain purpose proposed by Schoonenboom, et al. (2018) in part consists into quantifying or testing relationships uncovered in qualitative research to allow for a more in-depth understanding of the dynamics at play. Finally, when using multiple purposes for mixed methods results, one needs to be clear as to what each stage of the research process aims to achieve as well as how the overall goal of the research will be informed by the combination of the purposes and methodological approaches (Schoonenboom, et al., 2018).

Here is where the researcher should consider what results will originate from this research and how they will look as a whole. Using different methods in the same research project may lead to contradictory results (De Silva, 2011; Mertens, 2010). At the same time, some methods might be more dominant than others (Johnson et al., 2007; Powell et al., 2008). For example, when reporting results, one could provide more detail and evidence for quantitative methodologies than for qualitative findings. This is due to existing publication bias toward mixed methods studies that use a prominent qualitative component. Creamer and Reeping (2020) have commented on the differences in rates of publication between mixed methods studies and solely quantitative studies in highly-rated journals such as those published by the American Psychological Association. The authors concluded that the rates within the psychology field were lower than in other applied fields like education and nursing (13% for journals with an applied focused on school psychology and 7% for journals with a theoretical quantitative focus). Thus, in this thesis, the general discussion will explore the results of the qualitative and quantitative studies together, highlighting instances of supporting or contradictory results. Furthermore, the general discussion of this thesis will delve into the implications of the results of all three studies combined in order to extract to most out of using a mixed methods approach.

3.2.3. Integration

One of the key elements of mixed methods research is integration. This consists in the process and moment of combination of both qualitative and quantitative methodologies used in one research (Bryman, 2007; Creswell & Plano Clark, 2013). Additionally, it is important for mixed methods research to consider when and how integration occurs, as it enables the ability to assess the extent to which and how the different methodologies used complement each other. By integrating both research methodologies, there could be confirmation, expansion, or discordance of the different studies results (Fetters et al., 2013). The present thesis looks to expand the results from an initial qualitative study in two subsequent quantitative studies. Integration can be as complex as the number of components and elements one has in a piece of research (Schoonenboom et al., 2017). Integration can be done both at a data and a theoretical level (Creswell et al., 2011; Fetters et al., 2013). This means that a researcher can explore findings from two different methodological perspectives, allowing at times a more developed and nuanced insight into participants' experiences. Simultaneously, researchers can also explore how each methodology, can influence the outcomes and interpretation of the findings and overall understanding of the concept being studied.

Fetters et al. (2013) suggested three stages of research where integration can occur: design, methodology, and reporting. At the design phase, integration happens as a result of how the researcher decides that each study builds on the other. According to Fetters et al. (2013), an exploratory sequential design would be a suitable definition for the current thesis. A qualitative study was used early on, prior to quantitative data collection, in order to support exploration of the relationships between variables in subsequent studies. Fetters et al. (2013) suggests that integration can also happen in the approach chosen for data collection (i.e., methods). This is where the researcher can connect, merge, embed, or build on datasets resulting from each of the studies conducted in mixed methods research. This thesis uses a building approach where one database (i.e., qualitative) is used to inform the approach for data collection and the database resulting from it (i.e., quantitative).

Finally, one can integrate results while reporting (Fetters et al., 2013). At this stage, the researcher can choose to transform the data and present all the findings as a result of a single dataset. On the other hand, a researcher could explore the results from different qualitative and quantitative studies by merging the in different visual aids (e.g., tables, figures). Lastly, and the one that has been adopted in this thesis, the researcher could explore the findings through narrative and by a staged approach through different publications for each of the studies done. This was selected for this thesis given the exploratory sequential nature of the integration used in this research. Each study was developed based on the previous on, improving and building on previous knowledge.

3.2.4. Reliability and Validity

Reliability is defined as the consistence associated with the obtaining the same results under different conditions, while validity focuses on the confidence associated with the results (Kirk & Miller, 1986). Both concepts are relevant when conducting research, however they can hold different forms depending on methodological approach (Cohen, 2007). Reliability has been mostly associated with dependability, consistency, and replicability (Cohen, 2007). Moreover, the term validity in quantitative studies is mostly associated with confirming a measurement provides the data it sets out to, but in a qualitative study this concept takes a different form. Thomas and Magilvy (2011) reference credibility, transferability, dependability, and confirmability as key elements when exploring the validity of qualitative studies. Despite the existence of different types of validity and forms to assure reliability when conducting research, given the scope and paradigms assumes in this research, as well as the integration plan described above (see section 3.2.3), it is relevant to address what steps were taken to improve reliability of results. Thus, following steps were taken to address concerns around these concepts:

- <u>Qualitative study:</u> multiple coders were used to improve reliability. Research has shown that multiple coders can improve reliability during the coding process by introducing different perspectives and meanings of the data (Olson et al., 2016). Further detail about this process will be presented in Chapter 4 (see section 4.3) and Chapter 5 (Methods section).

- <u>Quantitative studies</u>: values for omega in each of the measures used were calculated in order assess internal consistency. Omega was chosen instead of Cronbach’s alpha based on simulation studies suggesting that Cronbach’s alpha yields less accurate estimates than Omega (Trizano-Hermosilla & Alvarado, 2016). Further information will be presented in Chapter 7 (see section 7.1) and Chapter 8 when Study 2 is presented.

- Both methodologies: the interview schedule for Study 1, and the survey for Study 2, were piloted. Piloting is a form of asserting validity and increasing reliability through the testing of the interview schedule and the survey used in order to assess if these address the research questions (Cohen, 2007; Hayashi Jr et al., 2019). Furthermore, to increase transparency and replication, open science practices were applied, as already discussed in section 3.1.

3.2.5. Positionality and Reflexivity in Qualitative Research

As a researcher, I believe it is important to explore my own position and experiences to understand how these could have influenced each study. The PhD process involved more than just three studies; it involved both professional and personal development, and I believe it is important to explore these elements too when interpreting the results.

Introducing reflexivity and elements of positionality is predominantly done while conducting qualitative research. Ramani et al. (2018) proposes that qualitative researchers should engage in reflexivity in all stages of the research process (from design to report writing). This perspective has been supported by several other authors (Barrett et al., 2020; Dodgson, 2019) who highlight the need for a better understanding about the motivations that led a researcher to engage in this type of research, to ask specific questions, and to interpret the data in a given way. When exploring positionality and reflexivity, one could also explore in more depth epistemological and axiological philosophical assumptions (Creswell & Poth, 2017). These propose that the researcher's set of beliefs, worldviews, and values (i.e., epistemology), and their position within the field (i.e., axiology), can exert a great impact in the decision making throughout the research process. Both assumptions complete each other, given that how close and knowledgeable a researcher is about a particular topic can ultimately influence their views and experiences.

Thinking of the PhD as a whole, Stubb et al. (2012) explored the different meaning that PhD students attributed to their work. They concluded that students could view their studies as a process or a product, relating to different goals and outcomes that students strive towards with their studies. Stubb et al. (2012) concluded that viewing a PhD as a process is linked to the development of skills and gaining expertise in the hopes of becoming part of a community. In contrast, students who interpret the PhD as a product are more focused on obtaining a qualification and improving their professional career. These conceptions of the values and goals of the PhD are further linked with the positionality and previous experiences of the researcher.

Considering the research aspect of the thesis, reflexivity can clarify why specific design decisions were made, why data were interpreted and reported in a certain manner and, ultimately, can help further our understanding of our own biases, preconceived ideas, and expectations prior to data collection. Reflexivity can be shown during the research process by answering the following questions, which will be answered in the general discussion section of this thesis in order to provide a better understanding about the research process (Lazard & McAvoy, 2020):

- What is the research process and how am I influencing it?
- What motivated me to research this particular topic?
- Why did I ascribe to this particular theoretical position?
- How did my choices (and preconceptions) about the methods I used shaped knowledge production?
- Why did I decided to ask these questions?
- How does the relationship between researcher and researched contribute to the data collection and the entire research process?
- How did all of these answers impact my analytic interpretations?

In their study, Stubb et al. (2012) also delved into the associations between the meanings attributed to the PhD and the wellbeing impact that this could have on the student. They concluded that students who view their PhD as a product reported higher levels of stress and anxiety. On the other hand, if a candidate considers the PhD as a process, they are more likely to experience higher levels of motivation and interest. I believe that this is of particular interest, not only because this thesis explores outcomes from experiencing symptoms of mental illness, but also because a PhD can be a stressful process. Thus, in the general discussion, I will aim to address some of these issues and explore the implications that the PhD had on my own wellbeing.

Furthermore, positionality also covers the insider or outsider perspective. Holding an insider or outsider position is related to the level of knowledge the researcher has about the population and/or topic being studied (Mason-Bish, 2019). A researcher that holds an insider position holds detailed knowledge about the target population by previous experiences interacting with them, for example. Similarly, the researcher can hold an insider position if they have worked in the field of study for some time and have therefore developed a high level of understanding of some of the phenomena being researched. Insider/outsider status could ultimately influence access to participants, deeper understanding of the topic, and how variables might relate with each other (Berger, 2015). It is likely that worldviews and beliefs (as discussed previously) will have an impact in the position of the research towards the topic and the population.

At this stage, I believe it is relevant to provide some of my personal context that will allow for further understanding of my own positionality as a researcher. My previous experience with young people's mental illness focused mainly on the Portuguese context (I am myself Portuguese and was raised in Portugal). Thus, my knowledge about the Scottish context, when I started the PhD, was very limited. In Portugal, I was a psychology intern in a public school, in one of the most deprived areas in the Northern area of Portugal with high crime rates among young people. This gave me the opportunity to deal closely with students and staff members who required mental health assistance. During my time in that school, I developed my understanding about what elements contribute to the development of young people's mental illness symptoms. For example, socio-economic status, family circumstances, and academic stresses were some of the main factors that appeared to lead young people to the psychology service in the school.

Both my higher education (i.e., BSc in Psychology and MSc in Forensic Psychology) and my professional experience included culture-specific elements. For example, in Portugal, psychological provision in schools is extremely limited and students frequently do not have access to any type of support from mental health professionals in their schools. This means that most students must rely on their parents/carers or themselves to seek any type of support when going through any difficulties. Once in Scotland, I realised that there is a constant effort to provide support to students in school and inform them about the available options. This was visible since I became aware of designated staff in charge of mental health and wellbeing within schools, which is lacking in Portugal. On top of a failure to update legislation since 1991 (Decreto Lei no 190/91, 1991), there is a lack of investment in mental health provisions in schools even with the Programme of Government from Portugal projecting one psychologist for every 1,140 students by 2023 (POCH, 2020).

While Scotland's approach is not without limitations, it seems that in this context efforts and investments have been put into place more clearly than in the Portuguese context. Thus, the planning of the initial study and the overall concept of the thesis, was done with this in mind. Consequently, I could be considered an insider to the topic due to my professional experience within the school context; however, I was also an outsider given that this experience was in a different cultural context. Ultimately, this resulted in some additional difficulties (e.g., accessing participants) due to a lack of connections within the community.

Furthermore, when considering this insider/outsider perspective, one of the factors that I believe to be relevant is language and cultural context (Mason-Bish, 2019; Smith &

McGannon, 2018). Coming from Portugal, English is my second language. Thus, interviews with young people were inevitably affected by it. Although I speak English at a high-level, there were some culturally specific forms of expression that arose during the interviews which could hinder communication. For example, since the interviews were conducted at the early stages of my arrival in Scotland, I was not as familiar with the accent. So, at times, there was a need to ask participants to repeat an answer or clarify something that they had said. Similarly, there are cultural elements that could influence the overall understanding of the data (Charmaz, 2014; Mason-Bish, 2019). This is extremely relevant when exploring young people's experiences using an interview method because it can hinder rapport with participants and the overall analysis and interpretation of results. On the other hand, language could influence my insider/outsider position as a researcher, since both the participants and gatekeepers could consider these language differences as a barrier and, once again, hinder my access to samples or reduce the quality of the data being collected.

3.3. Ethical Considerations

As the participants of this research are young people between the ages of 11 and 15, four main elements were considered to account for their safety and protection when taking part in this research: a) informed consent; b) sensitive questions; c) anonymity and confidentiality; and d) privacy and data protection.

a) Informed consent. Due to the fact that this investigation involved participants aged below the age of 16 years, consent was sought from a caregiver, as well as from the young person themselves prior to data collection. As such, and in line with the BPS Code of Ethics and Conduct (BPS, 2021), and the University of Strathclyde Ethics Committee's code of practice, parental/carer consent was obtained in all three studies. Different formats were used for each study: in Study 1 consent was obtained online and/or by return of a paper consent form, for Study 2 solely via paper consent form, and Study 3 solely online. Each parent/carer (cf.

Appendix 1 for Study 1, Appendices 6 and 11 for Study 2, and Appendix 13 for Study 3) and participant (cf. Appendix 2 for Study 1, Appendix 7 for Study 2, and Appendix 14 for Study 3) had access to a Participant Information Sheet. This document explained all the relevant components of the research, parents/carers and participants were encouraged to read before giving consent to take part in each of the studies. For each study, this referred to explaining the aim of the research, clearly outlying that participation was voluntary and the path to withdrawing after taking part was detailed for each study.

In order to improve informed consent, the possible risks of taking part in each study were also detailed in the PIS. These were then followed by a brief description of the protocols in place to ensure young people's wellbeing. These included elements like a possible disclosure of any personal information that could be considered as putting the safety of the young person at risk. It was important for Study 3, given its characteristics (see Chapter 9 section 9.1) to address safeguarding by reporting in the PIS the most challenging items to which young people would have to respond to. This meant that parents/carers and participants were aware of these two items (i.e., "Thought about ending your own life" and "Self-harming (i.e., hurting yourself on purpose)") when deciding whether to give their consent.

In line with GDPR legislation and the Data Protection Act (2018), in the PIS for each study the data management and protection protocols were explained. This involved a clear description of gathering, storing, and analysis of the data collected. Specifically, for Study 1 an additional description of data protection protocols was described given that this study required the collection of audio recordings and transcription of these.

Active parental/carer consent (i.e., opt-in) was approved by the School of Psychology and Health Ethics Committee in the case of Study 1 and 2 (cf. Appendix 1 and 8 for Study 1 and 2 parental/carer consent form, respectively), and by the University of Strathclyde Ethics Committee for Study 3 (cf. Appendix 15 for parental/carer consent form). Only young people whose parents/carers had consented to the studies were approached to take part. Parents/carers were given at least one week to either return a signed consent form (paper copies) or provide consent online (electronic). During recruitment for Study 2, permission was sought from the School Ethics Committee to proceed with either opt-in parental/carer consent or opt-out. This followed a school request that parents/carers in their institution responded better to an opt-out type of consent then opt-in. Thus, ethical approval was obtained for this change under the condition that opt-in would be the first choice and opt-out only be used where it was requested by an institution (cf. Appendices 11 and 12 for opt-out PIS and consent form). Even though these procedures were in place, school closures in March 2020 due to COVID-19 restrictions meant no data were collected using opt-out parental/carer consent since all schools that had requested this did not proceed with data collection.

The researcher took steps to ensure that participants in the research understood the process in which they were engaging. During the in-person presentation of all three studies prior to participants starting the interview (i.e., Study 1) or the survey (i.e., Study 2 and 3), the researcher presented the PIS to the participants. The three PIS' for young people, were provided in paper format (despite data for Study 2 and 3 being collected through an online platform: Qualtrics.com) in an attempt to ensure that young people read the study details prior to completing the surveys. The exception to this were the 3 participants interview online for Study 1. For these three participants, the PIS was presented virtually as part of the web link created to obtain their consent. In both situations (i.e., paper and online formats), participants had the opportunity to ask questions regarding any aspect of the study that they wanted clarification on. Together, these steps ensured informed consent for this research. In Study 2 and 3, once young people read through the PIS they were given the link to the surveys asking for their consent after reading the PIS.

As this PhD research took place in a school setting, it is important to recognise that the participants were potentially open to coercion from authority figures. All three studies in this thesis were voluntary and young people were not obligated to take part. For example, the presence of school staff might imply that students have to take part in the study, unduly influencing their expressed consent. To overcome this issue, during the initial presentation of the study to the participants, it was made clear that participation was voluntary, and that taking part in the interview (i.e., Study 1) or completing the survey (i.e., Study 2 and 3) was not a school requirement. The researcher (and/or a trained assistant for Study 2) was present during all data collection to ensure that school staff did not inappropriately influence young people's decisions to take part. This was to ensure that consent was voluntary, free from coercion, and that participants were taking part of their own free will. The BPS Internet Mediated Research Ethical Guidelines (2017) highlighted that, studies with an online component can face issues of valid consent. Thus, asking participants to provide active consent in person by presenting the PIS in paper as it was done for both Study 2 and 3, might have helped to overcome some of these issues.

b) Sensitive questions. This thesis invited young people to reflect on what are mental health problems and on ways of dealing with these, either through hypothetical scenarios or via their lived experiences. Thus, the questions could be considered of personal and sensitive in nature if the young person has experiences of dealing with mental illness. It is also possible that discussing what is meant by the term 'mental health problems' could cause distress if a young person recognises their own experience of those symptoms. However, the research protocol was designed in a way to address and mitigate this risk.

The PIS also addressed this issue. All participants were provided with information regarding the background and purpose of the research, as well as details regarding the nature of questions that they would be asked to answer. They were given time to consider the information that they had been provided with and to decide whether they wanted to participate. As such, potential participants had the opportunity to make an informed decision regarding consent and could at this point choose not to take part if they did not feel happy providing this sort of information.

Participants were able to keep a copy of their participant information sheet. This contained contact details for the research team and an independent person, in this case the Chair of the School Ethics Committee for Study 1 and 2, and University Ethics Committee for Study 3. Participants were told that they could contact any of these individuals if they had any questions or concerns following the investigation. Further, contact details for the supervisors and PhD student were provided. This was done to ensure that participants could contact the research team if they would like to be informed of the outcomes of the research. In addition, all participants were provided with a Debrief sheet designed to thank them for their participation and to reinforce the purpose and nature of the research, as well as confirming that their data would remain private and be stored securely where no unauthorised persons would have access (cf. Appendices 5, 10, and 17 for Study's 1, 2 and 3 debrief sheets, respectively). The Debrief sheet also provided telephone, postal, and electronic contacts for useful helplines and support organisations for any adolescents that were worried about mental health issues that they may be experiencing, or if they were feeling in any way distressed following the interview/questionnaire.

c) Anonymity and confidentiality. In this thesis, two types of anonymity were used. For Study 1, pseudo-anonymity was used as the interviews were audio recorded and stored under a code name to guarantee anonymity. This coding was stored in a different location from the data to avoid identification from the recordings alone. The interviews were transcribed with no young person being identifiable in any of these transcripts. Recordings were deleted as soon as the interviews were transcribed. Only the named researchers in this thesis had access to the data, except in the situations stated above (i.e., if information was disclosed that revealed potential present or future harm to the child). For Study 2 and 3, data were fully anonymous with young people were only asked to provide general demographic information (i.e., age, gender, ethnic identity, and nationality).

d) Privacy and data protection. A big component of this thesis is the use of online platforms to collect data, whether to conduct online interviews *via* Skype or to use Qualtrics to obtain parental/carer consent and collect data with participants. As such, privacy issues were taken into consideration when designing the studies. Prior to interviewing participants, when parents/carers gave consent, they were also asked to provide a username on Skype where they could be contacted on the day of the interview. Thus, participants' online details (i.e., Skype IDs, emails) were stored on StrathCloud, which is an online GDPR conforming platform owned by the University of Strathclyde that allows students and staff to safely store information. Finally, the recordings were destroyed once the interview was transcribed.

In Study 2, the initial ethical approval was obtained for paper copies of the survey to be distributed to participants. However, in line with the context and population from which data were being collected, the School Ethics Committee was consulted to change the initial approval from paper to online format. This type of survey was viewed as more suitable for the population due to their virtual knowledge and expertise. Additionally, there were other benefits such as reduced physical waste (i.e., it is an eco-friendlier approach) and is a quicker way to deliver and collect data by cutting down time in distributing and collecting paper copies. When it comes to data analysis, there was no need to enter data since these could be downloaded directly from the online platform being used; using Qualtrics eliminated the time otherwise required to enter data into a statistical software package. This approach also eliminated the human error associated with data entry. Thus, in both Study 2 and 3, an online platform (Qualtrics) was used to deliver the survey.

Where participants were invited to complete an online survey (i.e., Study 2 and 3), they mostly used their mobile devices to do so. This method was chosen because of the nature of the topic, as it was considered that answering the survey in a computer laboratory setting (where the monitor is visible to others) may prevent anonymity and discourage participants from sharing their honest thoughts and experiences. However, the possibility that some young people might not have access to a mobile device was a potential ethical dilemma as it risked excluding some potential participants. As such, during data collection, the researcher took four extra mobile devices to allow students who might not have their own device to take part if they wished to. Some schools also provided Chromebooks and tablets for students without personal devices to complete the survey, without compromising confidentiality and anonymity.

In this chapter, there was an extensive discussion of the methodological elements that were similar across all three studies. The next chapter is the first of two study-specific methodology chapters that explores in more depth the decisions regarding method and procedure in Study 1. This allows for further details not present in the peer-review published paper (i.e., Chapter 5) to be discussed and for rationale to be presented in more clearly.

Chapter 4- Methodology of Qualitative Study 1

This chapter details the data collection methods pertaining solely to Study 1. This will include interview development, analysis technique, and recruitment procedures specific to this study.

4.1. Interviews

Initial ethical approval was obtained to conduct online interviews, later amended to include face-to-face interviews as well. This change was made due to difficulties recruiting using only an online protocol. The interview was piloted with two young people (one boy and one girl both 11 years old) prior to data collection.

4.1.1. Interview Piloting

Piloting was conducted in line with guidelines for best practices when conducting qualitative research and aiming to assess comprehension and length of the interview (Malmqvist et al., 2019; Sampson, 2004; Vogel & Draper-Rodi, 2017). These took place through videoconference (i.e., Skype) and were audio recorded, leading to minor changes in phrasing of questions to improve comprehension. Piloting also clarified that the initial interview schedule lacked depth and detail in order to explore possible answers and probes that could bring up more information. Furthermore, the pilot highlighted questions that participants did not understand and that were subsequently changed. For example, a question that aimed to assess young people's primary appraisals when exposed to symptoms of poor mental health was phrased as: "Can you think of anything positive/negative resulting from experiencing symptoms of poor mental health?". Neither participant understood what was being asked here, and so the terms "positive" and "negative" were replaced by "good" and "bad". Additionally, to support this information, a probe was added to the guide that asked participants about anything that they would expect to change as a result of symptoms of mental poor mental health. In this way, the interviewer was able to explore with the participants the meaning of that change and further understand the positive or negative effects of it (i.e., primary appraisal attribution). Similarly, the pilot interviews revealed details about why specific resources such as mental health professionals were not spontaneously referenced as preferred sources of support. As such, this was also added to the revised interview guide as a probe to gather extra insight into the participants' perceptions. These changes were then approved by the School of Psychological Sciences and Health Ethics Committee at the University of Strathclyde.

4.1.2. Interview Schedule Used

In the final interview there were four main elements: 1) Mental health understanding; 2) Appraisals; 3) Coping strategies; and 4) Differences between coping with self and a friend's symptoms. The researcher started by establishing a consensus with the participants about the definition of 'mental health problems'. Young people were asked what they thought a mental health problem was, and then the researcher provided the following adapted definition from WHO (2021a) "when someone is having troubled thoughts, emotions, and behaviours. Or it can even be when a person is having trouble relating to people around him or her. Some examples of this could be depression or anxiety". This was done in order to allow for all the participants to share the same understanding of what was being discussed throughout the interview.

Next, the interviewer asked participants to imagine that they were experiencing symptoms of poor mental health. The questions that followed looked to explore how young people coped with experiencing symptoms of poor mental health themselves, through the lens of the TTC. This meant that questions explored attribution of primary and secondary appraisals and whether participants made a distinction between emotion- and problem-focused coping. When considering primary appraisals, young people were asked how they would feel about experiencing symptoms of poor mental health, and if they could think of anything good or bad that might happen as a result of it. This questioning relates back to the literature presented in

Chapter 2 and was used to distinguish between three main types of primary appraisals: threat, harm/loss, and challenge (Lazarus & Folkman, 1984).

To further assist with this distinction, the interviewer also asked about any positive or negative changes in their lives that the young person could think about as a result of the symptoms. Questioning about this distinction was informed by the TTC where Lazarus and Folkman (1984) expressed that, positive emotions were related with challenge appraisals, and harm/loss and threat with negative emotions. As such, expressing the possibility of positive or negative alterations in the young person's life as a result of experiencing symptoms of poor mental health could aid in understanding the appraisal process. At the same time, the participants were also asked about the level of concern they attribute to the symptoms. This provided further insight into the changes in the young person's life, as well as what could be considered to be of most value and at most risk when dealing with symptoms of poor mental health. This is also an element from the initial Lazarus and Folkman (1984) conceptualisation of appraisals, where the extent to which a stressor impacts an individual's beliefs and goals can influence their appraisal process. Next, the interviewer questioned the participants about what they would do to change the situation (i.e., coping strategies). Initially, this was a very general question that aimed at gathering the first thought that participants had about their hypothetical symptoms. This question was probed by two others trying to assess if young people made a distinction between emotion- and problem-focused coping, as suggested by the literature discussed in Chapter 2 (see section 2.3.2).

Questions relating to secondary appraisals assessed the level of confidence that the young people attributed to the coping strategies mentioned in the previous questions. This was to ensure that the concept of self-efficacy, described in Chapter 2 (see section 2.3.1), was explored. Two probing questions were included. These referred to the young person's perception about the situation being one that requires outside help and whether they believed they had someone who they could ask for help. Finally, the last section of the interview protocol was designed to gain more insight into what type of resources and elements young people seek when coping with symptoms of poor mental health. Mainly, these last questions aimed to understand what resources were mostly referred to by the participants as a source of support. Additionally, these questions were designed to gain a better understanding of why some resources were not as frequently mentioned as others. Furthermore, a specific probe about online support was added as a way to gain some insight about how young people use available online resources to seek help when dealing with symptoms of poor mental health. All participants answered the same set of questions when they were asked to imagine that a friend disclosed symptoms of poor mental health to them. The elements and associated questions are included in Appendix 18.

4.2. Recruitment Strategy and Procedure

Initial ethical approval was obtained to recruit participants through community groups and institutions that worked with young people aged 11 to 14 of this research (e.g., Scouts, Guides). Recruitment in community groups involved dissemination of an advertisement via email, or via a paper advert. In some instances, the researcher also contacted theses community groups by phone to gauge their interest in the research and to assess the possibility of advertising the study among their users. Furthermore, ethical approval was also obtained to advertise online (e.g., via Twitter). As such, an advert was posted on the researcher’s social media platforms. Links with the information described in Chapter 3 (section 3.3) were provided in these adverts. Community groups were encouraged to share these links with any parents/carers of young people involved in their group. Similarly, when recruiting online the researcher requested that interested parents/carers contacted the researcher or visit the link to learn more about the study and, if happy with the information provided, to give consent.

After consent was obtained, the parent/carer was asked to share a second link created for their children. Here, the young people had access to the PIS detailing the study as per described in section 3.4. of the previous chapter, and they could give consent to take part in the study if they wished to. During the completion of the consent form, a time and date suitable for the interviewee was requested. Since ethical approval was obtained in relation to online interviews, the young person's consent form also asked for a valid Skype or Facetime ID in order to establish contact on the day of the interview. The interviewer then contacted the parents/carers to arrange a date and time for the interview to take place. This was done as parents/carers were filling out the consent forms, they were asked for contact details (i.e., phone and email) so that the researcher could later contact them. These details were later deleted once the interview was completed and transcribed.

A decision was taken to alter the recruitment plan due to a slow recruitment: in five months, only three out of the target 10 interviews had been conducted. Specifically, ethical clearance was sought, and granted, to seek to conduct interviews face-to-face within a private school setting. As such, letters to Head Teachers of private schools across Scotland were sent out. These explained the aims of the study, as well as the methods used to collect data, the expected length of the interviews, and how data were going to be handled (as per Chapter 3, section 3.3). Once a private school agreed to be involved in the study, recruitment proceeded using random sampling of students in each of the three relevant year groups. An initial 15 parental/carer PIS and consent forms were sent out to five pupils from each year group. While 15 participants were not required, this number was approached on the basis that consent (either parent/carer or child) would not be gained for 100% of these. Nine participants were recruited in this way, allowing for the desired sample size to be met. Data were collected in a room in their school with no other member of the school staff present.

4.3. Thematic Analysis

To analyse data from the interviews conducted in Study 1, a deductive approach to thematic analysis that follows Braun and Clarke's (2006) six-step structure was used. This focuses on analysing the themes in a critical and interpretative way, aiming to provide a detailed description of the data that relates back to the theory supporting the research (Braun & Clarke, 2006; Howitt, 2010). The choice of thematic analysis was based on the flexibility. Thematic analysis offers the possibility to explore a variety of epistemological and ontological perspectives. Similarly, there is a variety of research questions that can be explored with thematic analysis as well as no specifications when it comes to sample size like in Interpretative Phenomenological Analysis (IPA) for example (Smith et al., 2009). Furthermore, thematic analysis supports the exploration of patterns in the data and any overarching factors that are present across participants. Which is relevant to the assertion of the adequacy of application of a particular theory to a phenomenon.

Braun and Clarke (2006) describe six main steps to use thematic analysis. These were followed in order to undertake a robust analytic process. First, Braun and Clarke note that the researcher should familiarise themselves with the data. This could be done in variety of ways, but in this case one person was in charge of conducting the interviews and transcribing the data from audio to written format (i.e., the researcher). This initial process allows for ideas and concepts about the data to start forming, which in turn helps to have a better understanding of the overall meaning of the entire data collected (Braun & Clarke, 2006).

Next, the authors suggest that the researcher should start generating initial codes where first impressions and thoughts about meanings and connections are highlighted (Braun & Clarke, 2006). This was achieved by systematically going through each interview and highlighting any element that was of interest for the overall research question. Each time there was something of interest, this was highlighted in the text and a comment was added in the document. This process was repeated two times, once by hand and then electronically on a Microsoft Word document, to allow for an in-depth look into the data and to ensure that there was no information being left out that could be relevant. Third, themes should start to be developed (Braun & Clarke, 2006). This was done by going over the initial coding multiple times, organising and gathering all similar and relevant information in order to create meaningful themes that represent that specific information. The next stage involved reviewing the themes generated (Braun & Clarke, 2006). This focussed on representing, as best as possible, what the first and second steps capture upon initial scanning of the data. After, one can create a thematic map. Finally, the themes were named and defined (Braun & Clarke, 2006).

Though the steps described earlier were followed when analysing the data, the same authors later published a more in-depth consideration of their reflexive approach of thematic approach (Braun & Clarke, 2019). This more recent work explores elements that were not present in the initial work, such as the differences between domain summaries and themes for example. The authors refer to domains summaries as under-developed themes and that they believe should not be involved in their conceptualisation of reflexive thematic analysis. Furthermore, they also discuss that different authors will employ different definition of what constitute a theme and this depends on the methodological approach and epistemological stand of the research. As such, the initial process description of Braun and Clarke (2006) used in this research was interpreted as a guide to provide structure to the analysis allowing for reflexivity and flexibility (Braun & Clarke, 2019) to be introduced where necessary as the authors suggest.

In order to improve reliability in the coding process and to produce a richer understanding of the data, in each step of the process described above, the researcher discussed results with the supervision team. At the same time, an undergraduate Psychology student from the University of Strathclyde was recruited as an independent fourth person (i.e., with no previous knowledge about the project or contact with the data) to look at the anonymised data and provide codes and themes that were later crossed with the initial coding and themes that were generated by the researcher. When doing qualitative analysis, including multiple coders has been shown to improve reliability since it can help to have a better understanding of the data and uncover meanings of quotes that otherwise might be overlooked (Olson et al., 2016). On the other hand, using multiple coders can lead to inconsistencies and differences in coding and themes (Olson et al., 2016). In order to counterbalance this, open discussions between all the researchers about the meaning and interpretation of the data took place in order to reach an agreement (Levitt et al., 2017). In this particular analysis, there were no meaningful discrepancies between coders.

Finally, data were managed and stored using NVivo. This software was used throughout all the different stages described before. NVivo was used to categorise initial codes, then converted into different themes, and to create a thematic map that exemplified the relationship between each final theme. This software also allowed the researcher to gain a clear understanding of which quotes belonged to each theme and helped highlight which quotes were out of place and did not belong, or helped to convey that particular theme.

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Young people's coping strategies when dealing with their own and a friend's symptoms of poor mental health: a qualitative study

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Note. Formatting, layout, and APA style of this chapter may differ from the rest of the chapter in this thesis. As this paper was published in the Journal of Adolescent Research, formatting, layout, and APA style correspond to the journal's submission requirements at the time of submission. References for this chapter will be presented at the end of the chapter.

Young people's coping strategies when dealing with their own and a friend's symptoms of poor mental health: a qualitative study

Abstract

Young people struggle to seek help for their mental health, despite having different resources available. As the coping process is very complex, and elements such as trust and availability of resources have been said to influence it, this study aimed to understand how young people cope with their own or a friend's symptoms of poor mental health. Eleven young people (13-15 years old) were interviewed. Thematic Analysis of the interviews showed that participants reported different coping strategies for dealing with their own hypothetical symptoms and those of a friend. Participants identified the social impact of experiencing symptoms of poor mental health and choice of resources as the main factors influencing their coping strategies. For their own symptoms, young people expressed concern about being judged and that they would only disclose to someone they trust. Participants would not disclose a friend's symptoms because they did not want to break their trust. Finally, choice of resources was mainly influenced by the severity of symptoms being experienced, especially when it comes to asking for professional help. This study contributes to a better understanding of the different ways in which young people cope with their own symptoms and symptoms experienced by a friend.

Young people's coping strategies when dealing with their own and a friend's symptoms of poor mental health: a qualitative study

One in five adolescents experience symptoms of poor mental health, such as depression or anxiety (Deighton et al., 2018). A recent meta-analysis, showed that 41.5% of individuals experience their first symptoms by the age of 14 years old, irrespective of the mental illness diagnosis (Solmi et al., 2021). Despite this, young people still struggle to seek help when experiencing mental health difficulties (Collinson, 2017; Naughton et al., 2018). Lack of confidence about how to cope due to low mental health literacy (Hart et al., 2018; Mason et al., 2015) and social pressures (e.g., stigma) (Lannin et al., 2016; Schnyder et al., 2017) have been highlighted as negatively impacting how young people deal with these issues.

Young people who experience symptoms of poor mental health report higher levels of stress as a result (Auerbach et al., 2011; Moksnes et al., 2010). Adding to this, adults and mental health campaigns from different organisations such as *Young Minds* (UK), *See Me* (Scotland), and *headspace* (Australia) encourage young people to disclose their symptoms to others in order to get help. Young people often choose to disclose to a friend (Griffiths et al., 2011), mainly because they have a sense of comfort and higher levels of trust around their peers (Camara et al., 2017). However, most studies focus on how young people cope with their own symptoms of poor mental health and neglect to consider how a young person might react and deal with such a disclosure by a peer (Raviv et al., 2000; Rickwood et al., 2005; Yap et al., 2011b). Furthermore, research has not explored which possible factors might be playing a role in the coping strategies selected by young people when dealing with a friend's symptoms of poor mental health when in comparison to their own symptoms. Gaining insight into what coping strategies are used by young people when dealing with a friend's disclosure, could aid in implementation of provisions that facilitate help-seeking by young people.

Thus, this study aims to understand the differences in coping in young people when dealing with their own versus a friend's symptoms of poor mental health. We utilised the Transactional Theory of Coping (Lazarus & Folkman, 1984) as a framework to understand how the coping process develops. This is very timely research as the restrictions caused by the current COVID-19 pandemic have created extra pressures on young people's mental health (Dodson, 2020). Adolescent mental health has deteriorated throughout the pandemic (Creswell et al., 2021) and that young people have experienced higher levels of stress as result (Singh et al., 2020). A better understanding of young people's coping process can help us to provide appropriate support at this time.

The Transactional Theory of Coping (TTC)

Lazarus (1993) defined coping as a response to *"ongoing cognitive and behavioural demands that are taxing or exceeding the resources of the person"* (p. 237). The Transactional Theory of Coping (TTC) proposes that a multitude of factors play a role in the coping process, making it highly complex. Contributing to its complex nature, coping is constantly changing over time, and is both situation and person specific (Lazarus & Folkman, 1984). The TTC proposes that there are two main components in the coping process: cognitive appraisals and coping strategies. Figure 1 shows how these are proposed to interact in this study.

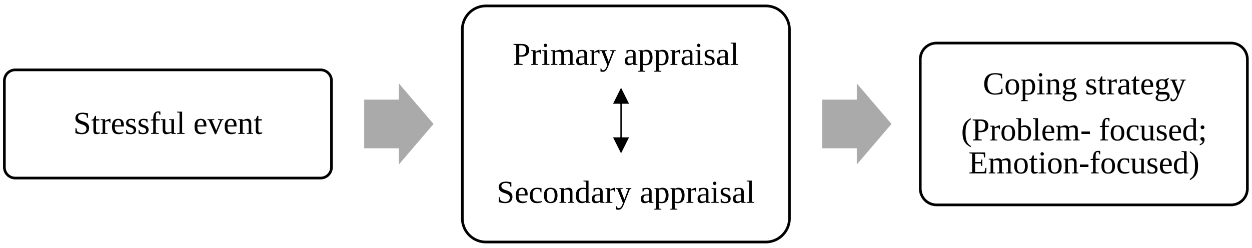

Figure 1. Transactional Theory of Coping (TTC).

According to the TTC, cognitive appraisals can be divided into primary and secondary appraisals. Primary appraisals correspond to the evaluation that the individual makes of the situation as *a) harmful*, where there was harm or loss caused by the stressful situation; *b) threatening*, where there is potential for physical or emotional harm to occur, and/or *c) challenging*, where there is space for growth and mastery. These appraisals are not mutually exclusive, meaning that they can occur simultaneously, for example, when an appraisal of harm occurs it is likely to be preceded by an appraisal of threat (Lazarus, 1999).

Secondary appraisals are the evaluation a young person makes of the resources available to them and to what extent these can be harnessed to deal with the stressful event (Lazarus & Folkman, 1984). Despite their names, primary and secondary appraisals can occur simultaneously and influence each other (Frydenberg, 2019). For example, it is more likely that a young person will find an event threatening if they do not identify any available resource to help them. Overall, the appraisal process is where differences in coping may start to emerge as an individual assesses the situation, their skills, and resources in order to achieve an optimal outcome (i.e. overcome the stressful situation).

Once a situation has been appraised, the individual deals with the stress by implementing coping strategies. Two overarching categories of coping have been proposed: problem-focused coping (i.e. dealing with the cause of the distress) and emotion-focused coping (i.e. regulating the emotion resulting from the distress) (Lazarus & Folkman, 1984). As the aim of the present study is to understand differences in coping in young people when seeking help for their own symptoms of poor mental health or for a friend’s symptoms of poor mental health, these two overarching categories were used to bring to light possible differences between coping with one’s own and with a friend’s symptoms.

Coping with symptoms of poor mental health

Research with young people has associated negative appraisals (i.e. threat or harm), with negative life events (Cole et al., 2019; Fosco & Lydon-Staley, 2019), such as symptoms of poor mental health. For example, higher levels of depression are associated with higher threat levels (Cole et al., 2019; Folkman & Lazarus, 1986). One appraisal that can influence the coping process is self-efficacy (Bandura, 1997). If a young person believes that they are well equipped to deal with their symptoms then they are less likely to ask for help and more likely to try to cope independently. Girls are reported to be more likely than boys to report a situation as threatening (Cole et al., 2019) and more likely to perceive a situation as stressful (Rose & Rudolph, 2006) and severe (Velasco et al., 2020).

Also important in the coping process is resource availability during a stressful situation. During the appraisal process, young people will consider the resources available and will evaluate how these may help them (Lazarus & Folkman, 1984; Rowe et al., 2014). There is a clear distinction between formal (e.g., mental health professionals) and informal (e.g., parents, friends) sources when considering mental health help-seeking behaviours, and young people will more often disclose their symptoms to parents and friends than to professionals (Camara et al., 2017; Rickwood et al., 2007). Adolescents report feeling that they can trust informal sources more than formal sources, and the possibility that confidentiality will be breached in a professional setting is one of the main barriers that they report when considering seeking professional help (Leavey et al., 2011).

When it comes to choosing a coping strategy, type and severity of symptoms both seem to play a role. For example, Cong et al. (2019) concluded that adolescents using problem-focused strategies reported less depressive symptoms. Furthermore, Horwitz et al. (2011) reported that adolescents with high levels of self-reported depressive symptoms tended to use more maladaptive coping strategies such as self-blame (i.e. emotion-focused coping). However, young people experience gender related changes that are social, emotional, and behavioural in nature that can influence how they cope (Frydenberg, 2019). A study by Brytek-Matera (2007) concluded that girls coping with anorexia nervosa are more likely to use emotion-focused coping by managing their emotions and avoiding focusing on the problem (e.g., finding a solution). In addition, girls tend to seek more help overall (Slone et al., 2013) though this is focused on specific forms of social support like the support of friends (Sesar et al., 2016). On the other hand, boys dealing with symptoms of poor mental health, report using avoidance and recreational activities as a way to gain control over their symptoms (Rose & Rudolph, 2006).

Adding to the already complex nature of the coping process, online interactions are now central in everyday life for adolescents (Horgan & Sweeney, 2010; Houghton et al., 2015). Considerations such as simplicity, accessibility of information, and privacy can influence young people’s decisions to use the internet as a source of support for sensitive issues (Gibson & Trnka, 2020; Pretorius et al., 2019). A young person might prefer to go online and independently search for professional services so that they can maintain their privacy and control over the information (Frost et al., 2016), rather than, for example, asking their parents for help. For this reason, the internet is considered as an additional source of support in the present study.

Coping with a peer disclosure of symptoms of poor mental health

Adults encourage young people to talk with someone about symptoms of poor mental health in order to cope and overcome their difficulties (Griffiths et al., 2011). Whereas we have some understanding about how young people cope with their own symptoms of poor mental health, little is known about either how young people cope with a peer’s disclosure of poor mental health or what their emotional response to this situation might be (Raviv et al., 2000). This is important since young people often prefer to disclose symptoms to informal sources such as friends (Camara et al., 2017). Additionally, in the context of the TTC, young people dealing with their own symptoms report experiencing appraisals of threat or harm/loss (Cole et al., 2019; Fosco & Lydon-Staley, 2019). It is still unknown if the same is true when they are coping with a friend's disclosure of symptoms of poor mental health.

Similarly, the coping strategies selected by young people after a friend's disclosure are also not known. In general, adolescent girls are more likely than boys to provide emotional support and to seek professional help for a friend if they perceive the need for it (Raviv et al., 2009; Rickwood et al., 2005). As coping capabilities develop as a result of maturation and development (Rickwood et al., 2015), older adolescents are more willing to refer a friend to professional help and offer emotional support to peers struggling with symptoms of poor mental health, than younger adolescents (Yap et al., 2011a).

It is also the case that young people are more likely to refer a friend who is experiencing mental health problems to a professional than to refer themselves for the same problems (Raviv et al., 2009; Rickwood et al., 2005). The reasons for this are not clear, however, it is known that self-stigma is related to less help seeking (Lannin et al., 2016) and it is possible that in the context of someone else needing help, there is a lower level of self-stigma. As such, professional help can be seen as more viable for a young person to recommend. Moreover, the level of threat might be influenced by previous experience. Thus, this study will explore how young people differ in their coping process depending on whether they are dealing with their own symptoms of poor mental health or a friend's symptoms.

The present study

The present study aims to explore how young people cope with symptoms of poor mental health. The following research questions guided this study: How do young people understand and cope with their own symptoms of poor mental health? How do young people cope with disclosures of a friend's symptoms of poor mental health? What differences and similarities exist in young people's appraisals and coping strategies across their own and friends' symptoms? By using a qualitative approach, we hope to explore young people's meanings and insights about the topic at hand (Levitt et al., 2017), that would allow for a better understanding of the differences between both situations.

Methodology

Participants

Eleven young people from the United Kingdom aged 13 to 15 years old (M= 13.55, SD= 0.69) were interviewed (6 female, 5 male). Three were interviewed online, and eight were interviewed face-to-face. Two participants lived in England and nine resided in Scotland. Ethnicity and race data were not collected during interviews.

Materials

A semi-structured interview was developed considering the TTC elements. Prior to data collection, the interview was piloted with two young people to check question clarity and duration. This was audio recorded, took place through videoconference (i.e. Skype), and led to minor changes in phrasing of questions. The researcher started by establishing a consensus with the participants about the definition of 'mental health problems'. Young people were asked what they thought a mental health problem was, and then the researcher provided the following adapted definition from WHO (2018) "when someone is having troubled thoughts, emotions, and behaviours. Or it can even be when a person is having trouble relating to people around him or her. Some examples of this could be depression or anxiety". This was done in order to allow for all the participants to share the same understanding of what was being discussed throughout the interview.

Next, participants were asked to imagine that they were experiencing symptoms of poor mental health and were asked what they would do and how they would feel about it. The researcher also asked about their primary appraisals of this hypothetical situation (e.g., "Can you think of anything good or bad that can come from having a mental health issue?") and what coping strategies they would use to deal with it (e.g., "If you had to think about acting about it, what would you do?"). They were asked how confident they would feel about using that strategy (i.e. secondary appraisal) and, finally, about what type of support they would look for in this situation (i.e. information, emotional support or professional help) (e.g., "Would you ask for information/emotional support/ professional help?"). All participants answered the same set of questions for a second scenario in which they were asked to imagine that a friend disclosed symptoms of poor mental health to them.

Procedure

Ethical approval was obtained from the School Ethics Committee at the administering institution. Participants were recruited through community groups (e.g., Scouts, Guides, etc.) and private schools. Active parental and participant consent was sought prior to data collection. Consent to audio record the interview was asked from both parents and participants. Parents and participants were given an information sheet describing the aims of the study, and data storage procedures to guarantee informed consent. After obtaining consent, young people were interviewed either online or face-to-face and no one else was present during the interviews.

For online interviews, two forms using Qualtrics.com were created: one for parental/ guardian consent and a second for children's consent. Recruitment in community groups proceeded via an advertisement of the details of the study disseminated by email, phone, or using a paper advert. An advert was posted on the lead author's social media platforms. The researchers asked groups and people who came in contact with the advert to share the links with parents/guardians so that, if interested, they could have access to the information sheet with details about the study and give consent for their children to be invited to take part in the study. After consent was obtained, the parent/guardian was asked to share a second link for their children to have access to the participants information sheet and, if they so desire, give consent to take part in the study. During the completion of the consent forms, a time and date suitable for the interviewee was requested. The interviewer then contacted the parents/guardians to confirm said date and time for the interview.

In schools, initial recruitment involved randomly selecting (by registration number) 15 potential participants (i.e. five from three different year groups) and sending information sheets and consent forms to parents. The overall parental consent form response rate was 60%. By year group, parental response rates were 40%, 80%, and 60% respectively. Data were collected from August 2018 until May 2019 and interviews ranged from 30 to 45 minutes. All interviews were conducted by the lead author. At the end of the interviews, all participants were provided with a support sheet with information about where to get help and advice when experiencing symptoms of poor mental health.

Interviews were transcribed verbatim, and data were pseudo-anonymised (i.e. transcribed interviews were given a code name). When transcribing the interview, any information that could possibly identify a participating organisation (whether school or community group) or person was redacted. Finally, to improve transparency and help replication, this study was preregistered using the template by Haven and Van Grootel

(2019). All the materials (including full interview schedule) and plans for data analysis can be found here: https://osf.io/wshfn/.

Analysis

A deductive approach to Thematic Analysis (i.e., theory-driven) was used. Braun and Clarke's (2006) six stages for conducting Thematic Analysis were followed. The analysis aimed for a critical and detailed exploration of the themes extracted (Howitt, 2010). The TTC framed the development of the interview schedule. This means that four main elements were explored during the interviews and framed the initial analysis: 1) Mental health understanding; 2) Cognitive appraisals (i.e. primary and secondary); 3) Coping strategies (i.e. problem- and emotion-focused); and 4) Differences between coping with self and a friend's symptoms.

It has been shown that multiple coders can help reliability in the coding process (Olson et al., 2016). As such, after all interviews were initially coded by the first author, they were then doubled coded by an independent person. However, this can lead to inconsistencies in coding between the coders (Olson et al., 2016). In order to counterbalance this, discussions between all the researchers about the meaning and interpretation of the data took place in order to reach an agreement (Levitt et al., 2017). In this study, there were no meaningful discrepancies between both coders. Finally, data were managed and stored using NVivo (version 12).

Results

The two main themes were social impact and choice of resources, containing three subthemes each. A thematic map displaying themes and subthemes and subsequent relationship is provided in Figure 2.

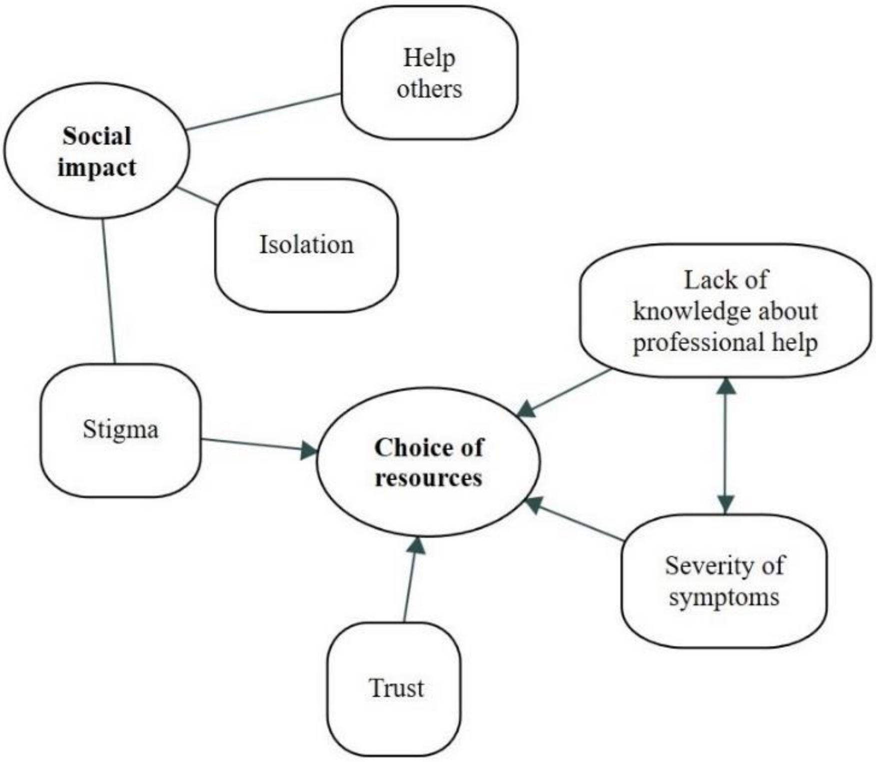

Figure 2. Thematic map.

Social impact

When exploring the appraisals of exposure to symptoms of poor mental health, participants mainly focused on the social impact. Participants were able to identify positive and negative social consequences in both situations (i.e. exploring to their own symptoms and a friend's symptoms of poor mental). As a form of positive consequences (i.e., primary appraisal of challenge), participants expressed that if they were able to overcome the symptoms they experienced, then they would be able to help others in the future. As negative consequences (i.e., primary appraisals of threat), young people expressed concern about possible isolation, and fear of being stigmatised because they would behave and feel different from others. These three subthemes will be further explored next and differences between participants' own symptoms, and a friend's symptoms, will also be explored in each of these.

Help others. Young people view being able to learn from their experiences, and consequently helping others, as a positive outcome. This was expressed in both situations (i.e. they or a friend experienced symptoms of poor mental health). According to the TTC, this could be interpreted as a challenge appraisal. One participant stated that if he went through this, he would be able to help others who are struggling to cope, emphasising his own empowerment as a result:

"I guess like it would actually make you stronger at things. And having the experience you could help others with it" (Boy, 13 years old).

Some participants also indicated that if they were faced with this situation, it would make them feel better prepared for the future. For example, one 14 year old boy said that having a mental health problem "*can teach you, like, how to deal with it…*". Similarly, one girl (13 years old) sees it as gaining a *"new set of skills"* that would allow her to help others struggling. She goes on to say that, if a friend discloses to her, and if she were to have experienced it before, they both could *"go together and talk about your experiences."* This shows an element of support that is clearly present in young people's appraisals.

Also, participants put emphasis on the future and how this could be impacted by being able to *"learn from your mistakes"*, especially when helping a friend after they have gone through something similar. A 13 years old boy adds that, if he goes through the same situation again, he might be able to *"(…) just rethink what [he] have done, [and] maybe do it differently in the future."* Finally, one girl made a clear relationship between being able to help others through her own experience and fighting feelings of isolation:

"(…) it might make you feel stronger about yourself once you dealt with it. And then you will have a story to tell and will show other people that they are not lonely." (Girl, 13 years old).

The next two themes focus on the possible negative consequences highlighted by young people when experiencing symptoms of poor mental health. These map on to the TTC as threat appraisals, since young people fear possible isolation and stigma as a result of poor mental health symptoms.

Isolation. Young people revealed concerns about feeling isolated from others as a result of experiencing symptoms of poor mental health, when considering their own or a friend's symptoms of poor mental health. Participants said:

"*Well, they [friend] might be really depressed and might sit by themselves"* (Girl, 13 years old).

"*Whereas if you are dealing with your own [symptoms] you feel more lonely, you feel more upset and you think that no one gets you"* (Girl, 13 years old).

Specifically, when faced with a friend's symptoms, a 13 year old girl expressed concern about the possible impact on their own well-being: *"if they [friend] are feeling lonely, it kind of rubs off on you so it can sometimes makes you feel sad (...)"*. She goes on to say that it might influence their time together as she would *"always keep thinking about it (...)"*, showing concern about possible changes in their friendship and their interactions.

Finally, one 14 year old girl was worried that she would not be able to *"go out with friends (...)"* and that "*they might start to wonder why [you] can't go anywhere*." Another participant stated that if she ever experienced any symptoms, she would "*(...) feel isolated from other people because they are not like the same as you*". She goes on to explore the reasons why she would feel different by saying that *"[they] cannot relate in the same way as you and feel the same way around you"* (Girl, 13 years old). These participants expressed fearing that they would be misunderstood by their friends, as well as feeling like others will not be able to relate to their experiences, so they would be more comfortable isolating themselves. There is a clear concern about others judging and not accepting them because of their symptoms.

Stigma. A 13 year old girl said that she *"would be worried about them [friends] judging me… if people knew about it and especially because nowadays some people use mental health as a joke".* Stigma seems to play a bigger role when young people are dealing with their own symptoms of poor mental health than when they are faced with a friend's symptoms. Participants also provided details about how perceived stigma could then impact their lives. One girl (14 years old), when asked about both situations, said that when dealing with her own symptoms she would *"fear getting stuff wrong and not being able to do certain things".* Thus, focusing on how the symptoms might influence her own levels of confidence when interacting with others, further elaborating that it could be *"hard to like leave the house (...) and find opportunities to do stuff"*. However, when asked about coping with a friend's symptoms, she said: *"Personally, I wouldn't mind what other people thought about [it]. I would just be trying my best to support them and not really care with what other people thought (...)."*

Participants were able to attribute origins to the stigma. One girl (14 years old) referred to the role that media can play: *"Probably because of the media… and the internet and seeing things just about depression and anxiety, and that it is not a good thing to have."* Also, one participant highlighted that stigma might be person-specific, influencing who they would disclose their symptoms to:

"*I think that some people would judge me because of it. It depends on the person… at my school people judge other people just because of their appearance so… Some people might judge me others might try to get to know me and what it is going on."* (Boy, 13 years old)

When it comes to choosing a resource to disclose to, one participant said that she *"would be concerned"* about what others might think, and that: *"(...) I wouldn't tell anybody specially my age because they would not be able to understand and they would be like 'oh you feeling this way…and why are you behaving this way?'"* (Girl, 13 years old). Thus, as she fears that her peers would judge her, she will most likely not disclose or ask for help from them. She goes on to say that she might use alternative sources of help in order to cope, in turn making her feel less exposed to potential judgement:

"I would go on the internet so that I don't have to see someone about it and feel embarrassed."

A girl (13 years old) explained seeing the value in talking to others, but because of fear of judgment she might not want to ask for help:

"But I know that I could [talk with someone] but I'd probably feel uncomfortable so I wouldn't tell them… I just wouldn't feel comfortable with it. [Interviewer: Why?] Maybe because people would judge me."

Choice of resources

Participants mainly reported using problem-focused strategies to deal with symptoms of poor mental health, for example getting information to deal with their symptoms:

"*I think I would try to like understand what it all meant and why I was like feeling that way. What I could do to change that and if I could… like work around it.*" (Boy, 14 years old)

"*I think I would want to… like… know what it is happening and why it is happening… like ask questions to understand why I am (…) feeling like that…*" (Girl, 13 years old).

Participants also often stated the need to ask for help from someone in order to deal with symptoms of poor mental health, since they felt unprepared to cope with it on their own. This became evident when dealing with a friend's symptoms. Participants often referenced seeking help from their parents to better understand how to help a friend overcome their symptoms. Factors highlighted by participants that influence resource selection are: trust levels, lack of knowledge about professional help, and perceived severity of the symptoms.

Trust. This subtheme was present in both situations (i.e. own and friend's symptoms), but interpreted differently. However, in the context of the TTC, trust could be interpreted as a secondary appraisal. In relation to a friend's symptoms, participants felt that if they needed to talk to someone about it (e.g., to ask for help) they would be concerned about breaking their friend's trust:

"(...) say that a teacher went up to them and says it [that they have told them about the symptoms] and they have no idea [that they told], that would be a bit… they would feel like their trust was betrayed, I think." (Boy, 15 years old)

"I don't want them to lose their trust in me (...)." (Girl, 14 years old)

They also highlighted the need to keep their friend's privacy and anonymity when considering disclosing to a third-party. One girl (14 years old) said that she *"(...) probably wouldn't say their names (...)"*, and that if she had to disclose, she would ask what *"(...) advice to give them or if [she] could do anything to help them (...)."* In addition, young people stated their concerns about not knowing if their friend would want others to know, so they would prefer to not ask for help from others when a friend discloses symptoms to them:

"Because I am not sure if my friend would want me to share that with a teacher (...)" (Boy, 14 years old).

“(...) I don’t know if they feel like talking with other people. Like… not sure if they want to share stuff with others” (Girl, 14 years old).

Moreover, suggesting professional help to a friend was viewed as something that would potentially damage the friendship. One girl (14 years old) said that she feared that *“(...) they might not trust you as much then [after suggesting professional help].”* She goes on to explore the reasons why by saying that they probably would think that *“(...) they can do it by themselves.”* This point of view is supported by another participant who, when asked about suggesting professional help to a friend, said:

“Not sure (...) it would be hard because, like I wouldn’t want them to like, lose their trust in me. They might not take that very well” (Girl, 13 years old).

Trust was also highlighted when young people were the ones experiencing symptoms. In this case, participants identified the need to feel comfortable and trusting someone prior to disclosing or asking for help. A girl (14 years old) said:

“I would maybe go and talk to a close friend that I (...) that I know that they wouldn’t go and speak to anyone about it. (...) it would just be between me and them. Just take them away and have a chat with them about it.”

However, young people do not hold much trust in resources other than parents and friends. For example, when asked about online resources, participants talk about not trusting chatrooms or websites where people share their experiences:

“(...) for example those people online that are feeling suicidal and talk about it and try to hide it, I don’t think I would trust those people” (Boy, 13 years old).

“(...) I wouldn’t probably just go off from some source of Google, *because it is not really reliable (...).”* (Boy, 13 years old).

Moreover, it seems that school staff are not considered to be a resource for dealing with symptoms of poor mental health. Participants expressed feeling uncomfortable disclosing these hypothetical symptoms to teachers. One participant (Girl, 13 years old) said that although she is *"with the teachers everyday"*, she does not think she *"would be as comfortable going up to them with something so serious."* Another young girl (13 years old) said:

"I would be comfortable talking with family and friends, but when it comes to my pastoral care at school not really".

She goes on to emphasise the lack of trust and issues pertaining to confidentiality that could be broken if confiding in a teacher at school who provides support for students' emotional wellbeing. Additionally, a 14 year old boy, when asked if he would consider talking with someone at school, said no because *"they are not people that I know well and trust (...)";* Indicating a need for rapport to be built beforehand in order to feel comfortable disclosing.

As with school staff, young people show an overall lack of trust in using professional help. They said that they *"would be a bit nervous to open up about it [symptoms] to a doctor that I don't really know that well (...)"* (Girl, 13 years old). Lack of trust in professionals could be related to an overall lack of understanding about this resource.

Lack of knowledge about professional help. Overall, participants did not consider professionals to be their main source of help. If in need of professional help, participants said that they would be unsure about how to find it and would most likely resort to using other resources, like parents or online information, to cope:

"I probably would have to ask my parents about it [where to go for professional help] (...)" (Girl, 14 years old).

"(...) I would probably start off by like Googling specialist help at first, to see the places I could probably go. And if there is none near me, then probably ask my parents if they know places (...)" (Boy, 13 years old).

One participant (Boy, 14 years old), when asked if he would consider professional help, shared that he *"(...) would go to a therapist (...)"*; however, he was unsure about *"(...) how to go and find them (...)"*. As a result, he would have to ask his parents for help or *"(...) probably the school help to find professionals"*. Nonetheless, he also said earlier: *"If it is something like bullying maybe [he would share with parents]... but if it was something more, I would probably keep it to myself"*. He added that he would not disclose to a teacher since he feels that he cannot trust them with that type of information. On the one hand, this participant is capable of identifying a strategy (i.e. professional help) that he considers would be beneficial for him; yet he also expresses the difficulty in accessing it. Thus, because he does not feel comfortable disclosing to either teachers or parents, he might not ask for professional help even if he was in need of it.

A lack of overall knowledge about professional sources is also present when young people say they would *"just look up what the symptoms are online and be sure before you go somewhere. Make sure that that it is really how you are feeling and speak to someone that have dealt with it before"* (Girl, 13 years old). This shows a need to confirm their feelings and symptoms prior to asking for help from a mental health professional.

Severity of symptoms. Overall, young people said that the more severe they perceived symptoms to be, the more likely they are to ask for professional help. This was true for their own and for a friend's symptoms. According to the TTC, this could be considered as a threat appraisal. When asked about what he would do when faced with a friend's symptoms, one participant considered severity of symptoms as a way to decide what to do:

"It depends… if it was suicidal I would get help first thing, because I would not risk it because… I don't know what would happen. But if it wasn't and was just pressure or mad at themselves for something they have done (...) I would try to get to the bottom of it first, and if I didn't know what to do, I would get professional help" (Boy, 13 years old).

Participants often said that they would ask for professional help if it was "*severe enough*" or if it got "*too bad*". When asked about what they meant by this, young people referenced suicidal thoughts or intentions to self-harm:

"If it was severe… like you can't stand your life and stuff." (Boy, 14 years old)

"(...) like when they are hurting themselves or they don't want to be here anymore (...)" (Girl, 13 years old).

"(...) more severe, like harder to deal with. Like suicide or self-harm type of things" (Girl, 14 years old).

"(...) if they thought about suicide and those things. I wouldn't be able to help them" (Boy, 15 years old).

This theme is even clearer in a quote by a 13 years old girl where she states her distinction between what can be consider minor and severe symptoms:

"I think if it got to quite a bad time I'd probably go to professional help. But if it's just like depression I would probably just keep it going with my friends and family".

Discussion

This study aimed to understand the coping process when young people deal with their own symptoms or a friend's symptoms of poor mental health, highlighting similarities and differences.

Cognitive appraisals

Primary appraisals.

Participants attributed an appraisal of challenge by expressing possible gains when helping others once they themselves overcame their symptoms. This reflects Lazarus and Folkman's (1984) description of challenge appraisals where an individual overcomes a stressful situation and expresses feelings of confidence and growth from it. However, reflecting previous literature (Cole et al., 2019; Fosco & Lydon-Staley, 2019), participants mostly highlighted negative appraisals when confronted with possible symptoms of poor mental health (whether their own or a friend’s). Feelings of embarrassment and possible isolation were important to the participants when assessing exposure to symptoms. When considering differences between both situations, young people feared more the impact of public stigma when they themselves experienced hypothetical symptoms. The results from this study are in line with a systematic review (Schnyder et al., 2017) that also reported that young people are less likely to seek help for their symptoms if they perceive high levels of public stigma.

Secondary appraisals.

When it comes to secondary appraisals, supporting previous research (Rickwood et al., 2007), young people preferred to talk to a friend or to their parents if they were experiencing symptoms of poor mental health. When dealing with their own hypothetical symptoms, participants said that they would only disclose to someone who they consider trustworthy. This is in line with previous research which has shown that young people expressed the need to keep control over the information being shared and to whom this is later shared with (Buchholz et al., 2015; Huggett et al., 2018). When considering a peer disclosure, young people say that they might feel threatened by the possibility of losing a friend if they (i.e. young person) decide to ask for help from a third-party. Indeed, in the context of mental health discussions, young people report social isolation as a result of losing a friendship and breaking their friend’s trust (Huggett et al., 2018).

Coping strategies and resources

The young people in this study did not spontaneously mention school staff as a source of support, and did not feel school staff would be helpful when asked directly about them. Rickwood et al. (2015) also highlighted that, adolescents are unlikely to turn to school staff when seeking help for mental health difficulties, despite the existence of relevant services within school grounds. Since this research provides further evidence of the lack of use of school staff by young people when dealing with symptoms of poor mental health, future research should focus on understanding why this is the case. It might be helpful to understand the underlying reasons why adolescents do not feel comfortable reaching out to school staff, despite schools highlighting that staff is available to help students with their mental health. Thus, understanding where this lack of confidence stems from could help to adapt school services approaches in order to provide better support to young people.

Young people infrequently mentioned turning to online sources of support to cope with the issues raised in the interviews. This was even the case when they were directly asked about accessing this type of help. This was unexpected given the high levels of engagement with electronic media by this age group (Houghton et al., 2015). Furthermore, participants were critical judges of available online support and did not trust chat rooms or websites where people share their experiences. Previous work has raised concerns about unsupervised information online and how this can negatively influence coping strategies (Calancie et al., 2017; McCrae et al., 2017). Thus, the fact that the young people in this study reported being sceptical about the trustworthiness of online information is encouraging, when we consider sources that are not from reputable sources. However, this could be problematic for online resources from trustworthy services, such as the websites of the WHO or a country's National Health Services, that offer support online.

Type of coping strategy also differed depending on the situation to which young people were exposed. When dealing with their own hypothetical symptoms, young people reported that they would be mostly focused on getting information and dealing with symptoms (i.e. problem-focused coping). This could be interpreted as being consistent with Lazarus and Folkman's (1984) assertion that problem-focused strategies are more often used to deal with situations considered changeable. The young people in this study may therefore perceive they have the skills or resources to deal with their symptoms, and consequently, a higher self-efficacy. It is possible that when helping a friend, young people struggle with fears of inadequacy and "doing the right thing" as they are unsure of what they should do in order to help their friend. This in turn impacts their coping strategies. On the one hand, they can refer their friend to a trusted adult but, on the other hand, they could refrain from acting as a result of the fear of not knowing what is the right thing to do. Research relating to young people's mental health literacy has focused on implementing programmes designed to aid symptom recognition and, consequently, help-seeking intentions for a friend (Hart et al., 2018; Mason et al., 2015). Future research should explore the potential role that investing in mental health literacy programs could play in young people's responses to a friend's mental health distress.

In this study, severity of symptoms was presented as being one of the main influences on seeking professional help. Young people reported that they would only consider professional help as an option if they or a friend were experiencing suicidal thoughts or self-harming behaviours. Reporting that higher levels of threat would make them seek help from a professional. This contradicts research showing that the higher the severity, the lower the likelihood of adolescents seeking help (Velasco et al., 2020). The contradiction can be a result of research mainly exploring help-seeking behaviours when dealing with their own symptoms and not a friend's. This theme could suggest that higher levels of threat are linked with higher levels of help-seeking when coping with a friend's symptoms. While higher levels of threat would be linked with lower help-seeking behaviours when young people are dealing with their own symptoms of poor mental health.

Furthermore, it is interesting to note that, at the beginning of each interview, when asking the young people to define what mental health problems meant to then, none of the participants mentioned suicide or self-harm. Instead, definitions mainly referred to symptoms of anxiety and depression such as sadness, stress, and isolation from others. Future research should explore how young people view severity of symptoms and in what way this can influence their help-seeking behaviour more broadly.

Strengths, limitations, and future directions

This study has many strengths. By using a qualitative methodology to understand the coping process, this study has described how coping strategies may differ when symptoms of mental health problems are experienced compared to when a peer discloses such symptoms. This study also provides further understanding of how young people may cope with a peer disclosure. Knowledge about the coping process (i.e. appraisals, resources, and strategies used) can be helpful in order to provide better mental health support to young people through these difficult times. It is also important to note limitations. The interviews were based on hypothetical scenarios. Responses from a sample of adolescents with lived experiences may reveal different themes.

It is worth mention that although background information other than gender and age was not collected, these results should also be interpreted considering the cultural context young people live in. It is known that young people from minority groups have a harder time seeking help when it comes to their mental health (Okur et al., 2016). Thus, future research should aim to understand differences between coping with one's own and a friend's symptoms in light of cultural background characteristics. Similarly, the results do not allow for conclusions to be drawn about age differences, due to the restricted age range of the sample. Future research should look into lived experiences and explore age differences so that further insight can be gained about young people's coping strategies across the breadth of late childhood and adolescence.

Additionally, when analysing the data, it was noticeable that participants did not consider online resources as a source of help. They highlighted that they would only use online resources if they had doubts about what symptoms meant (i.e., information seeking). Participants did not mention conversations online with peers or family members when asked about online help-seeking behaviours, despite online interactions with friends via social media being one of the most used ways of communication in adolescence. This might be due to how the question was asked. In the future, it will be helpful to probe in more detail how online interactions influence help-seeking behaviours. This could be accomplished by, for example, asking participants about each specific online interaction (e.g., social media, visiting websites, gaming). Further research exploring the link between coping strategy used and the source of support chosen could be beneficial to understand the relevance of online sources for young people when dealing with symptoms of poor mental health.

Finally, it is relevant to note that this study aimed to document the differences and similarities when comparing a situation where young people deal with their own symptoms of poor mental health and a situation where they deal with a friend's symptoms of poor mental health. The emotional effects of a friend's disclosure were not assessed here. Future research could explore the effects on adolescents' mental health and the stressors that emerge when they are the source of help for their peer's disclosure of symptoms of poor mental health.

Implications

The implications of this study are of interest to schools, parents, and mental health professionals. These findings emphasise the negative role that stigma plays when seeking help. There was a connection between stigma and young people's own symptoms of poor mental health, and, notably, this was absent when dealing with a friend's symptoms. Thus, stakeholders like schools, parents, and mental health professionals could focus attention on reducing the effects of stigma when a young person experiences symptoms themselves, but not when they are exposed to it by a friend.

Additionally, when it comes to seeking professional help, this study speaks to the potentially harmful belief that young people hold of mostly only seeking help from professionals when symptoms are characterised as severe. Thus, this finding can provide some support for the improvement of young people's awareness of the preventive nature of mental health professionals rather than a last resort solution. Finally, findings from this study revealed a reluctance by young people to seek help from school staff. Efforts should focus on improving young people's confidence with respect to disclosing to school staff and this is linked to wider discussions concerning the creation of a safe environment in schools for young people to disclose their symptoms.

Conclusion

This study provides a contribution to our understanding of how the coping process unfolds in young people when dealing with symptoms of poor mental health. The findings highlight the need to invest in anti-stigma campaigns that focus on helping adolescents' access helpful resources and demonstrate how those resources can be of benefit.

Additionally, anti-stigma campaigns could also play a role in reducing social isolation by giving adolescents a lived experienced example which they can relate to. Investment in these campaigns is also very timely given the negative consequences for young people's mental health due to the current COVID-19 pandemic.

This study also showed that the severity of symptoms experienced seems to impact the choice of resources and how coping unfolds, for their and a friend's symptoms. As such, further exploration of the relationship between severity and coping strategy, coupled with the influence of stigma and trust, could prove helpful in order to better support young people coping with symptoms of poor mental health. Finally, the lack of confidence in approaching school staff when coping with symptoms of poor mental health needs to be further explored in order to provide the most adequate support to young people.

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Chapter 6- Young People's Support Seeking Behaviours

In the previous chapter, it was found that young people differed in their coping process when dealing with their own or with a friend's symptoms of poor mental health. Young people's threat appraisals, in the form of stigma and trust in one's sources of support, appear to influence decisions concerning the choice of coping strategies in both situations (i.e., dealing with their own or with a friend's symptoms of poor mental health). Thus, this chapter will focus on exploring how stigma, trust, and threat can influence young people's decisions when dealing with their own or with a friend's symptoms of mental illness. As stated in Chapter 1, the focus from this point forward will shift from 'symptoms of poor mental health' to 'mental illness' (as per the definition given in Chapter 1).

Prior to moving forward, it is also relevant to provide further clarification about concepts related to the TTC and support seeking. As stated in Chapter 2, Lazarus and Folkman (1984) proposed that the individual uses a variety of coping strategies to deal with stressful situations. Seeking support is proposed by the authors as one possible coping strategy when dealing with stressful events. Throughout this chapter, and in the remainder of the thesis, support seeking will be referred to as the main outcome of interest instead of 'coping strategies', though the definition of this concept still stands as explained in section 2.3.2. under Chapter 2. This is also in line with the existing focus on support seeking already detailed in Study 1 (see Chapter 5).

Thus, a combined approach of coping (i.e., merging problem- and emotion-focused strategies) is used in this chapter ahead of Study 2. This conceptualisation of support seeking will be presented in this chapter. Specifically, literature on support seeking from friends, parents/carers, teachers, professionals, and online will be explored. These five sources were selected given the relevance that each of them possesses in an adolescent’s life, as detailed earlier when describing Bronfenbrenner’s (1977) Ecological Systems Theory (see section 2.4., Chapter 2).

It is helpful at this point to add that this conceptualisation of support seeking differs from help-seeking as it aims to be broader and more inclusive of different supporting behaviours that young people maybe engage in. Generally, help-seeking has been defined in the literature as the act of seeking help from an external source following a disclosure of psychological distress (Cornally & McCarthy, 2011; Tomczyk et al., 2020). Although help-seeking research has shown that elements such as social and emotional support influence help-seeking behaviours in young people (Sesar et al., 2016), some of the existing research and measures available did not allowed for the specificity needed in this research. Furthermore, the exploratory nature of the study, especially in regards to the friend’s disclosure component, limited the applicability of some of the existing concepts such as help-seeking or social support. As such, the inclusion of the term support seeking in this thesis as a concept that includes a variety of forms of dealing with the distress caused by symptoms of mental illness (e.g., going online for emotional support) is more suited to the research being proposed in order to better understand the dynamics at play.

Further to the definition provided before, help-seeking has been shown to be dependent on different aspects from the recognition of symptoms of mental illness, to the attitudes towards seeking help, intentions and willingness of seeking help when dealing with a mental illness, and finally the help-seeking behaviour in itself (Rickwood & Thomas, 2012; White et al., 2018). Considering all of this and, although all these elements are connected, Sheeran and Webb (2016) proposed that there is a gap between intentions to seek help and actual help-seeking behaviour. As this thesis focuses on both intentions of support seeking (i.e., in Study 2 by the use of vignettes as will be described later in

Chapters 7 and 8) and actual reports of support seeking behaviour (i.e., in Study 3, presented later in Chapter 9), results from this thesis can be used to provide further insights as to why this gap exist and what contributes to differences between intentions and behaviours when seeking support for mental illness.

6.1. Sources of Support Available for Young People when Dealing with Mental Illness

Young people recognise they can seek support for mental illness from a variety of sources (Velasco et al., 2020; Vostanis et al., 2022). Some of these include GPs, psychologists, social workers, sports coaches, friends, and family. Overall, these sources can be divided into two types: formal and informal. Formal sources include any mental health professionals (e.g., psychologists) and school staff, while informal sources are considered the ones involved in the social network of the young person (e.g., friends, family) (Camara et al., 2017; Husky, 2016; Velasco et al., 2020). In general, young people are more likely to ask for informal support when dealing with symptoms of mental illness than to ask for formal support (e.g., Camara et al., 2017; Lubman et al., 2017; Velasco et al., 2020). For the purposes of this thesis, the focus is on five specific sources: two formal (professionals and teachers), two informal (friends and parents/carers), and one which can assume both informal or formal properties (online). This last source of support is mixed because a young person could go online to talk to others online that they may or may not know in chatrooms for example (i.e., informal) or go online to discuss their symptoms with professionals (i.e., formal). Thus, this source will be explored in an isolated manner throughout this thesis.

Table 6.1 summarises some descriptive evidence available on informal and formal support sought by young people after experiencing symptoms of mental illness. This suggests that young people prefer to disclose symptoms to informal sources, most often friends (Fortune et al., 2008; Sears, 2020). Leavey et al. (2011) explored support seeking preferences of adolescents when dealing with anxiety and depression and found a higher preference for friends (66% and 68% respectively), followed by their mother (60%), and father (30%). Considering the formal sources explored in this thesis, research has been consistent in concluding that young people are less likely to use them. Leavey et al. (2011) concluded that only 30% of adolescents would consider asking for help from a GP, while Fortune et al. (2008) reported frequencies as low as 5% of adolescents who sought support from psychologists after an episode of self-harm.

Teachers are a valuable source in detecting, supporting, and guiding young people's experiences of symptoms of mental illness (Berger et al., 2013) and schools are seen by researchers and professionals in the mental health field as valuable sources of dissemination of mental health support (Vostanis et al., 2022), yet young people are reluctant to use this source (Daniel et al., 2010). Fortune and colleagues (2008) concluded that only around 6% of adolescents reported their intentions to self-harm to a teacher. Leavey et al. (2011) reported higher proportions when surveying adolescents about their help-seeking intentions, with 12% of adolescents taking part in the study reporting that they were willing to seek support from a teacher for symptoms of depression and 16% for symptoms of anxiety. These relatively low numbers reinforce the need to address young people's willingness to seek support from this source (Yablon, 2017).

There are not many studies that look at young people seeking support online when dealing with symptoms of mental illness (Mitchell et al., 2017). Though most of the existing literature focuses on how to best use and take advantage of the digital format to aid young people's mental health (e.g., Čuš et al., 2021; Liverpool et al., 2020; Moltrecht et al., 2022), studies comparing online behaviours with other sources of support are scarcer. However, a recent report from Ofcom (2022) concluded that, in 2021, nearly all children surveyed in the UK (aged 3-17) had access to the internet and used it at home. In Scotland, children’s access to, and use of, the internet equates to 93% of surveyed children. Furthermore, in Scotland, 68% of children between the ages of 3 and 17 have their own smartphone (Ofcom, 2022). Given the pandemic-related stay-at-home orders, some of these proportions might have been affected by the need for children to be dependent on technology to communicate with others as well as to learn (e.g., Nagata et al., 2021; Pandya & Lodha, 2021).

Adding to the evidence around prevalence of access to internet and devices, research has also explored, mostly using self-report, how much time adolescents spend using a digital screen. Przybylski and Weinstein (2017) surveyed 120,115 English adolescents (age 15) and found that 20% spent more than 12 hours of screen time during the weekday and that 35% reported spending more than 12 hours of screen time on weekends. Similarly, Haycraft and colleagues (2020) surveyed 204 British adolescents (aged 11 and 12) and concluded that one third of the time after school (between 3pm and 10.45pm) was spent using screens.

As shown in Table 6.1, Sawyer et al. (2012) found that 11% of participants would use the internet if they were to ever experience depressive symptoms. Furthermore, young people reported that discussing sensitive topics, like symptoms of mental illness, can be easier in an online setting rather than a face-to-face one (Callahan & Inckle, 2012). Going online to seek support can involve a variety of behaviours from the young person. Young people can go online to gather information about their symptoms (Birnbaum et al., 2017; Feng & Campbell, 2011; McKinley & Ruppel, 2014). A common form of search for symptoms and possible treatment used by young people are text-based enquiries online (Wetterlin et al., 2014). Searches can differ according to type of symptoms experienced.

Table 6.1

Informal and formal sources of support.

Study	Sample	Type of source	Outcomes
Berger et al. (2013)	N=2,637 12 to 18 years old	Formal and Informal	Of those who thought about self-injuring: 27% told a friend, followed by a parent/carer (15%), professional (8%), and teacher (1%). Of those who engaged in self-injuring: 43% informed a friend, 16% a parent/carer, 13% professional, and 2% a teacher.
Boldero & Fallon (1995)	N=1,013 11 to 18 years old	Formal and Informal	When in distress, participants would ask support from: Friend- 40%; Parents/carers- 36%; Teachers- 11%; Professionals- 13%.
Ciarrochi et al. (2003)	N=217 13 to 17 years old	Informal	Higher intentions of seek support from friends and parents/carers.
Fallon & Bowles (1999)	N=1,022 11 to 18 years old	Informal	Girls sought more support from friends (48%) and family (34%). Boys sought more support from family (46%) and friends after (34%).
Fortune et al., 2008	N=5,293 15 to 16 years old	Formal and Informal	Those who experience self-harm, sought support from: Friends (40%), family (11%), psychologist (5%), and teacher (6%).

Leavey et al. (2011)	N=298 13 to 15 years old	Formal and Informal	Anxiety and depression symptoms, adolescents would seek support from: - Friends (66%–68%, respectively), - Mother (60%), Father (30%), - GP (9%–10%, respectively), - Teachers (12% and 16%, respectively).
Rickwood & Braithwaite (1994)	N=715 16 to 19 years old	Formal and Informal	58% sought help from an informal source 9% sought help from professional source
Sawyer et al. (2012)	N=5,362 12 to 14 years old	Formal and Informal	If they experienced depressive symptoms: - 80% support from friends - 73% support from family members - 11% support from the Internet - 29% support from school counsellors/nurses - 8% would not seek support from anyone
Sears (2020)	N=488 14 to 18 years old	Informal	Between 51% to 65% would select a friend if they had an interpersonal problem.
Yablon (2017)	N=859 12 to 15 years old	Formal and Informal	After distress at home: - One in five approached a friend. - 8% of the students asked support from school counsellors, and 5% from teachers

Research has concluded that if young people want support for non-psychotic mood disorders, they will focus on how to overcome the symptoms, and if they are dealing with psychotic spectrum disorders, they tend to be more focused on why the symptoms developed (Birnbaum et al., 2017). Furthermore, when searching for symptoms and treatment options, it is videos, personal stories, and forums that seem to be the main vehicle through which young people access this information online (Wetterlin et al., 2014).

Access to online communities and forums is relevant when young people are searching for support online. Young people post messages describing their own personal distress and request feedback from other users (Feng & Campbell, 2011; Frost et al. 2016; Greidanus & Everall, 2010). When distressed, young people who self-harm have been found to prefer to use online services such as forums (around 49%) rather than asking for face-to-face support (Frost et al., 2016). Further to this, Čuš et al. (2021) interviewed 15 adolescent girls (aged 12-18) that met the diagnostic criteria for a current non-suicidal self-injury disorder to assess young people’s preferences and needs in digital interventions using smartphones. Participants revealed that contact with peers with past or current experience of similar disorders would be beneficial, though these interactions should be monitored to control for triggering effects when sharing experiences of this nature.

When it comes to professional support, evidence points towards a preference for online services (Best et al., 2016) or even professional social media accounts (Birnbaum et al., 2017). Haner and Pepler (2016) concluded that young people with higher levels of distress were more likely to use the chat function of a professional mental health service website when seeking support. Similarly, according to Frost et al. (2016), around 54% of their sample with history of self-injury preferred to be linked with a professional directly through a website using instant messaging. At the same time, Čuš et al. (2021) highlighted that young people still feel that digital interactions cannot replace a face-to-face one, with balance between online and face-to-face interaction needing to be considered when developing mental health interventions for young people.

Most of the studies in the field highlight anonymity and privacy as the main benefits and motivators for young people to use online support (e.g., Liverpool et al., 2020; Pretorius et al., 2019). The immediacy of the information from online sources is another benefit that has been highlighted (Yuan & Ip, 2018). Similarly, the possibility to connect with others that have similar experiences has been reported by young people as a strong motivator to use online sources when seeking support (e.g., Čuš et al., 2021; Pretorius et al., 2019). However, there are also drawbacks. Adolescents report failing to trust the information they find (Pretorius et al., 2019), and say that have concerns about confidentiality not being guaranteed online if data sharing agreements were to be broken (Liverpool et al., 2020; Pretorius et al., 2019). On the other hand, adolescents also reported trust in online sources and feeling confident online as the fear of rejection and embarrassment is not as prevalent as if they were discussing their symptoms with someone face-to-face (Liverpool et al., 2020).

Overall, different factors like age and maturation can influence adolescents' decision making when seeking support. For example, older adolescents report seeking more support from friends than parents/carers when compared to younger adolescents (Sears, 2020). Early research has suggested that girls are more likely to ask for support from friends (48%) and boys more likely to ask for family support (46%) (Fallon & Bowles, 1999). Low levels of mental health literacy, young peoples' understanding of the severity of symptoms (Kelly & Jorm, 2007), lack of confidentiality and, consequently, lack of trust (Leavey et al., 2011; Verhaeghe & Bracke, 2011), have all been reported by young people as important deterrents to seeking support from professionals. Despite the above-mentioned literature, evidence regarding the mechanisms by which young people decide to choose to seek support from a particular source is still scarce, particularly when it comes to dealing with a friend's disclosure. The remainder of this chapter will aim to provide the rationale of the mechanisms through which young people seek support as well as provide a framework for possible differences between seeking support, using each source, for their own or a friend's symptoms of mental illness.

At this stage, it is relevant to highlight and reflect on an existing theme from the literature. It has become clear that some of the tone of the existing research is focused on the young person being the driver and active searcher of support when in distress. This is in contrast with the need for young people being the receivers of existing support, almost as passive actors where the available sources of support are at their disposal at any given time without the need for search and look for information about it. Later on, the results of this thesis will be discussed in the light of this.

6.2. Factors Influencing Support Seeking Behaviours

Two systematic reviews have highlighted the facilitators and barriers that young people face when seeking support for mental illness (Gulliver et al., 2010; Velasco et al., 2020). Both reviews conclude that low mental health literacy can hinder the support seeking process for young people because lower mental health literacy leads to problems identifying symptoms and recognising the need for help. Similarly, concerns around confidentiality when asking for support from a mental health service has been noted by young people as a barrier to seeking help. Adolescents fear that they are not able to disclose sensitive information to mental health services staff because they are concerned that this will be shared with others. On the other end of the spectrum, positive past experiences with mental health services are referenced as a facilitator of seeking support.

Young people feel more comfortable accessing services if they have a positive, previous experience to draw on.

Both systematic reviews also concluded that stigma can act as a barrier to seeking support when young people are experiencing symptoms of mental illness (Gulliver et al., 2010; Velasco et al., 2020). Both public- and self-stigma were identified to be key deterrents when considering young people's support seeking behaviours. These two reviews also highlight the importance of trust in this process. The authors concluded that high trust levels can facilitate support seeking, with young people more likely to seek support from a source who they trust (Gulliver et al., 2010; Velasco et al., 2020). One further element worth reflecting on when reviewing both these systematic reviews, is the fact that although they were published 10 years apart, they found similar barriers and facilitators in young people's support seeking behaviours. Alongside the results from Study 1, the reviews support a focus on both stigma and trust in relation to support seeking and so these are described in more detail in this chapter.

6.2.1. Mental Illness Stigma

Social pressures, and prejudice surrounding mental illness, have been shown to play a role in support seeking (Corrigan et al., 2012; Lannin et al., 2016). Mental illness stigma is complex and our conceptualisation and understanding of it has evolved throughout the years. Overall, stigma can be defined by the beliefs, attitudes, and behaviours that one has that reveal prejudice towards a particular condition (Corrigan et al., 2004) and can reduce young people's support seeking behaviours (Bulanda et al., 2014; Clement et al., 2015).

Understanding how stigma related to mental illness occurs can aid in our comprehension of how young people cope with mental illness and what support they seek when dealing with symptoms of mental illness. Link et al. (1989) propose a five-step explanation of how stigma related to mental illness occurs. First, a person's beliefs about mental illness develops early in life through socialisation with others and their environment (Angermeyer & Matschinger, 1996; Chandra & Minkotivz, 2006). Based on their own experiences within society, people either reject or accept others who are experiencing symptoms of mental illness in different areas of their life (e.g., social, work), and act according to what they perceive others' symptoms to be (Gaebel et al., 2017). The second step proposed by Link et al. (1989) highlights the possible change in meaning and beliefs as a result of personal experiences of symptoms of mental illness. Acceptance of someone with a mental illness will be more likely if the individual perceives personal relevance in the symptoms being experienced by others (Link et al., 2018). This is relevant to the TTC, which references goal relevance as one of the components of primary appraisal (Lazarus, 1991a, 1999). Thus, stigmatising beliefs about mental illness could be changed during the primary appraisal process as a result of the goal or personal relevance of the stressful event (i.e., symptoms of mental illness).

The third step refers to the person being labelled as mentally ill, and how they decide to deal with the possible rejection (Link et al., 1989, 2017). This relates directly to selection of coping strategies and to the outcomes of that choice. Specifically, if someone decides to use avoidance, or to hide their treatment from others, this might lead them to feel more social isolation. Link et al.'s fourth step emphasises the emotional and psychological consequences of experiencing rejection and stigma. Feelings of shame and loneliness have been directly associated with higher levels of stigma (Link & Phelan, 2001; Link et al., 2017). Finally, the last step refers to the bidirectional component of the relationship between stigma and mental illness: experiences of mental illness are associated with experiences of stigma and rejection from others (Link et al., 1989) while, at the same time, these experiences of stigma can lead to an increase of mental illness symptomology and recurrence of stressful events that can result in mental distress (Link et al., 2017).

Essentially, stigma is the result of labelling others in ways that have a negative connotation (Link & Phelan, 2001). This can create a separation between different groups in society, resulting in feelings of discrimination. Corrigan (2013) developed these ideas to form the Social-Cognitive Model. According to the Social-Cognitive Model, stigma in composed of three social-cognitive constructs (stereotypes, prejudice, discrimination) and two forms of stigma (public-stigma and self-stigma) (Sheehan et al., 2017). The relevance of public- and self-stigma are supported by the work of Gulliver and colleagues (2010) in which young people reported these as the top two types of stigmas that have a negative impact in their support seeking behaviours.

Stereotypes are harmful thoughts and beliefs based on society's opinions, for example, that individuals with mental illness are dangerous or violent. These thoughts can be harmful to the individual who is the target of these thoughts (Corrigan et al., 2014; Gaebel et al., 2017). Symptoms associated with different mental illnesses can be associated with different stereotypes. For example, people who experience symptoms of bipolar disorders are usually labelled as, and perceived to be, unpredictable (Angermeyer & Dietrich, 2005; Cassidy & Erdal, 2020), while people with drug addictions are often perceived to be dangerous (Schomerus et al., 2011; Yang et al., 2017). Stereotypes can be a result of cultural influences as well as personal experiences, thus making them inevitable (Corrigan et al., 2014).

Such stereotypes can be present from an early age. Jorm and Wright (2008) surveyed Australian youth aged 12 to 25, assessing their levels of personal and perceived stigma. They found evidence that young people hold stereotypes that people with mental illness are dangerous, unpredictable, and that they are weak and not sick. Commonly, stereotypes can include perceptions that an individual experiencing mental illness symptoms is dangerous, incompetent, or that the symptoms will never go away (Angermeyer & Dietrich, 2006; Corrigan et al., 2014; Rüsch et al., 2005; Sheehan et al., 2017). Dangerousness has been reported by individuals as the primary stereotype held about mental illness. Adults who endorse this stereotype tend to view individuals who have been diagnosed with schizophrenia as someone who could be violent (Broussard et al., 2012; Link et al., 1999). In addition, when people endorse the stereotype of dangerousness, they are less likely to be friends with someone experiencing symptoms of mental illness (Angermeyer & Matschinger, 2005).

Pescosolido and colleagues (2013) concluded that stereotypes of incompetence are also commonly associated with mental illness. If the public endorse this stereotype, it is more likely that they will treat others with symptoms in a condescending way (Corrigan et al., 2014). Usually, this stereotype is linked with a loss of independence given that, for example, family members might assume that someone experiencing symptoms of mental illness will not be able to support themselves (Sheehan et al., 2017). Finally, the belief that symptoms are a constant, and that there is no solution to them, is also a common stereotype related to mental illness (Corrigan et al., 2014; Gaebel et al., 2017). If a disorder is perceived to be ‘severe’ or ‘chronic’, an often-held stereotype is that the disorder is permanent and that symptoms cannot be changed (Hayward & Bright, 1997).

Prejudice refers to the emotional response resulting from stereotypes and is defined by agreement with the stereotypes described earlier (Corrigan et al., 2014; Sheehan et al., 2017). For example, when an individual is afraid of someone who is diagnosed with a mental illness (Corrigan et al., 2014; Gaebel et al., 2017) this can reflect prejudice. Finally, discrimination is the behavioural response associated with these stereotypes and prejudice. This is an action of a person that has a negative outcome in the stigmatised individual. This can include avoidance and withdrawal from a person diagnosed with a mental illness (Corrigan et al., 2014; Gaebel et al., 2017; Thornicroft, 2006). For example, teachers might treat pupils differently if they believe that because they have a mental illness, they are unable to complete their schoolwork. As a result, pupils might feel excluded and singled-out from the rest of their class.

Stereotypes, prejudice, and discrimination can manifest themselves in different forms. Sheehan et al. (2017) suggests the existence of different types of mental illness stigma. Among these, the authors propose the existence of public- and self-stigma. For the reasons stated earlier, a definition and explanation of the impact of both these types on support seeking will be provided next.

6.2.1.1. Public-Stigma.

Public-stigma is characterized by the endorsement of stereotypes or discriminatory beliefs towards a particular group (Corrigan et al., 2004; Corrigan & Kosyluk, 2014). MacLean et al. (2013) reported that young people aged 10 to 15 years old hold stigmatising views and beliefs about people with symptoms of mental illness that they are, for example, “rare” or “weird”. Faulkner et al. (2010) found that over a third of adolescents would not want to be friends with someone who had a diagnosis of schizophrenia and that over a quarter would be afraid to talk to someone who had that same diagnosis. Furthermore, Moses (2010) showed that young people undergoing treatment for mental illness chose to hide that information from their peers in order to protect their relationships and to avoid feelings of embarrassment and judgement.

As far as gender is concerned, research with adult samples shows that females report lower levels of public-stigma (Dietrich et al., 2014; Griffiths et al., 2008; Wang et al., 2007). Research with youth samples mimic this trend with girls being reported to hold fewer stigmatising attitudes and beliefs than boys (e.g., Bradbury, 2020; Jorm & Wright, 2008; Pfeiffer & In-Albon, 2022). DuPont-Reyes et al. (2020) used a vignette-based study with an adolescent sample with a mean age of 11.5 years old, to assess gender differences of mental illness related public-stigma. They concluded that boys had higher social distance and avoidance / discomfort towards the peers depicted in the vignettes when compared with girls. Additionally, boys were also more likely to characterise the person in the vignette as "bad" than were girls (DuPont-Reyes et al., 2020). Similarly, when assessing the intentions of young people to have future interactions with peers experiencing mental illness, Townsend et al. (2019) concluded that females demonstrated significantly lower mental illness stigma than males. Further, research has also reported that females are more likely to express lower levels of stigma towards peers who experience mood- and anxiety-related disorders (Dey et al., 2020; Yap et al., 2014).

Although exploring the roles of gender bias and inequality when young people seek support is outside of the scope of this thesis, it is important to recognise that research has concluded that boys have more difficulties to, not only identify symptoms of mental illness, but to actually seek support due to societal roles imposed them (Wilkins, 2010). Given the pressures that individuals are under during adolescence already been described in Chapter 1, it becomes increasingly more complex for boys and girls to conform with the social norms when experiencing symptoms of mental illness.

Stereotypes and prejudiced beliefs may also change from childhood throughout adolescence (Heary et al., 2017). An early study on this topic showed that children were more likely to associate negative attitudes with mental and emotional symptoms than physical symptoms when presented with adults experiencing symptoms of mental and physical diagnosis (Adler & Wahl, 1998). More recently, Kaushik and colleagues (2016) reported that when adolescents mature and get older there is a tendency for more stigmatising views and beliefs to appear. This could be a result of an increase in young people's knowledge about mental illness as they get older. However, this may vary according to condition: from 12 to 16 years old, young people report being more accepting of peers disclosing symptoms of ADHD, yet less accepting of male peers reporting depression symptoms (Swords et al., 2011).

6.2.1.2. Self-Stigma.

Self-stigma is the internalisation of views and beliefs endorsed by the community towards a particular group of people (i.e., the internalisation of public-stigma) (Corrigan et al., 2004; Corrigan & Shapiro, 2010). Corrigan et al. (2006) summarised the three steps needed for the development of self-stigma: awareness, agreement, and application. One must first be aware of the existence of the stereotypes (e.g., "People diagnosed with schizophrenia are violent"), then agree that these are valid (e.g., "I agree that people with schizophrenia are violent"), and apply said beliefs to themselves (e.g., "Since I have schizophrenia, I believe that I am violent"). Self-stigma can have an effect on a person's overall psychological wellbeing by decreasing their sense of worth, efficacy, and self-esteem (Corrigan & Watson, 2002). At the same time, feelings of shame and embarrassment increase as a result of this internalisation (Corrigan et al., 2014).

Research on self-stigma experienced by adolescents has been scarce (Kaushik et al., 2016). This suggests that further research on this area is necessary to better understand this phenomenon during adolescence. Some of the existing literature suggests that older adolescents appear to have higher levels of self-stigma (Moses, 2009, 2010). When it comes to gender differences, Talebi et al. (2016) concluded that boys reported higher levels of self-stigma than girls. This expresses similar patterns when exploring research conducted with adult samples. In large population sample studies from different countries (i.e., Germany, Australia, and Canada), men have been shown to be more likely to endorse public-stigma (Dietrich et al., 2014; Griffiths et al., 2008; Wang et al., 2007). However, further research is needed to better understand the mechanisms through which self-stigma impacts experiences of young people dealing with symptoms of mental illness. Contrary to public-stigma, it is still somewhat unknown if levels of self-stigma differ according to mental illness disorders being experienced. Similarly, the effects of self-stigma on peer disclosure of symptoms of mental illness needs further exploring. Similarly to what was presented in the previous section, some gender bias could also be at play here. However, this is outside the scope of this thesis.

6.2.3. Trust in Sources

Trust can be defined as "*optimistic acceptance of a vulnerable situation in which the truster believes the trustee will care for the truster's interests*" (Hall et al., 2001, p.615). Trust has different dimensions, namely confidentiality, competency, honesty, and fidelity (Hall et al., 2001). Confidentiality refers to the assumption an individual makes, when disclosing sensitive information to another person, that it will be kept private (Hall et al., 2001). Young people attribute higher levels of trust to those offering social support when they perceive that confidentiality is higher (Betts & Rotenberg, 2008; Flanagan & Stout, 2010). Honesty is defined by the expectation that an individual's network of support will share their thoughts and opinions truthfully (Hall et al., 2001). Competency relates to the person's assessment of whether they believe a particular source will be of help and would be able to provide the support they need. Finally, fidelity is the extent to which a person perceives that a given source of support will keep their best interests in mind (Hall et al., 2001).

Adolescence is a time when young people attribute a lot of significance and value to their social network (Newman & Newman, 2020). During this time, they start accounting for the ability that their network might have to support them in a stressful situation (Cohen & Wills, 1985). When researching mental illness, the value of trust is closely related to how young people respond to their symptoms. For example, adolescents expressed fear of a negative reaction when they disclose and ask for support from a trusted source, such as a parent/carer (Rasmussen et al., 2022). Thus, looking at how trust might be associated with support seeking can provide further insight into how adolescents structure their decision making when seeking support, as well as how they decide who to turn to for help.

Studies have shown that the perception of social support is associated with perceptions of public-stigma (Mueller et al., 2006). Most of the research that explores this relationship focuses on the use of mental health services and very little is known about this relationship when it comes to the remaining four sources explored in this study (i.e., friends, parents, teachers, and online). Nevertheless, research has shown a negative association between trust in mental health services and both public- and self-stigma (Gaebel et al., 2014; Verhaeghe & Bracke, 2011).

6.3. Effects of Stigma, Threat, and Trust on Young People's Support Seeking

The TTC framework (Lazarus & Folkman, 1984) presented in section 2.3. under Chapter 2 (Figure 2.2) served as the theoretical background to the model tested in the quantitative studies of this thesis. The TTC has potential to support a better understanding of the effects of stigma and discrimination relating to mental illness (Major et al., 2002; Major & O'Brien, 2005; Miller & Kaiser, 2001). Below, the ways in which stigma and trust have been shown to be associated with different forms of support seeking is presented.

6.3.1. Public- and Self-Stigma Influence on Support Seeking

Research has highlighted the negative association between public-stigma and support seeking behaviours (Clement et al., 2015; Heary et al., 2017; Moses, 2010; Nearchou et al., 2018). This negative association is also present when young people are dealing with a friend or a family member's mental health problem (Yap & Jorm, 2011). Young people who perceive high levels of public-stigma are likely to refrain from seeking support from formal sources and are likely to avoid dealing with their own symptoms (Corrigan, 2004).

Research has also explored how mental illness stigma is related to seeking support from mental health professionals (Dopmeijer et al., 2020; Vogel et al., 2007). Overall, this evidence is somewhat contradictory; multiple studies have stated that there is a negative association between public-stigma and support seeking from professionals (Aromaa et al., 2011; Mojtabai et al., 2002; Schomerus et al., 2009; Yap et al., 2013), yet others have concluded that there is no such association (Dopmeijer et al., 2020; Jorm et al., 2000).

Pattyn et al. (2014) explored the impact of public- and self-stigma on support seeking attitudes among adults. They concluded that public-stigma was negatively associated with seeking support from informal sources (e.g., family, friends) while self-stigma was associated with seeing professionals as a less valuable source of support. Although this research focused on adults, these results provide some support for the proposal that different types of support could be associated with different forms of stigma. Additionally, the use of online sources of support have been shown to be related to lower levels of stigma with young people reporting that they can share feelings online without the fear of judgment and embarrassment from others (Horgan & Sweeney, 2010; Mar et al., 2014; Naslund et al., 2016; Wetterlin et al., 2014).

Some gender and age differences have been highlighted in the literature when it comes to stigma and support seeking. Boys have been shown to report higher levels of self-stigma than girls (Talebi et al., 2016). Chandra and Minkovitz (2006) showed that around 42% of boys who took part in their study reported moderate to higher levels of stigma related to seeking help from a mental health professional. Furthermore, boys are also more likely to agree with stigmatising beliefs such as seeing a counsellor being a sign of being “different and weird” and disagree with statements that relate to a person showing strength and courage when asking for help from a professional (Chandra & Minkovitz, 2006). This supports the contention that boys may have higher levels of public-stigma than girls.

When it comes to support seeking, girls are twice as likely to report support seeking intentions for depression than boys are (Nearchou et al., 2018). Finally, Nearchou et al. (2018) suggested that some developmental differences exist where young people between the ages of 12 and 18 years old are more likely to be willing to seek support than their younger counterparts. Berger et al. (2017) suggests that this relationship might be due to effects of developmental changes and to young people being more aware of stigma and having a better understanding of mental illness.

6.3.2. Appraisals of Threat as Mediators between Stigma and Support Seeking Behaviours

In Chapter 2 (section 2.3.1), it was stated that threat appraisals are commonly accompanied by negative emotions and feelings, such as fear and worry (Lazarus, 1991a); this is also true for stigma (Corrigan & Shapiro, 2010; Link et al., 2004). As such, it is plausible that threat and stigma may be associated with each other. Specifically, it is proposed in this thesis that the relationship between both forms of stigma (i.e., public and self) and support seeking may be mediated by appraisals of threat. This is based on evidence that young people’s appraisals of threat increase when they fear the possibility of embarrassment and judgement from others if they disclose of their own symptoms. Threat can, in turn, be negatively associated with the intention to seek support (Eisenberg et al., 2009; Honey, 2004; Mojtabai, 2010; Vogel & Wester, 2003).

Rüsch and colleagues (2009) concluded that participants with higher public-stigma levels also had higher levels of stress. As previously noted in Chapter 2 (section 2.3.1), higher levels of stress are associated with threat appraisals (Lazarus & Folkman, 1984). At the same time, research has concluded that higher levels of stigma are associated with higher levels of threat (Link et al., 2004; Major & O'Brien, 2005; Yang et al., 2007). This association between stigma and threat has been explained by fears of judgment resulting from society's stereotypes (i.e., public-stigma) increasing the threat reported by young people experiencing symptoms of mental illness (Major & O'Brien, 2005; Rüsch et al., 2014). This supports the possible mediating role of threat.

Experiences of stigma can threaten a young person's identity by, for example, reducing their self-esteem (Major & O'Brien, 2005) or increasing their fear of being excluded from a community or social group (Rubin et al., 2015). As a result, this could lead to difficulties in disclosing their symptoms (Chung et al., 2019), and consequently, young people can have more difficulties seeking support (Major & O'Brien, 2005; Rüsch et al., 2014). As such, experiencing stigma may lead to a reduction in support seeking behaviours, an association which may be mediated via threat appraisal.

Finally, Muris and colleagues (2000) concluded that both anxiety and depression were associated with higher levels of perceived threat by children aged 8 to 13 years old. This is an age where relationships have a very important meaning and role in young people's lives. Adolescents may refrain from disclosing and seeking support for their symptoms if they perceive their peer group to hold highly stigmatising views about mental illness, especially since the potential for peer rejection is associated with high levels of threat appraisal and lower likelihood of support seeking (Rubin et al., 2015). Thus, it is hypothesised that threat will mediate the relationship between stigma and support seeking.

6.3.3. Trust as a Moderator of the Relationship between Threat Appraisals and Support Seeking Behaviours

In the context of the TTC (Lazarus & Folkman, 1984), it is hypothesised that trust will act as a moderator in the relationship between threat and support seeking. A young person is less likely to seek support for their symptoms if they believe that they do not have any available and trustworthy source of support (Camara et al., 2017). As such, trust levels are relevant to the assessment a young person makes when considering what sources are available to support them to deal with mental illness. In this thesis, these trust judgements are interpreted as a secondary appraisal. Young people's trust in a given form of social support may buffer them against the influence of stigma on support seeking (Khesht-Masjedi et al., 2017; Mueller et al., 2006). As such, the role of trust as a moderator of the effect of in the relationship between threat and support seeking is explored in the current thesis.

Lack of trust in sources of support is one of the main reasons why young people do not seek support when dealing with symptoms of mental illness, even if these are available to them (Camara et al., 2017; Corry & Leavey, 2017; Jobe & Gorin, 2013). When young people do not trust those around them to confide in and talk to about mental illness, they are likely to be reluctant to seek their help (Leavey et al., 2011; Sears, 2020). Overall, studies point to a consistent preference for friends and/or family when young people are dealing with their own symptoms of mental illness (Camara et al., 2017; Rickwood et al., 2015). Informal sources of support, like friends and family, are for the most part, characterised by higher levels of trust (Camara et al., 2017). As such, young people's willingness to seek support from these sources may be partly because of levels of trust and existing positive relationships (Sears & McAfee, 2017).

Although some studies show that young people feel that they are willing, and can trust and ask their parents/carers for support when discussing sensitive issues (Leavey et al., 2011), this changes with age (Boulter & Rickwood, 2013; Sears, 2020). As adolescents get older, they develop more complex support seeking strategies that allow them to assess which source of support would be better suited to the type of problem they are experiencing (Zimmer-Gembeck & Skinner, 2011). This complexity includes assessing elements like the type of problem, the availability of sources, previous positive experiences with sources, and trust levels (Sears, 2020). Thus, it is possible that the buffering effect of trust on the relationship between threat and support seeking might also changes with age.

When it comes to formal sources of support, adolescents report that they would only approach teachers who they trusted and with whom they felt “an established and valued relationship” with (Jobe & Gorin, 2013, p.433). With regards to professionals, Chandra and Minkovitz (2006) concluded that lower trust in mental health services was associated with a lower likelihood of seeking support. In general, professionals (e.g., psychologists, GP) do not seem to be considered as an initial source of support because of a perceived lack of confidentiality and inherent lack of trust (Leavey et al., 2011). Verhaeghe and Bracke (2011) explored the experiences of adult mental health service users, and concluded that higher symptomology was associated with lower levels of trust. Thus, exploring the moderating role of trust in sources of support when young people are dealing with symptoms of mental illness seems to be of relevance.

In the present thesis, one of the sources of support explored is online. Gibson and Trnka (2020) state that trust is one of the key elements that young people refer as needing to be present in order for them to engage with online support seeking. Young people only share information online with people who they feel they can trust (Liverpool et al., 2020), though it may be the case that young people place *too much* trust in online sources (Pretorius et al., 2019). Nevertheless, as stated earlier, the literature around the use of online sources of support by young people is still scarce, and this is also the case for the hypothesised influence of trust in the relationship between threat and online support seeking.

6.3.4. Mental Illness Disclosure from a Friend

One of the aims of this research is to provide further insight into how young people differ in their support seeking when they are dealing with their own symptoms of mental illness as compared to when they are dealing with a friend's symptoms of mental illness. As noted in Chapter 2 (section 2.5), this distinction is relevant when discussing how young people deal with mental illness since adolescents are encouraged to disclose their symptoms in order to get support and disclosing to a friend is often their first port of call. Additionally, results from Study 1 supported the contention that there may exist different coping processes for dealing with one's own symptoms of mental illness as compared to dealing with a friend's disclosure. As such, exploring how stigma, trust, and threat appraisals differ in their influence of support seeking for the self or for a friend is relevant.

Though research exploring a friend's support following disclosure of symptoms is scarce, it has been reported that young people are more willing to refer a friend experiencing symptoms of mental illness to a professional than to refer themselves (Raviv et al., 2000). The authors hypothesised that this might be due to young people believing that the referral of a friend is less threatening than self-referral. This is supported by research which indicates that feelings of shame, weakness, and maladjustment are *not* generated when referring peers for professional support (Raviv et al., 2000; 2009). Thus, a lower sense of threat when seeking support from a mental health professional may be more evident when dealing with a friend's symptoms than when dealing with one's own.

Furthermore, it has been established that support seeking behaviours develop as a result of previous experiences and development (Rickwood et al., 2015). This may help explain why older adolescents are more willing to refer a friend for professional help, and to offer emotional support to peers experiencing symptoms of mental illness, than younger adolescents (Lubman et al., 2017; Yap et al., 2011a). Furthermore, girls have been shown to be more likely to suggest that a peer seeks help from formal sources and online for symptoms of depression (Kelly et al., 2006; Lubman et al., 2017).

In the field of suicide research, there has been some, albeit limited, exploration of how young people deal with a friend's suicidal thoughts or attempts, and self-harming behaviour. Fisher et al. (2017) and Fortune et al. (2008) concluded that participants were more likely to involve friends (rather than adults) when seeking support to deal with a disclosure. Also, adolescents report that talking with someone they trust about how they are feeling and the stresses of supporting a friend can be beneficial for dealing with the stressful situation (Fisher et al., 2017). This further supports the importance of trust when researching support-seeking for mental illness. At the same time, fears of confidentiality and loss of friendship were present when adolescents thought about discussing the disclosure with an adult (e.g., parents/carers, school staff) (Fisher et al., 2017). These same issues were brought to light during Study 1. Thus, this evidence suggests that a preference for informal sources (particularly, friends) and existence of high levels of trust might be of importance when young people are dealing with a friend's disclosure.

Research has looked into related concepts such as mental health literacy and symptom recognition as ways to influence a young person's ability to support their friend (Kelly & Jorm, 2007; Lubman et al., 2017; Singh et al., 2019). If a young person fails to recognise symptoms that a friend is experiencing as worthy of, or in need of, support, they might not act or seek support for their friend. However, in this research, the focus is to understand how young people deal with a friend’s disclosure, and not how they would support or advise a friend in need. In any case, it could be helpful to draw a parallel with this existing research in order to try to understand how young people might behave in this situation.

6.4. Summary

In sum, this chapter has shown that both stigma and trust play a role in support seeking when young people are dealing with symptoms of mental illness. This chapter also explored how the TTC (presented in Chapter 2) can be used to further explore the role of stigma and trust in the coping process. Literature in this chapter has proposed that public- and self-stigma have a direct influence in support seeking, and trust to have a possible moderator role in the relationship between threat appraisals and support seeking. The aim in this thesis is to further explore these links by investigating how both stigma and trust associate with different sources of support seeking.

Additionally, as stated in this chapter, research referent to young people’s support seeking when dealing with a friend’s symptoms of mental illness is scarce. Thus, an added aim of this thesis is to explore how stigma and trust influence support seeking in the case of a friend’s disclosure.

Chapter 7- Methodology of Quantitative Study 2

In this final methodology chapter, a description of the methodology used in Study 2 will be presented. This chapter starts with a brief description of the measures used, results of factor analysis performed on one of the measures, and the analytic plan for the multi-group analyses.

7.1. Survey

Study 2 used a survey-based approach to collect data. The survey used in Study 2 collected data on six elements and was presented to the participants in the following order (see Appendix 19):

a) **Demographics**: gender, age, ethnicity, and nationality were assessed at the start of the questionnaire. Information about categories offered for gender and age to the participants are described in Chapter 8 (i.e., paper in press referent to Study 2 findings). Ethnicity and nationality were assessed separately due to evidence suggesting that the use of one single categorical question to measure a highly complex and dynamic concept such as ethnicity is problematic (Burton et al., 2010; Williams & Husk, 2013). As such, the use of multiple questions to explore each individual's identity and to allow for a more robust picture was considered beneficial (Aspinall, 2002; Burton et al., 2010). Similarly, when answering ethnicity questions that include race and nationality in the same options (e.g., census categories "Black British, Black African, or Black Caribbean), individuals express a preference for these to be separated (Bonnett & Carrington, 2000). This is because individuals interpret ethnicity, race, and culture as different concepts.

As a result of this evidence, in this study, presented participants with two separate open-ended questions. One for nationality and another for ethnicity. With these, the aim was to account for the issues highlighted in the literature and to also account for differences in how young people define themselves in terms of their nationality ("What is your nationality? For example, you might be British or Polish or Indian.") and their heritage ("What is your ethnic identity? For example, you might be British or Scottish or Scottish-Pakistani.").

b) **Stigma**: Participants were presented with two subscales of Moses' (2009) stigma measure: the Societal devaluation subscale (to measure public-stigma) and the self-stigma subscale. Overall scale scores were calculated by creating a mean score of the items for public- and self-stigma. High scores for public- and self-stigma, corresponded to higher levels of public- and self-stigma. Further details (e.g., example items, internal reliability, Likert-scale) of both these subscales are presented in Chapter 8 (see Methods section).

Choosing a measure to assess public- and self-stigma was challenging. According to McKeague et al. (2015), standardised measures for children and adolescents that assess stigma in its entirety are scarce. Throughout the years, measures initially developed for adult samples have been revised to attend to children and adolescents' needs (Catthoor et al., 2015; Kaushik et al., 2016). However, the majority of these revisions assess only selective components of stigma such as prejudice, stereotypes, or discrimination (e.g., Campbell et al., 2004; Law et al., 2007; Mavropoulou & Sideridis, 2014).

For this reason, and given the conceptualisation of stigma used in this thesis, it was important to identify a measure that assessed stigma in all its forms (i.e., prejudice, stereotypes, and discrimination) and not only focused on one or two components. The subscales used in this study were adapted by Moses (2009) from existing measures targeted at adults and explored all three components of stigma. Specifically, the subscales selected for this thesis cover two forms of stigma: public- and self-stigma. Moses (2009) reported that internal reliability was high for both subscales (Societal Devaluation: α = .76; Self-Stigma: α = .81) in a sample of adolescents from 12 to 17 years old.

c) Trust: No measure appears to exist that assesses young people's levels of overall trust in difference sources of support. Thus, a trust measure exploring trust in each of the five sources of support investigated in this thesis was developed. This focused on assessing what degree of trust participants had in each of their source of support (i.e., friends, parents, teachers, professionals, and online). Six items were developed based on the four dimensions of trust proposed by Hall et al. (2001), namely confidentiality, honesty, fidelity, and competency. Further information can be found in the following Chapter in the methods section. This will detail the items included in the measure, how these were developed, and what items corresponded to which dimension of trust.

A total trust score of each source of support was created by calculating the mean of all the six items of trust in each source of support. This means, that each participant had five different mean trust scores, one for friends, parents, teachers, professionals, and online. Higher scores corresponded to higher levels of trust in each source of support. As with the stigma measures, further details (e.g., example items, internal reliability, Likert-scale) are presented in Chapter 8 (see Methods section). Since this trust scale was a novel development within this thesis, an exploratory factor analysis (EFA) was conducted and the results of this are reported below in section 7.3.1.

d) Vignettes: Although there are multiple studies that use a vignette-based methodology when exploring stigma (e.g., Bellanca et al., 2013; Coleman et al., 2009), and when assessing young people's help-seeking behaviours in response to dealing with symptoms of mental illness (e.g., Lubman et al., 2017; Sawyer et al., 2012), novel vignettes were created for this study. This is because some studies that use vignettes do not openly share them or because some existing vignettes were exploring issues outside of the scope of this thesis (e.g., adolescents' responses to ADHD; O'Driscoll et al., 2015).

Sheringham et al. (2021) proposed six considerations relevant to the development of robust vignettes. First, one must focus on credibility. This means that the vignette should be focused on clinical expertise and extract data from reputable sources. The second consideration is the number of vignettes, specifically that it is beneficial to present participants with more than one vignette, given that this allows for assess to what extent responses are influenced by the vignettes themselves.

For this thesis, all participants were presented with two vignettes: one depicting symptoms of depression and a second one depicting symptoms of anxiety (examples of these can be found in in the next Chapter in the appendix section of the published paper). Only two disorders (i.e., depression and anxiety) were presented given their high prevalence among young people within the age range being studied in this thesis (e.g., Polanczyk et al., 2015; WHO, 2021b).

Furthermore, given the already highlighted issued of how low levels of mental health literacy can potentially impact support seeking (e.g., Gulliver et al., 2010; Kelly & Jorm, 2007; Velasco et al., 2020), the vignettes were developed presenting only examples of symptoms related to depression and anxiety, but did not explicitly mention these disorders. This offered the opportunity for participants to focus on what the person depicted on the vignette was experiencing and what they would do as a result (which was the aim of the study), rather than focus on the knowledge and identification of what constitutes a disorder. Symptoms were chosen on the basis of the most common manifestation of depression and anxiety in the targeted age range to allow for an easier recognition from participants of what was being depicted.

The third element to consider when creating a robust vignette is variety (Sheringham et al., 2021). This can be achieved by clustering multiple vignettes together to avoid over-estimation of statistical effects. As such, since the current study aimed to assess support seeking for mental illness in general, and not for any specific disorder, construct validity was enhanced by collapsing responses across the two vignettes presented to each participant.

The final two considerations that Sheringham et al. (2021) suggests are evaluation and description. Evaluation in this thesis happened during the pilot phase of the questionnaire where the participants were able to offer any feedback and comments on the entire questionnaire (vignettes included). Description pertains to the open availability of the vignettes being used in a study so that a reader can get a sense of what participants responded to and what was the stimuli offered (Sheringham et al., 2021). As stated in Chapter 3 (section 3.1), as a result of the open science practices used in the course of this thesis, all materials used in all the studies are openly available to the public.

e) **Threat appraisals**: After reading each vignette, participants completed six items to assess their appraisal of threat in the situation described. Six items that corresponded to appraisals of threat were adapted from the Cognitive Appraisal of Health Scale (CAHS) (Kessler, 1998). This measure was selected due to the reported high reliability (α = .85; Kessler, 1998) and due to the flexibility of the items which allow it to be adapted to a vignette-based study. An overall score was calculated by creating the overall mean threat appraisal of the 12 items across both situations. Higher scores corresponded to higher levels of Threat appraisals. Additional information (e.g., example items, internal reliability, Likert-scale) can be found in the following chapter.

f) **Support seeking**: Finally, to assess support seeking, participants were presented with an adapted version of Carver’s (1997) Brief COPE. Two items which assess emotion-focused support seeking strategies (α = .71) and two items which assess problem-focused strategies (α = .64) were used. These four items were chosen because of their psychometric characteristics but also because they were able to be adapted to the hypothetical nature of the vignette-based methodology being used. In the next chapter, further detail will be presented on the changes made to these items to allow for them to be adapted to a vignette-based study.

The overall score was determined by creating the mean support seeking score for each source. Using parents as source of support as an example, the overall score for support from parents was created by taking the mean of all eight items across both vignettes (i.e., four items for emotional-focused support and four for problem-focused support). The published manuscript in the Child and Youth Care Forum presented in the following chapter will detail further information on this measure (e.g., example items, internal reliability, Likert-scale).

7.2. Recruitment Strategy and Procedure

As the study involved collecting data in a school setting, a number of different permissions were sought before young people were invited to take part. Permission was initially sought from Local Education Authorities (LEAs) and Headteachers. This practice conforms to the British Research Association Guidelines (2018) which suggests that schools act in “loco parentis”, and therefore decide which research is appropriate for pupils to engage in. LEAs were contacted and, depending on their internal procedures, applications explaining the details of the study were completed. For the most part, these applications aimed to clarify for the LEA who the target sample was, what the aims and goals of the research were, and how the data would be collected, stored, and used. Attached to each application, all the materials used and presented to both participants and parents/carers were also provided to support the application (i.e., parent/carer’s and young people’s PIS and consent forms, example of the survey, debrief sheet). In total, twelve LEAs gave consent for schools within their authority to be contacted. Those that did not consent reported schools being at capacity at the point of contact, too many similar mental health initiatives and research happening in schools already, and that they needed to prioritise learning and pupils' attainment over research.

If a positive decision was obtained from the LEAs, this meant that schools within that authority could be contacted in order to seek their inclusion, though Headteachers were not obliged to take part. Headteachers were sent a letter explaining the broad details of the study (i.e., aims, estimated sample size, methods used, time necessary with the pupils, and details about data protection and use). Additionally, they were also sent all the materials used in this study. Out of ninety-five schools, six agreed to take part. Similar reasons to the ones reported earlier by LEAs were given by schools when declining to take part. Additionally, some Head Teachers mentioned staff shortages and different Government initiatives taking place at the same time as recruitment for this study was taking place, which meant they were not able to accommodate data collection for this research.

Once permission had been received from a school, PIS and consent forms were distributed to the parents/carers of the relevant year groups in order to begin the recruitment process. For this study, this was completed in a paper format and parents/carers were asked to return their consent to the school. Next, with the school staff member providing support for the data collection, the researcher arranged a suitable time for data collection. Students whose parents/carers had returned consent forms were brought into the room where the researcher was set up. These students were then approached to take part in the study. They were given the PIS. For this study, participants gave their consent online. As such, the PIS contained link for the survey. When logging into the survey, participants were presented with a consent form that they had to accept prior to moving forward to the questions in the survey. Finally, irrespective of young people's decisions to take part in the research or not, they were provided with a debrief sheet at the same time as the PIS. This ensured that all potential participants had access to information about helpful resources in case they needed (further detail has been described in Chapter 3, section 3.3.).

7.3. Data Analysis

7.3.1. Exploratory Factor Analysis

Exploratory factor analysis was conducted in SPSS 25. This looked to assess, for each of the five sources of support (i.e., friends, parents, teachers, professionals, and online), the validity of the trust measure and to find a common set of constructs or factors that could explain the variation between measured variables (Loehlin & Beaujen, 2017; Watkins, 2018). By using factor analysis, one can provide support for theoretical assumptions and validate measures (Haig, 2014; Izquierdo et al., 2014). This was the aim when conducting these five factor analyses. Additionally, this is a necessary and relevant step to take for the trust measure because the items were developed and created for the purpose of this thesis.

According to Watkins (2018), when conducting exploratory factor analysis, following the assumption checks, there are four elements that one should consider. First is the model of factor analysis. There are two main models that can be used: principal components analysis, and common factor analysis. For this thesis, the focus will be on common factor analysis. This is because as Fabrigar and Wegener (2012, p. 32) stated "when the goal of the research is to (…) create measurement instruments in which the researcher wishes to make the case that resulting measurement instrument reflects a meaningful underlying construct, we argue that common factor analysis procedures are usually preferable." Common factor analysis aims to separate the total variance that corresponds to the measured variables, by common and unique variance. In this way, the analysis will clarify how much of the variance is explained by each factor.

Watkins (2018) suggests that the researcher should then focus on the estimation method used. Again, there are two overarching methods: maximum likelihood and the principal axis. Here, principal axis was used. This method makes no assumptions concerning the distribution of the sample and produces least-square estimates. This is a suitable estimation method for this thesis since principal axis has been shown to perform better for smaller samples (as in this study, N<300) (MacCallum et al., 2001). As a result of using this estimation method, eigenvalues were provided for each of the resulting factor indicating the amount of variance corresponding to them.

Following the choice of estimation method, a scree plot is examined to estimate the optimal number of factors to retain (Watkins, 2018). The 'elbow' in the scree plot is an indication of many factors should be retained. Finally, the rotation type should be considered. Between orthogonal and oblique, in this thesis, the focus will be in the latter. Oblique rotations are suitable where intercorrelation between factors can be anticipated. Overall, rotation is used so that a more theoretically meaningful solution can be achieved.

Table 7.1 reports on two tests that are conducted to aid on the determination if factors analysis is appropriate: these are the Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO) and the Barlett's test of Sphericity (Field, 2005). This value varies between 0 and 1, and Kaiser and Rice (1974) reported that a KMO of equal to or above .80 is the best outcomes when looking for fitness for factor analysis. According to Table 7.1, all the KMO are above .80, with only Trust Online having a marginal value of .80. The Bartlett's test is essentially a null hypothesis test. In order to be able to conduct factor analysis, this test needs to be significant at a $p < .05$, indicating that there are stable relationships between the variables. Table 7.1 shows that for all the trust measure items tested, the Bartlett's test is significant.

Table 7.1

Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO) and Bartlett's Test for Trust scales.

		Trust				
		Friends	**Parents**	**Teachers**	**Professionals**	**Online**
KMO		.82	.86	.87	.88	.80
Bartlett's Test of Sphericity	χ^2	637.62	752.59	755.84	973.54	695.45
	df	15	15	15	15	15
	p	<.001	<.001	<.001	<.001	<.001

Scree plots (Appendix 20) suggested a single trust factor solution for each of the five sources of support. This is also supported by the eigenvalues generated by the SPSS outputs. The default retention criterion refers to eigenvalues higher than one associated to an eigenvector, usually indicating that that component should be retained (Guttman, 1954; Hayton et al., 2004). In all of the five measures of trust, no eigenvalue lower than one was reported (Friends = 3.38; Parents = 3.64; Teachers = 3.80; Professionals = 4.16; Online = 3.46). While rotation had been planned, this was not possible since there was only one factor for each measure.

Table 7.2 reports on the total variance explained by each of the factors. When comparing each of the resources being explored, the factor proposed by this model in the Trust in Friends scale accounted for 49.1% of the total variance, making it the lowest of the five. This rose to 63.2% for Trust in Professionals. Table 7.2 also reports on the unrotated factor loadings which reflects the common variance in the data. So, looking at the Trust in Friends scale, shared variance associated with the first item is of 87.9%. It is worth noting that Item 3 for both Friends and Parents has a lower shared variance but still acceptable, 31.4% and 33.9% respectively. According to Child (2006) any item recording a shared variance of below 0.2, should be removed. Items with shared variance below 0.2 can be cause of concern when considering the overall performance of the scale. No variance below 0.2 was found in any of the six items, thus all items were maintained in the appropriate scales to increase consistency of measurement across measures.

Table 7.2

Total variance and unrotated factor loadings for each of the trust scales.

		Trust in Friends	Trust in Parents	Trust in Teachers	Trust in Professionals	Trust Online
Total variance explained		49.1%	54.4%	56.2%	63.2%	50.1%
Factor matrix	**Item 1**	.879	.813	.730	.809	.776
	Item 2	.761	.851	.753	.861	.831
	Item 3	.314	.339	.728	.810	.509
	Item 4	.683	.667	.665	.742	.536
	Item 5	.742	.823	.785	.788	.796
	Item 6	.694	.801	.826	.754	.729

Note. Using Trust in Friends as an example: Item 1 = “I have friends that I can trust to keep a secret.”; Item 2 = “I have friends that I can trust to keep their promises”; Item 3= “My friends keep secrets from me”; Item 4= “My friends are honest about what they are thinking”; Item 5= “I believe that my friends know how to help me”; Item 6= “My friends try to understand me”.

7.3.2. Analytic Plan for Multigroup Path Analyses

Study 2 used path analysis to estimate the model proposed in that study. For this, AMOS 25 was used and maximum-likelihood estimation (MLE) parameter and bootstrapping techniques were used. MLE has been shown to be a robust statistical procedure that maximises the production of estimates that resemble the “true” value of the factor scores (Hershberger, 2005; Kline, 2011). Bootstrapping techniques aid in testing indirect effects, standardised estimates and confident intervals (Caty & Davison, 2005; Efron & Tibshirani, 1993).

Path analysis can be seen as a multivariate regression model and aims to test the relationship between variables by testing the association between observed variables (Barbeau et al., 2019). This type of analysis allows a researcher to have information about direct and indirect effects by looking at associations between variables instead of causality. These relationships between variables are normally expressed through a path diagram (see Figure 1 in Study 2 paper in Chapter 8).

Path analysis follows similar assumptions to multiple linear regression (Streiner, 2005). As such, five multiple linear regression models were performed in SPSS 25 (i.e., one for each of the sources of support tested in this study) prior to path analysis in order to test these assumptions. Using parents' source of support as example, linear regressions had as predictors mean scores of public-stigma, self-stigma, threat, and trust in parents, on support seeking from parents.

The first assumption refers to the need for these relationships to be linear. For all five regressions, P-P plots supported the presence of a linear relationship (Appendix 21). This also supported the assumption that the data were normally distributed and no outliers were present. By outlier, this research has considered any extreme value such that might be a result of recording or entering data (Loehlin & Beaujean, 2017). These are typically defined by values that are more than 2 SD above or below the mean (Aguinis et al., 2013; Martin & Roberts, 2010).

Secondly, looking through the scatterplots of the residuals that were generated for each regression model, there was no obvious pattern of distribution (Appendix 21): Values are, for the most part, equally distributed below and above zero on the X axis, and left and right to the zero on the Y axis. This means that the assumption of homoscedasticity was confirmed (e.g., Berry & Feldman, 1985; Yang et al., 2019). Multicollinearity was checked by inspecting the variance inflation factors (VIF) values, all of which were below 10 (in fact, all below 1.4; see Appendix 21) and were therefore acceptable (O'Brien, 2007). Finally, the endogenous variables (i.e., dependent variable) need to be continuous. Thus, all the necessary assumptions were checked prior to starting the analysis and they were all met. Additionally, the analysis should also include bootstrapping techniques that allow for the generation of *p*-values, confidence intervals, significance of indirect paths, and standard errors from an automatic resampling technique, in this case with N = 200.

Once the analysis was conducted, the model fit indices were interpreted. These included: Chi-square, Root-Mean-Square Error of Approximation (RMSEA) and its 90% confidence intervals, and the Comparative Fit Index (CFI). The boundaries of each of these indexes are presented in the next chapter as part of the published manuscript (see Methods section). When it comes to the model being tested in Study 2 (see Figure 1 of Chapter 8), this was a mediated moderation multigroup path analysis. In total five models were estimated, one for each form of social support (i.e., Friends, Parents, Teachers, Professionals, and Online). Using the Parents model as an example, the manuscript in the next chapter clearly details how this model was expected to perform.

The 'multigroup' aspect of the analysis related to the assessment of differences between the Self and Friend conditions and the estimated paths within each. According to Byrne (2010), multigroup analysis allows for the estimation of two or more groups simultaneously by estimating standardised parameters for each of the groups. Direct comparisons are possible by examining the standardised differences between estimated paths. Differences between conditions were considered statistically significant when these standardised differences for equivalent paths were greater than ±1.96. For example, a standardised difference score is reported for the path from Self-stigma to Support seeking from Parents. This standardised difference score reflects the standardised difference between the estimate for the Self vignette and the estimate for the Friend vignette. Overall, each of the five models (one for each support from a Friend, Teacher, Parent, Professional, and Online) were simultaneously estimated for the Self and for the Friend condition, resulting a total of ten individual models estimating eleven different pathways.

Chapter 8- Paper Published at the *Child and Youth Care Forum*

The influence of stigma and trust in young people seeking support for their own or a friend's symptoms: the role of threat appraisals

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Consent to participate: Informed consent was obtained from all participants and their guardians prior to data collection.

Consent for publication: In the participant information sheet and consent form, participants and their guardians were asked for their consent to openly share the data, and to use the data for different dissemination formats (e.g., conferences, papers).

Acknowledgements: We would like to extend our sincere thanks to all involved in this study: the young people who took time from their day to be interviewed for this study; the Parents/Guardians who gave consent for their child to be approached about the study; and finally, a special thank you to all the Local Education Authorities that gave permission for the study to take place in their councils and the schools who agreed to take part in this study.

Abstract

Background: Stigma and trust influence how adolescents seek support for mental illness, though it is unclear how these influence their decisions to approach a range of potential sources of support. Moreover, even less is known about the ways in which these issues are related when a friend discloses symptoms of mental illness.

Objective: The study's aims were to understand the role of stigma, trust, and threat appraisals in adolescents' support seeking when exposed to their own, or to a friend's, symptoms of mental illness.

Method: A vignette-based study comparing reports of support (friends, parents, teachers, professionals, and online) was completed with reference to either (i) experiencing symptoms of mental illness or (ii) having a friend disclose these types of symptoms. Two hundred and fifty adolescents (M = 12.75 years) answered questions pertaining to stigma (public and self), trust levels, threat appraisals, and support seeking.

Results: When dealing with their own symptoms, threat accounted for 4.8% and 2.5% of the variance when seeking support from parents and professionals, respectively. Self-stigma accounted for 2.4% of variance when seeking support from parents and 0.8% of variance when seeking support from professionals. Trust moderated the association between threat and the use of online support. When responding to a friend's disclosure, higher levels of public-stigma were associated with lower support seeking from friends, parents, and professionals.

Conclusions: This study showed a distinction in how adolescents deal with their own or a friend's symptoms of mental illness, and what resources they choose to ask for support from. Self-stigma, threat, and trust levels were particularly relevant when experiencing their own symptoms, while dealing with a friend's disclosure was related to levels of public-stigma.

Keywords: stigma, trust, young people, support seeking, disclosure

The Influence of Stigma and Trust in Young People Seeking Support for Their Own or a Friend’s Symptoms: The Role of Threat Appraisals

One in five adolescents aged 11 to 14 years old experience symptoms of mental illness (Deighton et al., 2018). At the same time, young people experiencing these symptoms report difficulties accessing and seeking support (Collinson, 2017; Naughton et al., 2018; Velasco et al., 2020). Chandra and Minkovitz (2006) concluded that young people’s top three barriers to accessing and seeking support were the possibility of experiencing mental illness stigma, a reluctance to talk about their symptoms, and a lack of trust in the sources of support available. In their qualitative study, Pimenta et al. (2021) also identified the importance that young people placed on trusting others when considering the disclosure of symptoms of mental illness. As young people are most likely to trust their friends and to feel comfortable disclosing symptoms of mental illness to them (Camara et al., 2017; Sears, 2020), it is important to understand how they seek support for both their own symptoms, and how they seek support when a friend discloses symptoms to them. Thus, this study aims to better understand young peoples’ support seeking, and specifically their use of available sources of support, when dealing with their own or with a friend’s symptoms of mental illness.

Transactional Theory of Coping (TTC)

Dealing with mental illness can be stressful (Galaif et al., 2003). The Transactional Theory of Coping (TTC: Lazarus & Folkman, 1984) describes how an individual deals with stressful events and represents a useful way to understand the processes involved when young people are seeking support. The theory proposes two different components: cognitive appraisals and coping strategies. Primary appraisal refers to the evaluation that an individual makes about a situation (Lazarus & Folkman, 1984), and threat is likely to represent the most relevant primary appraisal in the context of experiencing symptoms of mental illness. A threat appraisal occurs when there is potential for physical or emotional harm (Lazarus, 1999), and studies have reported an increase in threat appraisals when young people experience symptoms of mental illness (Dougherty et al., 2019; Lee, 2020; Muris et al., 2000; Thompson et al., 2016).

Coping is defined by the actions and intentions behind what an individual does to overcome stress (Lazarus & Folkman, 1984). Two overarching categories of coping are of interest for this study: problem-focused coping (i.e., dealing with the cause of the distress) and emotion-focused coping (i.e., regulating the emotion resulting from the distress) (Lazarus & Folkman, 1984). Problem-focused coping strategies may include seeking information about, or creating possible solutions to deal with, the symptoms being experienced (Compas et al., 2001; Lazarus & Folkman, 1984). Examples of emotion-focused strategies might be denial or wishful thinking (Compas et al., 2001). Different mental illness can lead adolescents to use different coping strategies (Cong et al., 2019; Horwitz et al., 2011), and higher levels of threat appraisal, in the form of fear, leads to the use of more problem-focused strategies, while higher self-reported anxiety leads to more emotion-focused strategies being used (Skinner et al., 2003; Zimmer-Gembeck & Skinner, 2010). In the current study, the focus was on five key sources of support (parents, friends, teachers, professionals, and online) and on how perceptions of threat might relate to the intended use of these.

Mental Illness Stigma and Trust in Resources

Stigma is defined by the beliefs, attitudes, and behaviours that one has that reveal prejudice towards a particular condition (Corrigan et al., 2004) and these can reduce young people’s support seeking behaviours (Heary et al., 2017; Moses, 2010; Talebi et al., 2016). Stigma is mainly expressed as public-stigma and as self-stigma. Public-stigma is characterized by the endorsement of prejudice or discriminatory beliefs towards a particular group, while self-stigma is the internalisation of public-stigma (Corrigan et al., 2004). Self- and public-stigma have been highlighted by young people as having a negative impact on their support seeking behaviours (Cheng et al., 2018; Gulliver et al., 2010; Rüsch et al., 2014). This negative association is also present when young people are dealing with a friend or a family member's mental health problem (Yap & Jorm, 2011). Also, higher levels of stigma can increase a young person's threat levels when dealing with mental illness (Major & O'Brien, 2005; Yang et al., 2007).

Young people's trust in a given form of social support may reduce the influence of threat levels on support seeking. Trust has been defined as "*optimistic acceptance of a vulnerable situation in which the truster believes the trustee will care for the truster's interests*" (Hall et al., 2001, p. 615). When young people do not trust those around them to confide in and talk to, they are likely to be reluctant to seek their support (Leavey et al., 2011; Sears, 2020). This is most evident regarding adults who are not family members. With regards to teachers, adolescents report that they would only approach those who they trusted and with whom they felt "*an established and valued relationship*" (Jobe & Gorin, 2013, p. 433). Similarly, professionals (e.g., psychologists, doctor) are not considered as a primary source of support because of a perceived lack of confidentiality and inherent lack of trust (Leavey et al., 2011; Rickwood et al., 2015; Verhaeghe & Bracke, 2011). Concerning support from online sources, Gibson and Trnka (2020) showed that young people only share information online with people who they feel they can trust, though it may be the case that young people trust online sources too much (Pretorius et al., 2019).

Dealing With Disclosures of Symptomatology from Friends

When it comes to dealing with a friend's symptoms of mental illness, the research is scarce (Lubman et al., 2017). Support seeking behaviours are a result of previous experiences and adolescent development (Rickwood et al., 2015), perhaps explaining why older adolescents are more willing to refer a friend for professional support when they share symptoms of mental illness with them (Raviv et al., 2000; Rickwood et al., 2005; Yap et al., 2011). Mental health literacy, and the ability to recognise symptoms, are important for understanding a young person's ability to support their friend (Burns & Rapee, 2006; Lubman et al., 2017; Singh et al., 2019). The focus of the current study is to understand how young people deal with a friend's disclosure. There is very little relevant literature in this regard, though there has been some exploration of it in the field of suicide and self-harm research. Young people giving support to peers who self-harm are more likely to turn to other peers than to adults (e.g. school staff, parents) when seeking assistance for how to deal with these disclosures (Fisher et al., 2017; Fortune et al., 2008). In particular, fears of confidentiality, loss of friendship, and the ability to help effectively all influenced adolescents' judgements about discussing a disclosure with an adult (Fisher et al., 2017).

A Model of The Role of Stigma, Trust, and Threat on Support Seeking for Symptoms of Mental Illness

The study model is shown Figure 1. Based on literature suggesting that young people refrain from disclosing symptoms to others due to fears of judgment and embarrassment (Faulkner et al., 2010; Moses, 2010; Yap & Jorm, 2011), the first hypothesis in this study explores the direct effect of two forms of stigma on support seeking:

H1: Self- and public-stigma will be negatively associated with support seeking.

Similarly, higher levels of threat have been associated with higher levels of stigma in the literature (Link et al., 2004; Major & O'Brien, 2005; Yang et al., 2007). Fear of judgment and possible prejudice from others (i.e., public-stigma) can increase the level of threat reported by young people (Major & O’Brien, 2005; Rüsch et al., 2014). Stigma can threaten a young person’s identity by, for example, reducing their self-esteem (Major & O’Brien, 2005) or increasing their fear of being excluded from a community or social group (Rubin et al., 2015). As such, experiencing stigma may lead to a reduction in support seeking behaviours via threat appraisal.

H2: Self- and public-stigma will be positively associated with threat, which in turn will be negatively associated with support seeking.

Young people’s trust in a given form of social support may buffer them against the influence of stigma on help-seeking (Khesht-Masjedi et al., 2017; Mueller et al., 2006). As such, the role of trust as a moderator of the effect of public- and self-stigma on support seeking is explored in this study.

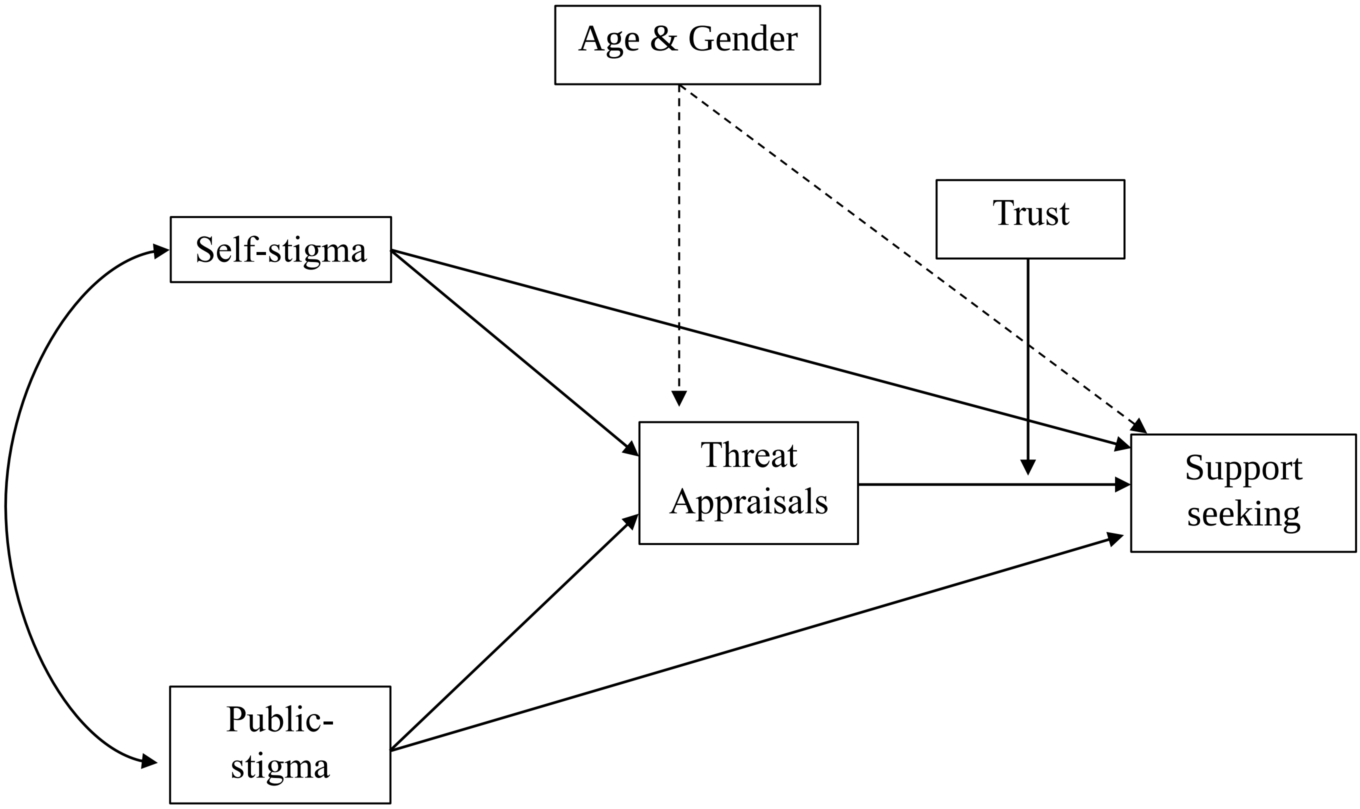
H3: Trust will moderate the relationship between threat and support seeking (i.e. threat appraisals will be negatively associated with support seeking when there are lower levels of trust, but when there are high levels of trust the relationship between threat and support seeking will be positive).

The same analytic models will be applied in the ‘Friend’ condition, but these will be exploratory in nature due to the limited research in the field (as detailed earlier). It is expected that hypothesis one will hold true for the ‘Friend’ condition due to similar research exploring stigma effects on young people responses to a friend or family member’s mental illness (Yap & Jorm, 2011). Similarly, it is expected that hypothesis three will also hold true for the ‘Friend’ condition given comparable research developed in the field of suicide and self-harm. However, when it comes to hypothesis two, it is unclear how stigma will influence threat levels in the scenario where a friend discloses symptoms of mental illness. It is also not clear how threat and stigma will be associated with support-seeking.

Finally, age and gender will be use as covariates and are hypothesised to influence both threat levels and support seeking (as seen in Figure 1). As young people grow older, more complex forms of support seeking behaviours are reported (Renk & Creasey, 2003). Also, as a result of maturation, older adolescents are expected to report lower levels of threat (Sillars & Davis, 2018). As such, it is expected that older adolescents will report lower levels of threat and higher levels of support seeking. Finally, girls are more likely to report higher levels of threat (Mak et al., 2004; Sillars & Davis, 2018), to suggest that a peer seeks help from formal sources and online for depression (Kelly et al., 2006; Lubman et al., 2017), and to seek emotional (Frydenberg, 2019; Horwitz et al., 2011). Thus, it is expected that girls will report higher levels of both threat and support seeking than boys.

Figure 1

Hypothesised model of the influence of stigma, threat, and trust on support seeking: an adaption from the TTC.



Methods

Participants

There were 250 young people from 11 to 15 years old: 110 were male (44.0%), 140 female (56.0%) (M = 12.75 years; SD = 0.94). An additional 8 participants preferred not to disclose their gender and but were omitted from our analytic sample because our analyses examined binary gender as a variable. Two hundred and fifty-five of the participants reported their nationality to be British (i.e., from England, Scotland, or Northern Ireland), while three participants reported their nationality to be Polish, South African, or Greek. In terms of ethnicity, 97.2% of participants identified themselves as being from England, Scotland, or Northern Ireland, and 2.8% of the sample identified themselves as having other heritage including Pakistani, Russian, Portuguese, South African, Polish, Turkish, and Australian.

Measures

The survey was composed of two sections: non-vignette specific and vignette specific measures. The non-vignette specific measures included demographics, stigma (i.e., public- and self-stigma), and trust in sources of support. The vignette specific measures included two vignettes, threat appraisals, and reports of intentions to seek support from five possible sources.

Non-Vignette Specific Measures.

Demographics: Gender, age, ethnicity, and nationality were assessed at the beginning of the questionnaire. Participants were given three options for gender *Male (boy)*, *Female (girl)*, and *Prefer not to say*. Young people were asked for their age in years. Finally, for nationality and ethnicity, they were asked two separate open-ended questions (*What is your nationality? For example, you might be British or Polish or*

Indian, and *What is your ethnic identity? For example, you might be British or Scottish or Scottish-Pakistani.*, respectively).

Stigma: Moses' (2009) Societal devaluation (14 items, example item: *Most adolescents my age will tease/harass kids if they know he/she is receiving mental health treatment.*) scale was used to assess public-stigma. This was modified to use hypothetical language, e.g. *If you had a mental health problem…how often would you feel different from other kids your age?*. Responses in the original scale ranged from 1 to 4 (*Strongly agree* to *Strongly disagree* for public-stigma, and *Almost Never* to *Very often* for self-stigma). However, Nadler et al. (2015) have provided evidence that labelling mid-points on scales helps to reduce ambiguity concerning what they mean. One additional scale point was therefore added (public-stigma: 1 = *Strongly disagree*, 2 = *Disagree*, 3 = *Neither agree nor disagree*, 4 = *Agree*, and 5 = *Strongly agree*; self-stigma: 1 = *Almost Never*, 2 = *Sometimes*, 3 = *About half the times*, 4 = *Frequently*, and 5 = *Very often*). Scale scores were calculated by creating a mean score of the items for public- and self-stigma. Internal reliability was estimated using Omega, and both subscales had good internal consistency (ω = .84 and .89, respectively).

Trust: The degree of trust that participants had in each of their sources of support was assessed using items that were based on the four trust dimensions proposed by Hall et al. (2001), namely Confidentiality, Honesty, Fidelity, and Competency. Confidentiality was assessed using three items, the first of which was taken from Flanagan and Stout's (2010) Interpersonal trust scale (*how often classmates keep secrets*), and was amended to *My friends keep secrets from me*. This item was adapted to be relevant to parents as a resource by phrasing it *My parents keep secrets from me*. For professionals, teachers, and online interactions, this item was phrased as *My teachers/ Professionals/ Online information tell me everything I need to know*. The remaining two items for

Confidentiality were taken from Betts and Rotenberg's (2008) Peer trust measure, which were adapted to fit the different resources and aims of the scale (*I have friends that I can trust to keep a secret* and *I have friends that I can trust to keep their promises*). The dimensions of Honesty, Competency and Fidelity were assessed by developing appropriate items: *My friends are honest about what they are thinking*, *I believe that my friends know how to help me* and *My friends try to understand me*, respectively. With the exception of the item described above (i.e., Confidentiality), the word "friends" was replaced by each of the other four resources (i.e., parents, teachers, professionals, and people online) when assessing trust in each of them.

The scale score ranged from 1 to 5 (1 = *Strongly disagree*, 2 = *Disagree*, 3 = *Neither agree nor disagree*, 4 = *Agree*, and 5 = *Strongly agree*) and the total trust score of each resource was created by calculating the mean of all the six items of trust in each resource. Internal reliability was good for all five scales (ω_{Friends} = .84, ω_{Parents} = .87, ω_{Teachers} = .88, $\omega_{\text{Professionals}}$ = .91, and ω_{Online} = .85).

Vignette Specific Measures.

Following the trust items, each young person read two vignettes in either a 'Self' or 'Friend' condition (cf. Appendix). In the 'Self' condition, participants answered questions concerning vignettes describing situations where they themselves experienced symptoms of mental illness. In the 'Friend' condition, the same questions were asked but they were about a friend's symptoms. In both the 'Self' and the 'Friend' conditions, one vignette described symptoms of depression and the other described symptoms of anxiety; responses for both threat appraisal and support seeking were collapsed across vignettes in order to assess young people's support seeking when dealing with commonly experienced symptoms of mental illness rather than focusing on a specific disorder.

Threat appraisals: After reading each vignette, six threat items from the Cognitive Appraisal of Health Scale (CAHS) (Kessler, 1998) were used. Items were reworded in order to meet the target population as well as to fit the hypothetical scenario. For example, *Frightening to me* was amended to *In this situation, would you be frightened?* Responses varied from 1 to 5 (1 = *Strongly disagree*, 2 = *Disagree*, 3 = *Neither agree nor disagree*, 4 = *Agree*, and 5 = *Strongly agree*) and the overall score was calculated by creating the overall mean threat appraisal of the 12 items across both vignettes. The scale had good internal reliability (ω=.85).

Support seeking: Participants were presented with an adapted version of Carver's (1997) Brief COPE. In the present study, two items on the emotional component of support seeking (*Get emotional support from them* and *Get comfort and understanding from them*), and two items on the problem focussed component of support seeking (*Try to get advice or help about what to do from them* and *Get help and advice from them*) were used. Each of these items were adapted to focus on the five sources of support relevant here (i.e., parents, friends, teachers, professionals, and online) and were rephrased to fit the vignette methodology. For example, *I've been getting emotional support from others,* was amended in the parent/guardian context by presenting the stem *Thinking about your parents or guardians. Would you…* followed by the items. Since the same four items were repeated 10 times for the same participant (i.e., once for each of the five sources of support in the first vignette and once for each of the five sources of support in the second vignette), the items and resources were presented in different orders in each vignette to counterbalance any exposure or fatigue effects. Scores varied from 1 to 5 (1= *No,* 2= *Probably not,* 3= *Maybe,* 4= *Probably yes*, and 5= *Yes*). The overall score was determined by creating the mean support seeking score for each resource; for example, by taking the mean of all eight items relating to both emotional and problem support from parents across both vignettes. There was good internal consistency for each of the five resources ($\omega_{friends}$= .94; $\omega_{parents}$= .95; $\omega_{teachers}$= .95; $\omega_{professionals}$=.96; ω_{online}=.93).

Procedure

Ethical clearance was obtained from the lead author's institution. A total of 31 Local Education Authorities (LEAs)[1] in Scotland were contacted for approval to invite schools to be involved. Upon approval from 12 LEAs, 95 schools were approached and 4 schools (4.2%) agreed to take part. Parents/guardians' positive consent was sought in paper format. After parental consent was obtained, every pupil's own consent was also required for them to participate. Participants had access to the assent form in the same web link as the survey and had to give assent prior to completing the survey. Overall, out of the four schools approached, the rate of students participating in the study was of 13.8%.

The survey was piloted in paper format with 27 participants to check for comprehension of questions and to accurately estimate the time it would take to complete. No participants reported comprehension difficulties, and the average time of completion was around 45 minutes. The survey was delivered online using Qualtrics.com. Pupils were asked to complete the survey during school hours in a separate room from the rest of the class. The survey was competed on each pupil's own mobile phone to ensure privacy and anonymity of the answers. When the use of mobile phones was not possible, laptops were used, and participants were placed so as to block the view of the screen from others. The first author was present during all data collection and took four extra tablets to the school for students to borrow if they needed.

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[1] In Scotland, LEAs are in charge of making sure that policies and guidelines are applied in each school. Additionally, they are also responsible for managing research requests and giving permission for schools in specific administrative areas to be contacted in regards to taking part in research (Scotland Act, 2010).

Participants first completed demographic questions, the stigma questions, and then the trust questions. Qualtrics then randomly allocated participants to either the 'Self' or the 'Friend' vignettes condition. After reading the vignette presented to them, participants were presented with the threat appraisal question followed by the support seeking questions. All the materials used in this study are available online: https://osf.io/et28h/. Participants were not offered compensation for participating in the study.

Analysis

A path analysis (as per Figure 1) was estimated using Amos 25 and employing Maximum-Likelihood parameter estimation and bootstrapping techniques. Model fit was assessed using the Chi-square, Root-Mean-Square Error of Approximation (RMSEA), and the Comparative Fit Index (CFI). The Chi-square statistic is dependent on sample size, model, and normal distribution of data, and a non-significant result reflects a good fitting model. A value of <.06 for the RMSEA indicates a close fit, however a value < .08 is considered an acceptable fit. A CFI value of .95 or above is considered a good fit while values greater than .90 reflect acceptable fit (Hu & Bentler, 1999).

Five models were estimated, one for each form of support (i.e., friends, parents, teachers, professionals, and online). Both mediation and moderation were tested. Using the parental support model as an exemplar, it was expected that both self- and public-stigma would have a direct effect on the degree to which parents were approached for support. Additionally, it was expected that the effect of self- and public-stigma on seeking support would be mediated by threat.

Additionally, given existing concerns around the feasibility of mediation analysis when using cross-sectional studies (e.g., Maxwell & Cole, 2007; Maxwell et al., 2011), a unique variance analysis was used in this study. This identifies the unique variance attributed to each variable in the model (Weems & Stickle, 2012). A multiple regression analysis was estimated using SPSS. This examined the relationship between public-stigma, self-stigma, threat, trust in parents, as well as the interaction term between threat and trust in parents (i.e., independent variables) and support seeking from parents. Age and gender were included in the model as possible covariates.

Finally, as hypothesised, the effect of threat on seeking support from parents was expected to be moderated by how much trust participants had in their parents. This was done by testing the effect that an interaction term between threat and trust in parents had on support seeking from parents. Where there was a statistically significant interaction, simple slopes analyses were planned to understand how these variables influence each other. The two forms of stigma were allowed to correlate. Gender and age were included as covariate and were regressed on both threat and support seeking from parents.

In order to analyse differences between the estimated paths for both groups (i.e., 'Self' and 'Friend' conditions) a multigroup approach was used. This approach estimates the standardised difference between model parameters (Byrne, 2010), allowing comparison between parameters in the 'Self' and the 'Friend' conditions. A statistically significant difference between groups was inferred when the standardised estimates of the difference between any given parameter for the 'Self' version and the 'Friend' version was above ±1.96.

Finally, six independent *t*-tests were performed to investigate group differences. The grouping variable had two levels (i.e., 'Self' and 'Friend') and the dependent variables were threat level and support seeking from each of the five resources (i.e., friends, parents, professionals, teachers, and online).

Results

The eight participants who selected “Prefer not to say” in response to the gender question were excluded from the analyses and the gender variable was coded such that *Male* = 0 and *Female* = 1. The level of missing data were under 5% and so listwise deletion was used to deal with it (Young et al., 2011), meaning that data were available for 110 participants in the ‘Self’ condition and 140 in the ‘Friend’ condition (N_{total}= 250).

Model Fit

The model in Figure 1 was tested five times, one time for each resource (friends, parents, teachers, professionals, online interactions). Each analysis also incorporated a multi-group comparison: ‘Self’ versus ‘Friend’ condition. Table 1 shows the model fit results for each of these models. All models, except that for support from parents, had adequate fit (i.e., at least two out of the three measures of fit were within the required range). The parent support model had a sub-optimal fit: a significant Chi-square, a CFI narrowly under the desired value, and an acceptable RMSEA. The results for the parent support model are therefore reported while acknowledging that fit was marginal.

Table 1

Model fit results for each of the five models.

Model	Chi-square (df)	*p*	CFI	RMSEA (90%CI)
Friends	34.50 (20)	.023	.909	.054 (.02, .08)
Parents	44.46 (20)	.001	.893	.070 (.04, .10)
Teachers	31.66 (20)	.047	.944	.048 (.01, .08)
Professionals	26.13 (20)	.162	.974	.035 (.00, .07)
Online	22.17 (20)	.331	.987	.021 (.00, .06)

‘Self’ Condition

In all models there was a significant, positive direct effect of self-stigma on threat (see Table 2). Additionally, trust had a significant, positive direct effect on support seeking in all models. In the parent support model, threat had a significant direct effect on support seeking (*β* = .25, *p* = .030) and self-stigma had both a significant direct (*β* = -.10, *p* = .030) and indirect effect via threat (*β* = .10, *p* = .010) on asking for support from parents. For the professional support model, threat had a significant direct effect on seeking support from a professional (*β* = .18, *p* = .030). Also, self-stigma had a significant indirect effect via threat on asking for support from a professional (*β* = .07, *p* = .017). Finally, age was negatively related to seeking support from parents (*β* = -.20, *p* = .023).

‘Friend’ Condition

In the ‘Friend’ version, trust had a direct significant effect on support seeking in all five models (see Table 3). Self-stigma had a significant direct effect on support seeking in the Friends model (*β* = .16, *p* = .034). Public-stigma had a significant direct effect on asking parents (*β* =-.15, *p* = .044), friends (*β* = -.17, *p* = .042), and professionals (*β* = -.17, *p* = .030) for support. There were no significant indirect effects.

Finally, gender negatively influenced support seeking from professionals (*β* = -.17, *p* = .035) and online (*β* = -.15, *p* = .048), indicating that girls were less likely to seek support from professionals and online. Finally, age had a significant direct effect on support seeking from parents (*β* = -.15, *p* = .032).

Table 2

Significant bootstrapped paths (and 90% Confidence Intervals) for each model for the Self condition

Model	**Pathways**	***β* (90% CI)**	***p***
Direct effects			
Friends	Self-stigma -> Threat	.41 (.24, .55)	.013
	Trust -> Support seeking	.52 (.41, .63)	.008
Parents	Self- stigma -> Threat	.39 (.22, .54)	.012
	Threat -> Support seeking	.25 (.10, .34)	.030
	Self- stigma -> Support seeking	-.10 (-.32, -.03)	.030
	Age -> Support seeking	-.20 (-.33, -.07)	.023
	Trust -> Support seeking	.60 (.50, .69)	.008
Teachers	Self- stigma -> Threat	.40 (.23, .54)	.012
	Trust -> Support seeking	.67 (.57, .75)	.009
Professionals	Self- stigma -> Threat	.38 (.20, .52)	.015
	Threat -> Support seeking	.18 (.03, .28)	.041
	Trust -> Support seeking	.64 (.55, .73)	.009
Online	Self- stigma -> Threat	.38 (.22, .53)	.013
	Trust*Threat -> Support seeking	.33 (.15, .45)	.025
	Trust -> Support seeking	.34 (.20, .46)	.011
Indirect effects			
Parents	Self- stigma -> Support seeking	.10 (.04, .18)	.010
Professionals	Self- stigma -> Support seeking	.07 (.02, .14)	.017

Table 3

Significant bootstrapped paths (and 90% Confidence Intervals) for each model for the Friend condition

Model	Pathways	*β* (90% CI)	*p*
Direct effects			
Friends	Self- stigma -> Support seeking	.16 (.04, .36)	.034
	Public-stigma -> Support seeking	-.17 (-.31, -.04)	.042
	Trust -> Support seeking	.46 (.31, .59)	.010
Parents	Public-stigma -> Support seeking	-.15 (-.28, -.03)	.044
	Age -> Support seeking	-.15 (-.00, -.04)	.032
	Trust -> Support seeking	.52 (.35, .64)	.013
Teachers	Trust -> Support seeking	.45 (.57, .75)	.011
	Gender -> Support seeking	-.17 (-.28, -.04)	.030
Professionals	Public-stigma -> Support seeking	-.17 (-.31, -.05)	.030
	Trust -> Support seeking	.52 (.37, .64)	.015
	Gender -> Support seeking	-.17 (-.27, -.04)	.035
Online	Age -> Support seeking	.18 (.04, .30)	.051
	Trust -> Support seeking	.42 (.30, .57)	.006
	Gender -> Support seeking	-.15 (-.26, -.03)	.048

Unique variance analysis

All regressions estimated in SPSS accounted for a significant portion of the variance in the relevant outcomes. For the Self models, the multiple regressions indicated that there was a significant effect between the independent variables (i.e., self-stigma, public-stigma, threat, and trust), both covariates (i.e., age and gender) and support seeking from friends ($R^2 = .28$, $F(7, 102) = 5.57$, $p < .001$), support seeking from parents ($R^2 = .51$, $F(7, 102) = 15.33$, $p < .001$), support seeking from teachers ($R^2 = .50$, $F(7, 102) = 14.67$, $p < .001$), support seeking from professionals ($R^2 = .49$, $F(7, 102) = 14.10$, $p < .001$), and support seeking online ($R^2 = .28$, $F(7, 102) = 5.58$, $p < .001$).

The Friend models showed a similar result with the multiple regressions indicating a significant effect between self-stigma, public-stigma, threat, trust, gender, age, and support seeking from friends ($R^2 = .21$, $F(7, 132) = 5.10$, $p < .001$), support seeking from parents ($R^2 = .33$, $F(7, 132) = 9.46$, $p < .001$), support seeking from teachers ($R^2 = .22$, $F(7, 132) = 5.38$, $p < .001$), support seeking professionals ($R^2 = .39$, $F(7, 132) = 12.11$, $p < .001$), and support seeking online ($R^2 = .24$, $F(7, 132) = 6.02$, $p < .001$).

Further, the multiple regressions showed that threat accounted for 0.4% to 4.8% of variance in the Self models and for 0.1% to 0.3% for the Friend models. Self-stigma accounted for 0.1% to 2.4% variance in the Self condition and for 0.3% to 1.8% in the Friend condition. Public-stigma variance in the Self models was between 0.1% and 0.9%, while for the Friend models the variance was of 0.3% to 2.6%. Finally, the trust in sources of support accounted for 10.2% to 37.0% of the variance in the Self models and 14.5% to 18.6% in the Friend models (cf. Tables 4 to 8).

Table 4

Zero-order and semi-partial correlations with dependent variable seeking support from friends.

	Self		Friend	
	Zero-order	**Semi-partial**	**Zero-order**	**Semi-partial**
Public- stigma	-.01	.10	-.16	-.16*
Self-stigma	-.02	.01	-.03	.14
Threat	.11	.06	.02	-.04
Trust Friends	.50**	.50***	.41**	.41***
Gender	-.04	.01	.06	.06
Age	.02	-.07	.01	-.03

*p <.05; **p < .01; ***p < .001

Table 5

Zero-order and semi-partial correlations with dependent variable seeking support from parents.

	Self		Friend	
	Zero-order	**Semi-partial**	**Zero-order**	**Semi-partial**
Public- stigma	-.17	-.10	-.26**	-.13
Self-stigma	-.20*	-.15*	-.25**	.02
Threat	.13	.22**	-.09	-.00
Trust Parents	.64**	.58***	.51**	.43***
Gender	-.20*	-.09	-.16	-.07
Age	-.67	-.19**	-.24**	-.14

*p <.05; **p < .01; ***p < .001

Table 6

Zero-order and semi-partial correlations with dependent variable seeking support from teachers.

	Self		Friend	
	Zero-order	**Semi-partial**	**Zero-order**	**Semi-partial**
Public- stigma	-.11	.04	-.08	.00
Self-stigma	-.10	-.02	-.09	.06
Threat	.03	.08	-.00	.03
Trust Teachers	$.69^{**}$	$.61^{***}$	$.43^{**}$	$.40^{***}$
Gender	-.01	-.05	$-.20^{*}$	$-.16^{*}$
Age	-.15	$-.16^{*}$	-.08	-.05

*p <.05; **p < .01; ***p < .001

Table 7

Zero-order and semi-partial correlations with dependent variable seeking support from professionals.

	Self		Friend	
	Zero-order	**Semi-partial**	**Zero-order**	**Semi-partial**
Public- stigma	-.12	-.09	$-.26^{**}$	$-.15^{*}$
Self-stigma	-.04	-.09	-.045	.07
Threat	.15	$.16^{*}$	-.13	-.05
Trust Professionals	$.67^{**}$	$.60^{***}$	$.57^{**}$	$.43^{***}$
Gender	.01	.00	$-.30^{**}$	$-.16^{*}$
Age	-.00	-.07	.04	.09

*p <.05; **p < .01; ***p < .001

Table 8

Zero-order and semi-partial correlations with dependent variable seeking support online.

	Self		Friend	
	Zero-order	**Semi-partial**	**Zero-order**	**Semi-partial**
Public- stigma	.03	.03	.01	-.06
Self-stigma	-.08	-.12	.03	.05
Threat	.01	.12	.09	.01
Trust Online	$.36^{**}$	$.32^{***}$	$.43^{**}$	$.38^{***}$
Gender	-.10	-.14	-.16	-.15
Age	.11	.04	$.23^{**}$	$.17^{*}$

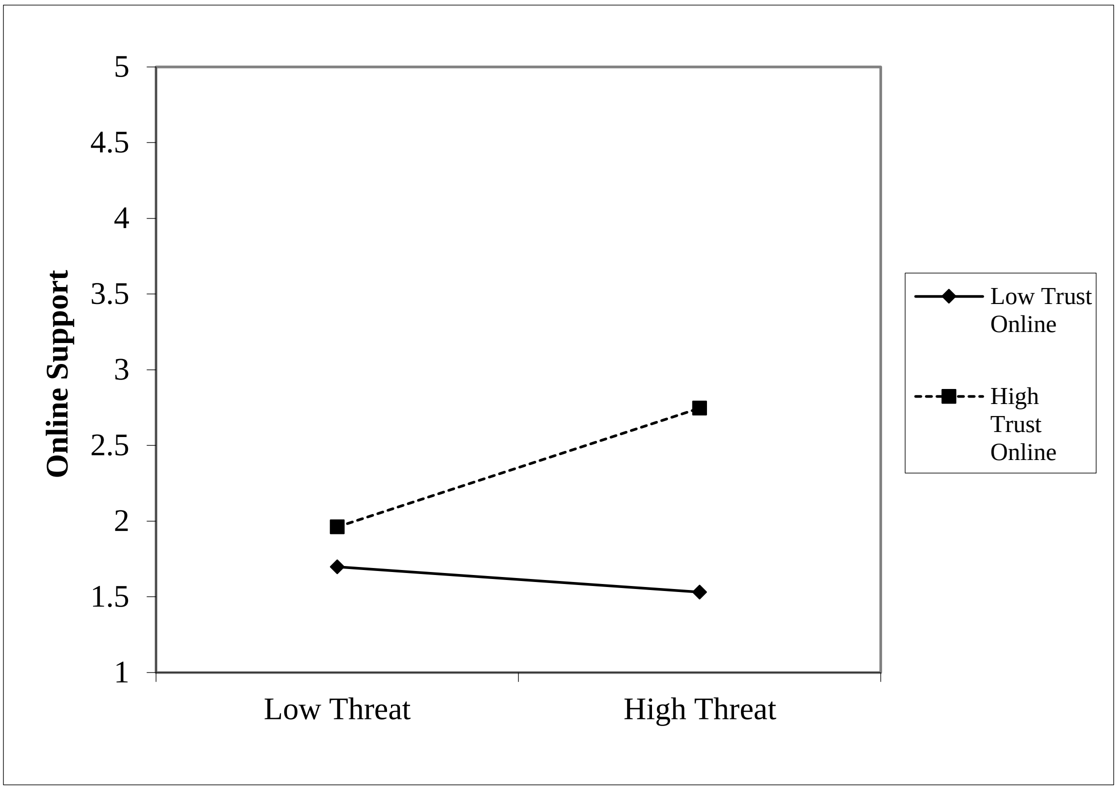
$^{*}p < .05$; $^{**}p < .01$; $^{***}p < .001$

Moderation of Threat by Trust

Only one moderation effect was observed, where there was a significant effect of the interaction term (trust*threat) on support seeking online in the 'Self' condition (β = .33, p = .025). A simple slopes procedure (Dawson, 2014) was followed to test if the relationship between threat and support seeking was significant when trust was either high (+1SD) or low (-1SD) (see Figure 2). This demonstrated that when trust in the online resource is low, levels of threat are unrelated to reports of going online to seek support (β = -.12, p = .421). In contrast, when trust in online is high, threat is positively related to reports of going online to seek support (β = .56, p < .05).

Figure 2

Simple slopes for the direct effect of the interaction term (trust online threat) and seeking online support for the Self condition.*



Differences Between Groups

Table 9 reports significant differences between paths in the models. The path from self-stigma to threat was significantly different in the models for parent (*z* = -1.99), teacher (*z* = -2.11), and professionals (*z* = -2.09) support. In all three cases, there were significant, positive effects of self-stigma on threat in the 'Self' condition but not in the 'Friend' condition. There was also a significant difference in the path between threat and support seeking in the models evaluating support from parents (*z* = -2.46) and professionals (*z* = -2.27). In both cases, there was a significant positive effect of threat on support seeking in the 'Self' condition but not in the 'Friend's condition. In only the parent support model, the path between self-stigma and support seeking was significantly different between groups (*z* = 2.04). There was a significant negative effect of self-stigma on support seeking only on the 'Self' version of the questionnaire.

Only the model assessing support from friends showed a significantly difference in the path between public-stigma and support seeking (*z* = -2.23). A significant negative effect of public-stigma on support seeking from a friend was found in the 'Friend' condition but not in the 'Self' condition. In the online support model, the interaction term and support seeking also showed a significant difference between groups (*z* = -2.21). This translates into a significant positive effect of the interaction term on support seeking in the 'Self' version and not in the 'Friend'.

Table 9

Significant pairwise comparisons for each model.

		Condition				
		Self		**Friend**		
Model	**Pathways**	***β***	***p***	***β***	***p***	**z-score**
Friends	Public-stigma -> Support seeking	.10	.227	-.17	.033	-2.23
Parents	Self-stigma -> Threat	.39	.000	.17	.055	-1.99
	Threat -> Support seeking	.25	.001	.00	.982	-2.46
	Self-stigma -> Support seeking	-.18	.018	.02	.758	2.04
Teachers	Self-stigma -> Threat	.40	.000	.16	.069	-2.11
Professionals	Self-stigma -> Threat	.38	.000	.15	.100	-2.09
	Threat -> Support seeking	.18	.021	-.06	.419	-2.27
Online	Trust*Threat -> Support seeking	.33	.000	.04	.635	-2.21

Finally, a *t*-test showed that threat levels differed between conditions, $t(248) = 4.27$, $p < .001$. Participants reported higher levels of threat in the ‘Self’ condition (M = 3.44, SD = .70) than in the ‘Friend’ condition (M = 3.09, SD = .59). The other five t-tests conducted to test if support seeking differed between groups revealed no significant differences.

Discussion

This study is the first to examine the ways that young people would deal with their own symptoms of mental illness or with a friend’s disclosure of symptoms of mental illness. This was investigated by testing a model of support seeking which integrated mental illness stigma, threat, trust, and the extent to which five different resources (parents, friends, teachers, professionals, and online) might be approached for support. Overall, there was some support for each of the hypotheses though this differed according to the source of support in question. This study is slightly underpowered and results should be interpreted taking this into consideration.

‘Self’ Condition

It was expected that both self- and public-stigma would be negatively associated with support seeking. However, for the ‘Self’ condition, only self-stigma was negatively associated with seeking support from parents. There was no association between seeking support from any of the other four resources and self-stigma, and no association between all five resources and public-stigma, as initially hypothesised. Higher levels of self-stigma have been shown to reduce support seeking behaviours (e.g., Heary et al., 2017; Talebi et al., 2016). Young people might feel that their role in the family is threatened and that parents will start treating them differently, reducing their levels of self-esteem and self-worth, which in turn reduces the likelihood of seeking support from them. Thus, seeking support from a parent can be particularly challenging for a young person who has internalised public stereotypes about mental illness due to fear of judgement and embarrassment.

There was also mixed support for the mediation hypothesis. Higher levels of self-stigma were associated with higher levels of threat, which in turn were associated with a higher likelihood of seeking support from parents and professionals. These are interesting findings for two reasons. First, these contradict results relating to hypothesis 1, where higher self-stigma was shown to be associated with lower support seeking from parents. Thus, this mediation effect goes against the direct effect described earlier. Second, these results contradict some of the literature that highlights a lack of willingness from young people to ask for support from formal sources such as mental health professionals (Camara et al., 2017; Rickwood et al., 2015). These different findings could be a result of the combination of the variables used in this study, or even efforts in the UK context to improve young people's knowledge about available sources and to reduce stigma when seeking support for mental illness (e.g., mental health campaigns such as *See Me* (Scotland) focused on educating young people and reducing stigma). Furthermore, the fact that this study focusses on hypothetical scenarios rather than lived experiences of support seeking may have contributed to the contradictions found in the results. In any case, these are encouraging results since they show young people's willingness to seek support when in need.

Finally, there was support for the moderation hypothesis in the context of online support in the 'Self' condition. Specifically, threat was positively associated with support seeking from online sources, but only when levels of trust in this resource were high. Online, young people may feel that they can have a high level of control over the information shared, and whom they talk to about their symptoms (Gibson & Trnka, 2020). Similarly, it is also possible that young people will feel less control over the information shared online when seeking support from parents or professionals, given the positive association between threat and support from parents and professionals. On the other hand, they might also feel more invested in the need for a positive outcome, when compared to a friend experiencing symptoms. Given that this effect was only found for online support, it is possible that other variables could play a more meaningful role for other sources of support, for example severity of symptoms is one candidate variable (Cong et al., 2019; Horwitz et al., 2011; Pimenta et al., 2021; Sears, 2020).

‘Friend’ Condition

Public-stigma was found to be negatively associated with support seeking from friends, parents, and professionals when dealing with a friend’s disclosure of symptoms of mental illness. Young people might refrain from seeking support from another friend as a result of characteristics of friendships like empathy and the ability to imagine themselves in their friend’s situation (Meuwese et al., 2017). Young people might imagine what they would do and feel in a similar situation and consider the negative consequences of sharing the symptoms with another person, in this case a friend. These consequences might include judgment or embarrassment (Major & O’Brien, 2005; Rüsch et al., 2014). On the other hand, fears of misunderstanding or criticism (Moses, 2010) might be behind the findings pertaining to public-stigma being negatively associated with using parents and professionals as a source of support.

Self-stigma was positively associated with support seeking from friends. This particular pathway contradicts the literature that shows that high levels of self-stigma reduces willingness to seek support for a mental illness (Cheng et al., 2018). This could be due to previous experiences where adolescents confided in their friends and were able to overcome their stress, leading young people to value a friend’s advice and support (Poulin & Pedersen, 2007). Similarly, feelings of security (Meuwese et al., 2017) and familiarity that characterise friendships could be influencing this outcome. Finally, there was no support for either the mediation or moderation hypotheses in the ‘Friend’ condition. Since research in this context is still scarce, it is possible that other more relevant variables (e.g., what symptoms are experienced, mental health literacy) are at play when a friend discloses symptoms of mental illness.

Differences Between Conditions

Levels of threat differed across the two conditions, with reports higher in the ‘Self’ condition. With this in mind, it is possible that threat might not be as relevant in the ‘Friend’ condition, but it is also possible that other variables are playing a more significant role in the decision to seek support when a friend is experiencing symptoms. For example, support seeking behaviours might be influenced by both knowledge about, and availability of, resources (Gulliver et al., 2010; Velasco et al., 2020). Young people are more likely to seek support if they perceive that there are services available to them. As such, it might be the case that adolescents’ perceptions about the resources that are available is influencing their choices. Thus, more research is needed on this particular topic.

Likewise, there were no differences between conditions when it came to choosing a source of support. When it comes to seeking support from professional sources, research has suggested that young people are more likely to refer a friend who is experiencing mental illness to a professional than to refer themselves when experiencing similar symptoms (Raviv et al., 2000; Rickwood et al., 2005). Thus, when it comes to seeking support from professional sources, the current study contradicts existing literature. Research on seeking support from the other four sources is still scarce, and the possible reasons for a non-significant result are still unclear. Future research might usefully consider forms of support beyond those considered in our study (emotion and problem focused). Research has suggested that several specific behaviours could be included in each of these categories of support (Compas et al., 2001). Indeed, the items used in this study to measure support seeking were adapted from a scale that includes a total of 14 two-items categories (Carver, 1997). Perhaps a more comprehensive and detailed look at different forms of support seeking suggested by these authors might lead to different results. For example, exploring how the model would perform when including items for active coping, planning, or positive reframing, could aid in the further understanding of adolescents' support seeking.

This study had both strengths and limitations. First, this study is slightly underpowered with an achieved sample of 250 rather than the 380 identified in a priori power analysis (Stone-Romero & Anderson, 1994). This meant that the results and conclusions from this study may be affected as an underpowered sample makes it difficult to test specific interactions and effects (Maxwell, 2004; van de Schoot & Miocevic, 2020). Considering that this study intended to perform a multigroup comparison, an underpowered sample could have contributed to the inconsistent results (Maxwell, 2004). For example, this may explain why the moderation effect was only found in the Self condition. Given the multiple and simultaneous tests in both conditions (i.e., ten times in total), this single result could simply be a Type 1 error.

In addition, this study used a cross-sectional design which limits inferences about the findings. Mediation analysis using cross-sectional studies have been shown to yield different results from mediation analysis using longitudinal approaches (e.g., Maxwell & Cole, 2007; Maxwell et al., 2011). Mitigations were put in place to address this (e.g., use of unique variance analysis), but future studies should explore the relationships in this study using a longitudinal approach to provide further understanding about these associations. Additionally, this study used vignettes to assess young people's support seeking. This methodology allows control over the situation and the context being presented to the participants (Leighton, 2010; Rickwood & Thomas, 2012) but also has limitations. Most notably, responses to hypothetical situations may not reflect how young people react in real life (Burns & Rapee, 2006; Marshall & Dunstan, 2013). Future research could expand on this in order to further understand the elements that influence adolescents support seeking in both contexts with a lived-experienced sample.

In conclusion, this study provided evidence that young people are likely to cope differently with faced with their own symptoms of mental illness as compared to when they are coping with a friend's symptoms of mental illness. When coping with their own symptoms of mental illness, it seems that self-stigma, threat levels, and trust play a key role in support seeking. Comparatively, public-stigma seem to have more impact when young people are dealing with a friend's symptoms of mental illness. Additionally, threat and trust do not seem to have as much of an influence when a friend reports experiencing such symptoms. It is possible that other variables might be more important when adolescents deal with a friend's symptoms of mental illness. This study adds to existing knowledge by concluding that young people responding to a disclosure by a friend are also impacted by stigma and trust. As such, a focus on responses by young people to a friend's disclosure when developing interventions and mental health awareness campaigns could be beneficial so that specific elements hindering support seeking can be addressed early on.

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Appendix

Self Vignettes

Situation 1. You have been feeling unusually sad and in a low mood for the last few weeks, and nothing special has happened to trigger this. You are tired all the time and you have trouble sleeping nearly every night. Also, your appetite has changed and you have lost some weight. In school, you are having some difficulties concentrating and your results are not as good as they normally are.

Situation 2. You have always felt shy and self-conscious around others, and never felt that you knew what to say or how to act. Lately, you started to feel physically tense, nervous, sick, and flushed, even during breaks from classes. You often replay these situations in your head in a very self-critical way. You are sometimes described by others as "odd" or "a loner", also you avoid almost all social situations.

Friend Vignettes

Situation 1. A friend has been feeling unusually sad and in a low mood for the last few weeks, and nothing special has happened to trigger this. They are tired all the time and have trouble sleeping nearly every night. Also, their appetite has changed and they have lost some weight. In school, they are having some difficulties concentrating and their results are not as good as they normally are.

Situation 2. A friend of yours was always shy and self-conscious around others, and never feels that they know what to say or how to act. Lately, they started to feel physically tense, nervous, sick, and flushed, even during breaks from classes. They will often replay these situations in their head in a very self-critical way, and they have mentioned this to you before. Sometimes they are described by others as "odd" or "a loner". They avoid almost all social situations.

Chapter 9- Study 3: Severity of Symptoms and Threat as Mediating Factors of the Relationship between Stigma and Support Seeking for Mental Illness

This chapter will contextualise Study 3 and its methodology. Moreover, it will describe the limitations that led to a change in the planned analyses due to a lower than desired sample size. This sample size was itself a result of COVID-19 lockdown restrictions and that too will therefore be discussed. Results and discussion will also be cognisant of these limitations. This study is not presented in a form of a journal submission due to the reduced sample size and the associated implications this may have for publication in a peer reviewed journal.

9.1. Contextualisation for the Study

Chapter 8 reported on the findings from Study 2 which examined how stigma, threat, and trust influenced young people's hypothetical support seeking behaviours. In summary, Study 2 showed some differences between both conditions (i.e., self and a friend's symptoms). When dealing with a friend's disclosure, young people's public-stigma was negatively associated with support seeking from friends, parents, and professionals. On the other hand, when dealing with their own symptoms, there was evidence that the relationship between self-stigma and support seeking from parents or professionals was mediated by threat levels. Also, trust moderated the relationship between threat and support seeking online.

Study 2 used a vignette-based approach which, despite its advantages of being able to control for the context of the situation participants are being exposed to (Leighton, 2010; Rickwood & Thomas, 2012), is limited by the possibility that responses to hypothetical situations might differ from responses to a real-life event (Burns & Rapee, 2006; Marshall & Dunstan, 2013). With this in mind, focussing on reports of lived experiences of support seeking when dealing with symptoms of mental illness is an important step in providing ecological validity to the results reported in Study 2. Using the same theorical frameworks (i.e., TTC and Ecological Systems Theory), the present study therefore examines the same issues that were examined in Study 2 but with reference to lived, rather than hypothetical, experiences.

The present study will also consider how perceived severity of symptoms might play a role in this context. In Study 1, young people stated that they would only resort to professional help if they would consider their or a friend's symptoms *"severe enough"*. This corroborates research that shows a tendency for young people to look for mental health services when the symptoms are perceived to be too difficult for one to deal with on their own (Lubman et al., 2017). However, the notion of 'perceived severity of symptoms' has been relatively unexplored when it comes to the perspective of young people and with reference to support seeking. Among young people, different perceptions about severity for the same symptoms could arise, and therefore their decisions to seek help might also be different. Furthermore, much of the research in this area explores 'clinical levels of severity' of young people undergoing treatment, meeting disorder criteria, or with a diagnosed psychological disorder (e.g., Radez et al., 2022). Very seldom are young people's own perceptions about the severity of their symptoms, and how this relates to their support seeking, investigated (e.g., Leighton, 2010; Husky et al., 2009).

In their recent review, Magaard et al. (2017) concluded that clinically assessed severity of symptoms of adults with diagnoses of major depression were positively associated with reports of seeking support from professional services. However, the authors note that most of the papers that they reviewed focused on clinical samples undergoing treatment, and as such it was possible that participants might perceive their symptoms to be more severe as a result their diagnostic status. Thus, measuring severity by only considering ‘clinical levels of severity’ might neglect a relevant step in the support seeking process. In order to seek any kind of support, young people assess to what extent the symptoms experienced could affect their wellbeing (i.e., a primary appraisal) (Lazarus & Folkman, 1984). As such, their own perceptions of severity of symptoms could play a role in their active support seeking. By exploring perceived severity of symptoms as a result of lived experiences, this study will be able to offer a deeper understanding about how young people’s perceptions occur. Moreover, by testing a similar model and using the same variables explored in the previous study (i.e., stigma, threat, trust, support seeking), it will allow for a direct comparison between intentions to seek support and actual experiences of support seeking.

9.1.1. Severity of Symptoms of Mental Illness

It is relevant at this stage to define severity of symptoms. The severity attributed to a symptom experienced can have influence in the treatment and support sought by the individual as well as an impact on the expectation of the outcome of that treatment or support (Zimmerman et al., 2018). However, what elements to consider when addressing severity of symptoms, and how to measure it, is still unclear (e.g., Wakefield & Schmitz, 2017a; Zimmerman et al., 2018).

There are no agreed definitions of what constitutes a severe mental illness, which means that often clinicians and researchers have to decide what is the best way to obtain this information (Zimmerman et al., 2018). A clear definition of severity of symptoms is important given the emphasis on resource allocation to deal with mental illness. In England, the allocation of future resources to improve mental health services is proposed on the basis of the prevalence of severity of mental illness of individuals registered with a General Practitioner (NHS, 2019).

One tool that can aid in tailoring this discussion and that offers some insight into how individuals are diagnosed with a severe mental illness is the DSM-5 (American Psychological Association [APA], 2013). This manual offers criterion for different disorders and explores what constitutes severity for some of them. Particularly, the DSM-5 (APA, 2013) offers severity rating scales for some disorders. The approach and the definition of what constitutes severity varies with disorders and is frequently specific to them. One of the disorders that has a severity scale is Major Depressive disorder. According to the DSM-5 (APA, 2013), the severity of a Major Depressive disorder is defined by the number and the intensity of the symptoms, as well as the level of functional impairment (i.e., in the individual's social and occupational life). This is in contrast to, for example, Anorexia Nervosa where severity is assessed by the body mass index of the individual as well as the number of episodes experienced in one week. Another example of severity in the DSM-5 (APA, 2013) is Attention-Deficit and Hyperactivity Disorder. In order for a clinician to assess severity of this disorder they should explore the severity of each individual symptoms, the level of impairment, and the number of symptoms experienced. This shows that some of the scales proposed offer the chance to go beyond symptoms and categories of diagnosis, and focus on the individual and their single experience. This being said, it is important to state that, though the DMS-5 may offer an avenue to better understand and define severity of symptoms, the disorders included as well as the diagnostic criteria also lacks consensus among professionals and researchers in the field.

All these examples vary in approach and considerations of what is relevant for severity, but they have one element in common: the number of symptoms experienced related to the disorder in question seems to be a relevant metric when assessing severity. Faravelli et al. (1996) found that number of symptoms experienced by individuals going through a major depressive episode was highly correlated with impairment to functioning and quality of life. On the other hand, more recent research has shown that there might be more relevant factors when considering severity like the type of symptoms experienced or the willingness to seek professional help (Wakefield & Schmitz, 2017a, 2017b).

In conclusion, the assessment of severity of symptoms can be complex and it is beneficial to have measures that offer complementary ways of empirically assessing severity of symptoms as a concept and that consider each individual's experiences and perceptions. In this thesis, this will be done by two elements: overall perceived severity of symptoms and number of symptoms.

9.1.2. Perceived Severity of Symptoms within the TTC

Cognitive Appraisals.

As described in earlier chapters, young people dealing with symptoms of mental illness have difficulties seeking support for many different reasons (Velasco et al., 2020). So far, it has been highlighted that both self- and public-stigma (Corrigan et al., 2012; Lannin et al., 2016), and lack of trust (Leavey et al., 2011; Verhaeghe & Bracke, 2011), are key barriers for young people seeking support. Study 1 found that young people would be more willing to seek help from a professional if they considered the symptoms to be "severe". This corroborates existing research showing a preference for support from mental health services if young people feel they are not able to handle the symptoms on their own (Colognori et al., 2012). However, as a concept, severity of symptoms has been relatively unexplored when it comes to the perspective of young people and its influence in support seeking.

Returning to the theoretical framework described in Chapter 2, Lazarus (1991a) proposed that both the emotion generated as a result of the stress experienced and the intensity of said stressor are highly dependent on cognitive appraisals. It has been discussed in an earlier chapter that negative emotions like fear and sadness are linked with primary appraisals of threat. During the appraisal process, people evaluate the stressful situation, its seriousness, and possible impact in their own wellbeing, as well as what can be done to change the outcome (Lazarus & Folkman, 1984). Furthermore, Lazarus (1991a) suggests that as stress intensity increases, so does the potential for a threat appraisal. Considering the current context of this study, it is possible to infer that if young people perceive mental illness symptoms to be severe, they will be more likely to appraise their symptoms as threatening. As such, in this study, perceived severity of symptoms is interpreted as an appraisal which has a direct impact on threat appraisals.

Coping Strategies.

Chapter 2 (sections 2.3.1 and 2.3.2) explored the negative association between threat appraisals and coping strategies with Lazarus (1991a) suggesting that higher levels of stress intensity are associated with higher levels of threat. This implies that the level of severity that young people perceive in a particular stressful situation may have an impact on their coping choice. Research has found that moderate-to-severe symptoms can be associated with the use and preference for professional mental health services (Aromaa et al., 2011; Lubman et al., 2017). In addition, higher levels of suicidal ideation and depression have been found to be negatively associated with help-seeking intentions from informal sources (e.g., family, friends), and positively associated with seeking help from no one (Wilson & Deane, 2010; Wilson et al., 2007).

Symptom severity is associated with better recognition of symptoms and higher support seeking rates (Thompson et al., 2004). Thus, if adolescents have low mental health literacy (i.e., lower knowledge about symptoms and how to recognise symptoms that might need help) (Hart et al., 2018; Mason et al., 2015), there could be a tendency to under-estimate the severity of symptoms and thus to delay help-seeking.

In summary, there is a lack of research examining the relationship between seeking support and young people’s perceptions concerning the severity of their symptoms. This study will evaluate whether perceived severity is relevant when seeking to better understand young people’s support seeking from friends, teachers, parents, and online.

9.1.3. Perceived Severity of Symptoms and Public- and Self-Stigma

Overall, studies show that high clinically severity of symptoms is associated with higher public-stigma (Freidl et al., 2008; Golberstein, et al., 2008; Griffiths et al., 2008). Fox et al. (2018) explored the possible role of severity of symptoms as both mediator and moderator of the relationship between public-stigma and help-seeking when adults were dealing with symptoms of depression. This study used a longitudinal methodology and concluded that for participants with high levels of severity of symptoms, high levels of public-stigma were associated with lower support seeking from a professional. Fox et al. (2018) suggests that one possible explanation for this could be that individuals might perceive a higher level of threat when their symptoms are more severe, which in turn will reduce the likelihood of seeking support due to fears of embarrassment and judgement from others.

Griffiths et al. (2018) explored how different mechanisms of public-stigma were associated with symptom severity, concluding that higher social withdrawal and avoidance were associated with reports of more severe symptoms when individuals were clinically diagnosed with a mental illness disorder. Similarly, self-stigma was also shown to be positively associated with severity of symptoms when individuals were clinically diagnosed with a mental illness (Boyd et al., 2014b; Livingston & Boyd, 2010). This demonstrates that both forms of stigma explored in this thesis are potentially associated with the perceived severity of symptoms.

9.1.4. The Role of Perceived Severity when Young People Deal with Their or a Friend's Symptoms

As previously stated in this thesis, research looking into young people's responses to a friend's disclosure of symptoms of mental illness is scarce. The majority of studies that explore the role of severity of symptoms do so from the perspective of the young person experiencing the symptom. Considering that cognitive appraisals are a result of individual differences and experiences (Lazarus & Launier, 1978; Lazarus & Folkman, 1984), young people might have different perceptions about the intensity of the stressor (i.e., perceived severity of symptoms) if a friend is the one experiencing the symptoms instead of themselves.

Drawing from suicide research, authors have explored how young people deal with a friend's non-suicidal self-injury (NSSI) and concluded that forms of NSSI perceived to be less serious corresponded to a higher likelihood of young people supporting their friends and helping them to deal with the situation (Fisher et al., 2017). The same authors concluded that more severe forms of NSSI were linked to a lower likelihood of young people engaging in outside support seeking for their friend (e.g., talking to an adult about their friend's disclosure). This provides some initial support for the importance of understanding the influence that perceptions of severity of symptoms can have on the coping process when considering either one's own or a friend's symptoms of mental illness.

9.1.5. A Model of the Role of Stigma of Mental Illness on Support Seeking: the Mediating and Moderating Role of Perceived Severity of Symptoms, Threat, and Trust

The current study tests the model that informed Study 2 (see Chapter 8), but with perceived severity of symptoms introduced into this model as a predictor of threat levels. At this point, it is worth clarifying why perceived severity was not included in the model tested in Study 2. Though results from Study 1 revealed that perceived severity was a relevant factor in deciding to seek support when dealing with symptoms of mental illness, there was a need to first explore the validity of the proposed model in light of the TTC. Thus, Study 2 was developed to consider the main elements of the TTC (i.e., primary and secondary appraisals as well as coping strategies) and applying a simpler model to assess the overall validity of the TTC in this context. Further to this, the literature reviewed earlier suggests that perceived severity can play a role in support seeking when young people can draw from previous experience. Thus, including perceived severity of symptoms in Study 2 was not appropriate since that study focused on hypothetical scenarios.

Thus, this study will test the same hypotheses described in Study 2 (see Figure 1 in Chapter 8), and two additional hypotheses that focus on the effect of perceived severity of symptoms in the coping process (Figure 9.1):

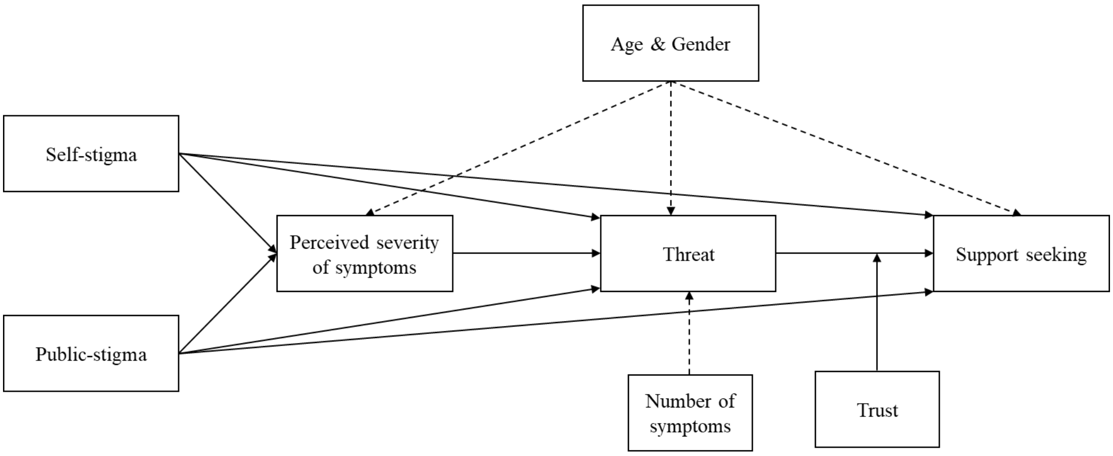
1) Self- and public-stigma will be positively associated with perceived severity of symptoms (i.e., higher levels of both self- and public-stigma will be associated with higher levels of perceived severity).
2) Both threat levels and perceived severity of symptoms will mediate the relation between stigma (self- and public-stigma) and support seeking from all five sources of support (i.e., higher perceived severity will be associated with higher threat levels, which in turn will be associated with higher support seeking).

The same hypotheses will be tested for both groups: Self and Friend. Moreover, in this study, group comparisons will be exploratory in nature. Studies looking into how young people deal with a friend’s symptoms are scarce, and this also pertains to their perception of severity of their friend’s symptoms. It is expected however, that similar patterns to the ones uncovered in Study 2 will be found in this current study, for all but the perceived severity of symptoms specific hypothesis detailed above. For these hypotheses, analyses will be mainly exploratory in nature.

Finally, age and gender will be used as covariates. These are hypothesised to affect threat and support seeking (as in the previous study) and perceived severity of symptoms. Building on the rationale developed in Study 2, research has shown that adolescent girls are more likely to report higher severity levels (Rose et al., 2011). Furthermore, according to what was presented in section 9.1.1., the number of symptoms experienced will be used as a control variable expecting higher levels of threat to be associated with higher number of symptoms reported by participants.

Figure 9.1

Study 3 model



9.2. Methodology

9.2.1. Participants

There were 76 participants with a total mean age of 13.11 (SD=0.84) with a minimum age of 12 and maximum of 15. More than half of the sample identified themselves as male (53.9%), 38.2% as female, and 7.9% either preferred to not say or it was not listed in the options provided and they did not fill-out the appropriate available open text box to indicate the gender they identified with. In terms of nationality, the majority of participants (92.1%) reported being from the United Kingdom, while the rest reported being from Thailand, Poland, Zimbabwe, Germany, or they omitted to answer the question.

9.2.2. Measures

The survey used in this study had the same measures as in Study 2 (see Chapter 7 section 7.1 and Chapter 8 Methods section) for public- and self-stigma, threat, trust, and support seeking. The current survey consisted of a change in the gender question and the addition of two new questions. The change of the gender question resulted from a limitation in Study 2 (see Chapter 8 Discussion section), where participants were only offered three options (i.e., male, female, and other). For the present study, participants were given a fourth option (adding to the three already described before) that read “Not listed”, and if selected, participants were asked to specify how they identified themselves. This was to attend to concerns that participants who might not identify as binary (i.e., male and female) could feel uncomfortable in taking part. The rest of the demographic questions (i.e., age, ethnicity, and nationality) were the same as described in Study 2.

After participants answered the public-stigma and trust measures, participants were asked: *“Think about the last two months. Have you had any thoughts or feelings that can be experienced by people who have a mental health problem? This might include sadness, difficulty concentrating, sleep problems, thoughts about ending your life, or self-harm (that is, hurting yourself on purpose)? Have any of your friends told you about thoughts or feelings like these?”*. When designing the study, it was considered that framing this question within two months would be the best option given that data was being collected in schools. This means that depending on when data collection occurred, it could be that if the timeframe proposed was shorter, pupils could have just returned from holiday or not have been around their peers. This could imply that there would have been a reduced change of young people disclosing their symptoms to their friends during that period.

The symptoms used as examples were selected in order to help participants to understand what was meant by the term “mental health problem”. For this question, there were five response options: 1) *Both – I have had thoughts or feelings like these AND a friend has told me that they have too*; 2) *I have had thoughts or feelings like these*; 3) *A friend has told me that they have had thoughts or feelings like these*; 4) *Neither – I have NOT had thoughts or feelings like these AND no friends have told me that they are having them*; and 5) *Prefer not to say*. Participants’ responses were used to direct them to complete one out of three available versions of the questionnaire. Table 9.1 presents a summary of what version of the survey was shown to participants depending on the answer to this question.

One version focused on their own symptoms (i.e., the ‘Self’ condition), and they would be directed to this if they answered that they have been experiencing symptoms of mental illness. The second version asked them about their friend’s symptoms (i.e., the ‘Friend’ condition), and they would be directed to this version if they had answered ‘Both…’ or ‘A friend has told me that they have had thoughts…’. The third version of the questionnaire presented a hypothetical scenario where a friend disclosed symptoms. This third and final version was to account for the last two possible answers (i.e., *‘Neither…’* and ‘*Prefer not to say...’*).

Table 9.1

Summary of versions displayed according to answer to branching question.

Answer options	Survey version/ Condition
1) Both – I have had thoughts or feelings like these AND a friend has told me that they have too	Friend
2) I have had thoughts or feelings like these	Self
3) A friend has told me that they have had thoughts or feelings like these	Friend
4) Neither – I have NOT had thoughts or feelings like these AND no friends have told me that they are having them	Hypothetical
5) Prefer not to say	Hypothetical

This final condition was for a hypothetical disclosure of mental health symptoms by a friend. By adding this third condition, participants that selected options 4) *Neither – I have NOT had thoughts or feelings like these AND no friends have told me that they are having them*; and 5) *Prefer not to say,* would still be presented with the same questions as the participants who selected options 1 to 3. This meant that they would still take the same amount of time to complete the survey, ensuring that young people reporting symptoms and those not reporting symptoms could not be identified by their peers. Thus, including this extra condition the study ensured that ethical guidelines around maintaining confidentially and anonymity were met.

After participants had answered this question, a novel measure developed to assess perceived severity of symptoms was presented. Depending on the answer they gave to the preceding question, these questions pertained to either their own symptoms, their friend’s symptoms, or a hypothetical scenario. From a total of 13 possible symptoms, participants were asked to select which had been experienced by them or a friend and to rate how severe they perceived each symptom to be. A five-point Likert-scale was used from (1=Not serious; 5=Very serious). For the hypothetical scenario, as described earlier, participants were invited to imagine that a friend disclosed symptoms of mental illness to them and they were asked to rate all 13 symptoms presented in the list from 1 to 5 on perceived level of severity.

Eleven of the thirteen possible symptoms were selected based on a range of essential DMS-5 (APA, 2013) criteria for depression and anxiety disorders. The final two symptoms were included as a direct result of the interviews conducted in Study 1, where the severity of self-harming behaviours or suicidal thoughts were explicitly highlighted as an important influence on the decision to seek help from a professional. Participants were instructed that if they or a friend had not experienced any of the symptoms then they should select N/A (i.e., Not applicable). Two scores were created. First, a mean overall perceived severity score was created out of the valid data points for each symptom participants recorded experiencing (either themselves or through a friend’s disclosure). The second score created was the total number of symptoms experienced (range 0-13) (see Appendix 22 for the complete survey used in this study).

9.2.3. Procedure

For this study, ethical approval was obtained from the University Ethics Committee at the University of Strathclyde. All thirty-one Scottish Local Education Authorities (LEAs) were contacted for approval to invite schools to be involved. Eleven LEAs (35%) authorised that schools were approached to assess their interest in taking part in this research. One hundred and five schools (6%) across the 11 LEAs were contacted, and at the point of the stay-at-home orders due to the COVID-19 pandemic (see more details in section 9.2.5.), six schools had agreed to take part. For these schools, parents/carers' positive consent as well as each pupil's own consent were required prior to data collection. Reasons provided by LEAs and schools for rejecting to participate in the study were similar to the ones presented in Chapter 7 (section 7.2.).

As in Study 2, the survey was delivered online. Since this survey touched on sensitive topics that required young people to disclose lived-experiences with mental illness (either their own or of a friend's), pupils were asked to complete the survey on their mobile phones to ensure privacy and anonymity of the answers. Additionally, this was a convenient way for young people to access the survey since most were expected to have access to an electronic device (as per Study 2). Additional measures were also put in place to ensure that all students who wanted to take part could do so even if they did not own an appropriate device. The researcher brought to every participating school four additional tablet devices. In the event, none of these extra devices were required since schools were able to provide their own tablets or Chromebooks for students who did not have a mobile phone in their possession. Students were free to use their own data, school Wi-Fi, or mobile 4G Wi-Fi that was also provided by the researcher. The survey was hosted on Qualtrics.com.

Participants first completed demographic questions, followed by trust questions, public-stigma questions, and then a question about whether they or a friend had experienced symptoms of mental illness in the past two months. This last question was used to apply branching in Qualtrics and directed participants to one out of three versions of the questionnaire. After this, they were presented with the questions for threat appraisals, perceived severity of the symptoms, support seeking, and self-stigma questions.

As with the procedure described in both previous studies (see section 3.3 in Chapter 3), when participants received the PIS, a debrief sheet was also provided. On top of all the information in the debrief already described, for this particular study the debrief included an extra section. Prior to data collection, a point of contact for students to seek support in the school was identified and added to the debrief sheet. Thus, for each school taking part, a different debrief sheet was supplied to the participants with the name, contact details and office hours (if applicable) of the school staff identified as point of contact. This was done with the aim to facilitate identification of resources in the participant's school.

9.2.4. Data Analysis Plan

As a result of a priori power analysis and literature review (Stone-Romero & Anderson, 1994), a sample size of 540 was planned for, with 180 for each group (i.e., Self, Friend, and Hypothetical). Data collection restrictions associated with COVID-19 (see section 8.2.5 for details) meant that it was not possible to undertake analyses as planned due to recruitment of fewer participants than were required (final total sample was of 76, see section 9.2.1.). The initial plan had been to perform five multi-group mediated moderation models, using AMOS 25. These models would have in part replicated those presented in Study 2 to allow for a direct comparison between both studies, while also adding perceived severity of symptoms as a mediator of the relationship between public- and self-stigma and threat, and number of symptoms as a direct effect on levels of threat. The initial approach had been to test all the same hypotheses as in Study 2 and to add the hypotheses presented at the end of Section 9.1. Path analyses employing the maximum-likelihood parameter estimation were planned to test the model in Figure 9.1. As in Study 2, the initial step would be to check the model fit of the five proposed models. This allows for assertion of the goodness of fit of each of the models in this study. To do this, values of Chi-Square, Root-Mean-Square Error of Approximation (RMSEA), and Comparative Fit Index (CFI) would have been assessed. A non-significant chi-square result, a RMSEA value between .06 and .08, and CFI >.95 would be expected to concluded a good model fit.

After checking for goodness of fit, it was planned that five identical models would be run to test for mediation and moderation effects, for each of groups. For example, for the model where the source of support was professionals, it would have been expected that self- and public-stigma would have a direct positive effect on support seeking from professionals. Furthermore, it was expected that this direct effect would be mediated by perceived severity of symptoms and threat levels. Number of symptoms would have a direct positive effect in threat levels. Finally, the moderating effect of trust in professionals on the relationship between threat and support seeking from professionals would have been explored. Where the interaction term for the moderation was significant, a follow up simple-slopes analysis would have been performed (Dawson, 2014).

Multi-group comparisons were planned to compared the models between two groups: Self and Friend. This means that only results from two versions of the questionnaire were used. Responses to the third version of the survey (i.e., hypothetical scenario) were planned to be excluded from the analysis since the aim of this study was to investigate lived-experiences. In order to infer statistically significant differences between groups, pairwise comparisons would have been used to identify standardised difference between each pathway estimates in the model for each group that were ±1.96. Furthermore, group comparisons would have been also performed by conducting six t-tests investigating group differences between Self and Friend symptoms for threat levels, support seeking from each of the five groups, perceived severity of symptoms, and number of symptoms. Gender would have also been included in group comparisons by providing information on differences between girls and boys in perceived severity, number of symptoms experienced, threat and trust levels, and support seeking.

9.2.5. Limitations and Rationale for Not Conducting Planned Analyses

It was not possible to execute the previously described data analysis plan due to a smaller than required sample size which resulted from the COVID-19 restrictions in place since the start of March 2020. As previously stated, in order to conduct the analysis and achieve the appropriate statistical power, at least 180 participants were required for each of the groups (self and friend symptoms), but due to the COVID-19 pandemic most planned data collection was cancelled. At the time of the first lockdown, six schools had been recruited. At this point, data collection had been completed in two of these schools and I was attempting to schedule dates with all other four schools. Participant information sheets for parents/carers as well as parental/carer consent forms in the form of a link had been sent out to schools and parents/carers via email. For all four schools, some parental/carer consents had been received and these were ready to start data collection. In all six schools, a total of 168 parental/carer consent forms had been obtained at the time of school closures in March 2020. However, once the national lockdown was announced, it was no longer possible to continue with data collection.

I discussed with my supervisors the possible options moving forward. The decision was taken to proceed with the existing data and to collect no more. This decision was taken based on several different considerations. First, schools closed immediately and, as such, my access to data as granted by the University Ethics Committee was not possible. Since both of my quantitative studies were already using an online platform, the *possibility* of a move to a fully online study was considered. However, with the focus of the study on mental health concerns, and with the ethical considerations discussed previously (see section 3.3 in Chapter 3), it was considered inappropriate for young people to complete a survey without the appropriate support afterwards that a researcher, or member of school staff, might be able to provide. Similarly, having pupils complete questionnaires in their home was potentially problematic as it was not possible to guarantee that they were able to complete the survey without other people present. Third, by the time a decision had to be made, it was still very unclear when schools would reopen, and as such waiting for schools to reopen to collect more data potentially meant a lengthy wait. At the same time, when schools eventually returned, they were expected to be (and indeed were) focused on catching up on lost education time with pupils, and time for collection of data and research was not a priority them. Additionally, when schools returned to face-to-face classes, the Ethics Committee was not approving face-to-face data collection to take place. Thus, making my return to data collection in schools impossible.

Furthermore, I discussed with my supervisors the possibility of designing a replacement study. For example, in the UK, young people 16 years-old and over do not need parental/carer consent to be involved in research, as such making it easier to collect data without needing to recruit via schools. However, aside from the issues described above, collecting data during this time would mean that, inevitably, the pandemic would have impacted upon the pupils' answers to the questionnaire. Reports (e.g., Burgess et al., 2020; Young Minds, 2021b) and scientific papers (e.g., Armour et al., 2021; Dewa et al., 2021; Silva Junior et al., 2020) published relating to young people's experiences of lockdown, highlight the negative impact that the pandemic has had on young people (e.g., increasing symptoms of depression, anxiety, and loneliness). These are all symptoms that relate to the present study and would inevitably influence the results of this thesis. Similarly, if a sample were recruited during or post-pandemic this might have impacted the results when it comes to seeking support from the different sources explored in this thesis. Building from the COVID-19 literature presented earlier, adolescents support seeking might have been different from pre-pandemic due to the higher level of mental health difficulties.

The possibility of collecting data with a different age demographic would mean that the intention to provide a comparison between studies might not be possible given existing evidence that mental illness (Sillars & Davis, 2018) and some of the key variables in this thesis, like threat (e.g., Mak et al., 2004; Sillars & Davis, 2018) and support seeking (e.g., Kelly et al., 2006; Lubman et al., 2017), are influenced by age. Finally, it was also important to consider that as a PhD student my resources and time were limited and I had to move forward with my thesis, even if that meant a reduced sample size. Thus, this study can be seen as a pilot study, and, therefore, a revised analytic plan had to be devised in order to best inform this.

9.2.6. Analyses Performed

The final total the sample size was of 76, which consisted of: 15 in the Self group, 24 in the Friend group, and 37 for the Hypothetical. As such, to test the hypotheses, descriptive analysis, correlations, and t-tests will be performed. This means that each of the individual pathways hypothesised earlier will be tested individually instead of as a whole, and the model will be broken down into more discrete analyses to account for the reduced sample size and to address the low statistical power of the current sample.

Descriptive statistics (i.e., medians, means and standard deviations) will be presented first. Descriptive statistics for overall trust levels, using the entire data set, will be included as these are independent of whether participants took part in the Self and Friend condition. Furthermore, descriptive statistics will also be presented by group (i.e., Self and Friend) for the following variables: threat levels, support seeking from each resource, number of symptoms, and perceived severity of symptoms.

To test the hypothesised relationships between variables (see Figure 9.1), correlations will be performed to provide initial evidence relating to these associations. These include results for the correlations between public- and self-stigma and perceived severity of symptoms. Correlations between perceived severity of symptoms and threat levels will also be conducted and will be part of the exploratory analysis since there is limited information about how these are related to each other. Furthermore, a correlation between number of symptoms and threat will be presented. Correlations between trust in each source of support and actual support seeking from said source of support will be explored by group (i.e., Self and Friend). Similarly, correlations between trust and threat levels by group will also be detailed.

Moderation will be examined by running a correlation between threat and support seeking for each of the five sources of support for when trust is either high or low. This will be achieved by creating a categorical variable based on the scores that are above and below the mean, where the values will be 0= Low trust (i.e., for values below the mean) and 1= Higher trust (i.e., for values above the mean). For all five hypothesised models, each significant correlation will be displayed in the model's path diagram depicted in Figure 9.1. Moreover, significant estimates from Study 2 will also be depicted in a path diagram allowing for a direct comparison where similar paths were tested in both studies.

Given the low sample size, seven Mann-Whitney U tests comparing participants in the Self symptoms group and the Friend symptoms group will be conducted. The dependent variables here will be threat levels and use of the five resources explored in this study. Finally, a comparison between Study 2's and Study 3's results will be presented. This will be done by presenting statistically significant pathways for each of the models for the two studies and commenting on differences and similarities.

9.4. Results

This section will present results based on the entire sample (i.e., using all three versions of the questionnaire) and analyses focused only on a subset of the sample (i.e., Self and Friend groups). When appropriate, at the beginning of each section there will be a presentation of the total sample size used.

Descriptive Statistics

Overall Sample Description.

For this section, the entire sample will be used and so the sample size is 76 (Self = 15; Friend = 24; Hypothetical = 37). Table 9.2 reports the medians, means and standard deviations for self- and public-stigma, and for trust levels. Self- and public-stigma were each scored using 1-5 scales and higher scores meant higher levels of stigma. For both types of stigma, the mean was below three. With the medians being 2.79 for self-stigma and 2.60 for public-stigma.

Trust in resources was also scored on a 1 to 5 scale with higher scores relating to higher levels of trust. It is possible to see from Table 9.2, the following sources of support were the three most trusted sources: professionals, friends, and parents. The corresponding medians were 3.67 for trust in professionals and friends, and 3.83 for trust in parents. The lowest mean score for trust was in relation to online support (median = 2.33), suggesting that young people in this study seemed to trust online support less than the other sources.

Table 9.2

Median, mean and standard deviation (SD) of self-stigma, public-stigma, and trust levels in each source of support (n = 76).

	Median	Mean	SD
Public-stigma	2.79	2.84	0.70
Self-stigma	2.60	2.71	1.26
Trust in friends	3.67	3.68	0.56
Trust in parents	3.83	3.66	0.90
Trust in teachers	3.67	3.13	0.93
Trust in professionals	3.33	3.70	0.81
Trust in online	2.33	2.28	0.85

By Group: Self and Friend's Symptoms.

For this section, given that the focus is on group comparisons, the total sample size is 39 (Self = 15; Friend = 24). Table 9.3 shows the descriptive analyses for Self and Friend groups for threat levels, support seeking from each resource, number of symptoms, and perceived severity of symptoms. Mean threat levels were higher in the Self group than in the Friend group. When considering support seeking, the three most trusted sources for the Self group were parents, friends, and teachers. While for the Friend group, the three most trusted sources were friends, parents, and professionals. Perceived severity of symptoms was slightly higher in the Friend group. Finally, the mean number of symptoms was slightly higher in the Self group.

Table 9.3

Median, mean and standard deviation (SD) for Self and Friend groups of threat levels, support seeking from each source of support, number of symptoms, and perceived severity of symptom.

	Self (n = 15)			Friend (n = 24)		
	Median	**Mean**	**SD**	**Median**	**Mean**	**SD**
Threat levels	3.75	3.57	0.79	3.33	3.30	0.72
Support seeking from friends	2.88	2.86	1.25	4.00	3.67	1.33
Support seeking from parents	3.13	3.07	1.37	3.25	2.92	1.25
Support seeking from teachers	2.00	2.23	1.20	2.00	2.13	0.98
Support seeking from professionals	1.50	1.88	1.17	2.00	2.26	1.37
Support seeking online	1.38	1.91	1.17	1.75	2.01	1.15
Number of symptoms	13.00	11.53	2.75	13.00	10.79	3.39
Perceived severity of symptoms	3.15	3.20	1.04	3.08	3.12	0.82

Correlations

Given the smaller than expected sample size, Spearman's correlations were conducted. Given the low statistical power, a decision to adjust the *p*-value was taken and a significance of .01 will be considered as the threshold for significance instead of .05. A complete table of correlations for each group is available in the appendices section (Appendices 23 and 24 for Self and Friend correlations respectively).

Self Group.

For the Self group, when looking at the correlation between trust levels and support seeking, there was only one significant correlation. As levels of trust in teachers increases, so too does support seeking from this source (r_s(14) = .77, p = .001). No other significant correlations were found when exploring participants' own symptoms.

Friend Group.

For young people who reported that a friend had experienced symptoms of mental illness in the past two months, a positive correlation between both forms of stigma was found (r_s(22) = .61, p = .003). Additionally, public-stigma was positively correlated with seeking support online (r_s(23) = .55, p = .007) but neither form of stigma was correlated with any other forms of support. Threat was positively correlated with self-stigma (but not public-stigma) (r_s(22) = .75, p < .001). Threat and support seeking were not significantly correlated for any of the five sources of support. On the other hand, negative significant correlations were found between threat and trust in parents (r_s(24) = -.59, p = .003) and trust in friends (r_s(24) = -.55, p = .006). Trust in friends was negatively correlated with online support (r_s(23) = -.56, p = .005). When it comes to number of symptoms, none of the expected correlations were significant. On the other hand, perceived severity of symptoms yielded significant positive correlations with self-stigma (r_s(22) = .67, p = .001) and threat (r_s(24) = .60, p = .002).

Moderation of Threat by Trust.

To test this, Spearman correlations between threat and support seeking from each of the resources were conducted for participants who scored either above or below the mean level of trust. It is important to note that these correlations were conducted using a small sample size for each of group (see note in Table 9.4). No significant correlations were found.

Table 9.4

Spearman correlation results for relationship between threat and support seeking when selecting high and low levels of trust on each source of support.

		Correlation between threat and support seeking from:				
Group	**Trust**	**Friends**	**Parents**	**Teachers**	**Professionals**	**Online**
Self	Low	-.21	-.63	.05	-.01	.79
	High	.32	.09	.00	.08	.14
Friend	Low	.03	.17	.43	.26	.36
	High	.61	.18	.41	.32	.48*

*$p < .05$

Note: Sample size for low and high trust levels for each source of support are as follows: Friends: High = 15, Low = 24; Parents: High = 20, Low = 19; Teachers: High = 18, Low = 21; Professionals: High = 20, Low = 19; and Online: High = 27, Low = 12.

Differences between groups and studies

Groups: Self and Friend’s Symptoms.

Table 9.5 reports the results of seven Mann-Whitney U tests performed to examine the differences in threat levels, support seeking, and perceived severity between both groups (Self and Friend’s symptoms). There were no significant differences.

Table 9.5

Mann-Whitney U tests results for group comparisons (Self = 15; Friend = 24) for threat levels, support seeking from each source of support, number of symptoms, and perceived severity of symptoms.

	Mann-Whitney U	*p*
Threat	134.50	.310
Support seeking from friends	102.00	.063
Support seeking from parents	151.00	.753
Support seeking from teachers	150.00	.895
Support seeking from professionals	135.00	.391
Support seeking online	151.00	.747
Number of symptoms	168.00	.697
Perceived severity of symptoms	164.50	.654

Gender Differences.

Gender differences were explored using the entire sample (i.e., 76 participants), but were not explored by Self and Friend. Independent *t*-tests (see Table 9.6) yielded significant results only for support seeking from Friends ($t(66) = -3.13$, $p = .003$). Girls had sought more support from friends ($M_{girls} = 3.98$, $SD_{girls} = .95$; $M_{boys} = 3.13$, $SD_{boys} = 1.20$) than boys. All the other *t*-tests were non-significant.

Table 9.6

Independent t-tests results for gender comparisons for each threat levels, trust in sources of support, support seeking from source of support, number of symptoms, and perceived severity of symptoms (n = 76).

	T	*p*
Threat	-0.08	.936
Trust in friends	-2.14	.036
Trust in parents	-0.16	.876
Trust in teachers	0.24	.809
Trust in professionals	0.78	.436
Trust in online	-0.22	.828
Support seeking from friends	-3.13	.003
Support seeking from parents	0.10	.920
Support seeking from teachers	0.17	.869
Support seeking from professionals	0.58	.567
Support seeking online	0.24	.809
Number of symptoms	1.55	.126
Perceived severity of symptoms	-0.58	.561

Differences between Study 2 and 3.

Finally, one of the aims of this study was to compare the responses to the hypothetical vignettes in Study 2 with actual experiences of support seeking reported here. Thus, it is relevant to comment on differences and similarities for each of the paths tested in both studies. Despite the fact that in the current study it was not possible to run the planned analyses, this section will aim to present significant paths based on the correlation results reported earlier and compared these with the significant paths from Study 2. When interpreting these results, it is important to consider that comparisons are based on different analyses and with an under-powered sample in Study 3.

There was no relationship that was significant in both studies. Each of the studies yield different significant pathways for each of the models tested. For the current study the only significant result for the Self group was a positive correlation between trust in teachers and support seeking from this same resource (i.e., higher levels of trust in teachers were linked with higher support seeking from teacher). On the other hand, Study 2 found support for the direct effect of both forms of stigma on support seeking (albeit associated with different forms of support). Still in the Self group, Study 2 also found partial support for the mediation hypothesis for seeking support from parents and professional (i.e., self-stigma was positively associated with threat, which in turn was positively associated with support seeking). Finally, Study 2 also found partial support for the moderation hypothesis, where higher levels of threat were associated with higher levels of support seeking online when levels of trust in online sources of support were also high.

For the Friend group, again, no significant results were present simultaneously in both studies. A significant positive relationship between self-stigma and threat was present in the current study, but had been absent in Study 2. Moreover, in the current study, support seeking online was the only source of support that was positively correlated with stigma, in this case public-stigma. For all other models, this relationship was present but only in Study 2. Study 2 also showed an association between self-stigma and seeking support from friends, while public-stigma was associated with seeking support from friends, parents, and professionals. Path diagrams depicting the significant relationships in both studies, for each form of support, can be found in the appendices (cf. Appendix 25).

9.5. Discussion

This study investigated young people's lived-experiences of seeking support when dealing with their own symptoms of mental illness or the disclosure of such symptoms from a friend. This study aimed to test a similar model to the one presented in Study 2 in order to identify differences and similarities between hypothetical and actual experiences of support seeking. At the same time, this study also extends Study 2 by building on findings relating to the impact of perceived severity of symptoms on support seeking that became evident in Study 1. This discussion will start by exploring the hypotheses specific to Study 3, then move on to the hypotheses that were re-tested from Study 2 to provide an in-depth analysis of the replication element of Study 3.

Novel Hypotheses of the Current Study

When it comes to the two new variables added to this study (i.e., perceived severity and number of symptoms experienced), only perceived severity of symptoms had significant effects. Higher perceived severity of symptoms in the Friend group was correlated with higher levels self-stigma. This shows partial support for the first hypothesis that states that both forms of stigma would be associated with perceived severity. This finding corroborates literature showing that higher levels of stigma are associated with higher symptom severity, but in a clinical setting (Barney et al., 2010; Boyd et al., 2014a; Livingston & Boyd, 2010). Adding to the existing knowledge, this study offers evidence about this relationship also being relevant in the context of a friend disclosing symptoms of mental illness. Up to this point, most research has explored the link between stigma and severity of symptoms where the individual was the one experiencing the symptoms. The current study, did not yield significant results for that relationship for the Self group, and only on the Friend. This might be due to low statistical power (as discussed later in this section) but it offers an avenue of research to explore experiences of adolescences when dealing with friend's symptoms and what could play a role in their support seeking decisions.

Partial support for the second hypothesis stating that perceived severity and threat would mediate the relationship between stigma and support seeking was found. This study showed that higher levels of perceived severity were correlated with higher threat levels. Further, higher levels of self-stigma were correlated with higher levels of threat. But, as before, only in the Friend group. Therefore, there was initial support for a mediation effect between self-stigma, perceived symptoms severity, and threat. This is in line with the literature, where each of these separate relationships have been shown to be positively associated (e.g., Boyd et al., 2014a). However, due to the already discussed limitations with sample size (see section 9.2.5.), these findings need to be considered carefully. There is a possibility that these results may be due to false positives, making them less reliable.

Comparison between Studies 2 and 3

In the current study, no support was found for the mediation hypothesis of threat on the relationship between self- and public-stigma and support seeking, despite the aforementioned mediation through perceived severity. It was expected that the results from Study 2 would be reproduced in the current study, however this is in line with research that suggests that intention (i.e., hypothetical scenarios) and action (i.e., lived-experiences) when seeking support, might not be aligned. For example, Mason et al. (2015) concluded that intentions to seek support from an adult were higher (59%) than young people's actual support seeking behaviours when dealing with depression. Thus, further exploration of the dynamic between support seeking intentions and lived-experiences, particularly, when dealing with a friend's disclosure is need. This would be relevant when trying to understand the mechanisms through which young people move from intention to action.

Strengths and Limitations

This study has several strengths and limitations. The introduction of perception of severity of one's own, or a friend's, symptoms of mental illness is novel. This builds upon the results from Study 1 which highlighted that young people would assess severity of symptoms prior to contacting a professional.

It is also a strength of the current study that young people's lived-experiences were captured and that these were contrasted to their intentions when exposed to hypothetical scenarios. Future research could look to explore this issue but with the same sample taking part in both studies so that direct statistical comparisons can be drawn. In this PhD, Study 2 and Study 3 used different samples and this may explain some of the different results between the hypothetical scenarios and actual support seeking behaviours. Finally, this study offers pilot data that can inform the design of future research aiming to use a similar methodology. For example, it provides a sampling framework that can be used to estimate the number of participants that should be recruited in order to obtain the minimum for the desired groups (i.e., 180 for Self and 180 for Friend). Taking the Self group as an example, if the estimated minimum sample size to run the planned analysis is 180, and it is known that for every 76 participants, 24 will report on their own symptoms, future research should recruit at least 570 participants across all conditions to obtain the desired and appropriate sample size.

On the other hand, this study also had some limitations. One of these was clearly the sample size. Underpowered studies have different consequences, and some of these were explored in some detailed in the previous chapter describing Study 2 (i.e., testing specific differences between groups) (e.g., Maxwell, 2004; van de Schoot & Miocevic, 2020). However, in Study 2, although the sample was slightly underpowered, there was still a large enough sample in each group to test most of the proposed pathways. In the present study this was not the case. In an attempt to counterbalance the effect of the low statistical power on this study, instead of attributing a *p*-value of .05 for significance as per Study 2, for this study the significance was set at .01 (for an extended discussion on the implication of setting *p*-values please see Greenland et al., 2016). As such, future research should aim to explore this model with an appropriate statistical power to assess if the relationships found in this study are maintained or not.

Additionally, the use of a convenience sample is a limitation. Though commonly used, convenience samples often may not yield results that can be generalised (e.g., Andrade, 2021; Jager et al., 2017). This is because convenience samples tend to not be representative of the target population. This can lead to issues around estimation biases and results not being a “true” reflection of the population, due to an over- or under-estimation of results for the target population (Jager et al., 2017). Future research should explore the use of a probability sample (e.g., Bornstein et al., 2013; Levy & Lemeshow, 2011) such as stratified sampling, in order to increase representativity of the target population and improve generalisation of the findings.

Finally, a pilot should have been conducted prior to data collection for the two new additional questions relating to symptom severity. As stated in Chapter 7 (section 7.1), piloting is a form of assessing validity and increasing reliability (Cohen, 2007; Hayashi Jr et al., 2019). By not piloting the additional two questions introduced in this study, the validity and reliability of the questionnaire could be questioned.

To conclude, this study provided initial evidence for the role of perceived severity of symptoms when young people seek support for their or for a friend’s symptoms.

Perceived severity of symptoms was relevant mostly when young people reported dealing with a friend’s disclosure of mental illness. This was revealed through the association between perceived severity and self-stigma, and the initial support for the mediation hypothesis in the Friend group. Given the already discussed limitations, these findings should be interpreted with caution. However, this study adds novelty by offering alternative avenues to explore how young people seek support, particularly when a friend discloses symptoms.

Chapter 10- General Discussion

The overarching aim of this thesis was to examine the differences in support seeking when young people deal with their own or with a friend's symptoms of mental illness. This was investigated in three studies, each drawing on the Transactional Theory of Coping (TTC: Lazarus & Folkman, 1984) and the Ecological Systems Theory (Bronfenbrenner, 1979). Study 1 applied the TTC and the Ecological Systems Theory to initially investigate the extent to which the coping process differed when young people were dealing with their own or with a friend's symptoms of poor mental health. The previous application of both theoretical approaches to the mental illness context has been well documented (e.g., Frydenberg, 2017; Lazarus & Folkman, 1984), and in Chapter 2 it was discussed at length how the coping process evolves in this context for young people (e.g., Fosco & Lydon-Staley, 2019; Murberg & Bru, 2005). While previous research has focused on the applicability of the TTC when young people are coping with their own symptoms of mental illness, research has not explored the role that the TTC has on how young people cope with a friend's disclosure of mental illness. Thus, Study 1's additional aim was to explore how young people cope with their own and with a friend's symptoms of mental illness through the both theoretical approaches. Through the use of a qualitative methodology, findings from Study 1 supported the applicability of the TTC as a framework when investigating how young people deal with their own symptoms, but also, when dealing with a friend's symptoms of mental illness. Findings from Study 1 also revealed differences in what young people considered relevant in each situation (i.e., self and friend's symptoms). Mainly, these differences referred to the impact of stigma and trust on strategies to get support from others. From an ecological perspective, Study 1 showed a preference for the microsystem (e.g., seeking support from friends and family) and relevance of the macrosystem (e.g., the role of stigma) as a result of the interaction between systems and actors.

As Lazarus and Folkman (1984) proposed, the TTC encompasses two different components: cognitive appraisals and coping strategies. Drawing on Study 1, Study 2 aimed to apply the TTC to the context of support seeking by young people when dealing with their own or with a friend’s symptoms of mental illness. Study 2 investigated the role of threat appraisals as mediators in the relationship between stigma (self- and public-stigma) and support seeking. Furthermore, Study 2 aimed to explore the role of trust as a moderator in the relationship between threat appraisals and support seeking. Unlike Study 1, Study 2 employed a quantitative methodology. This study further contributed to the understanding of the suitability of the TTC when dealing with mental illness, while at the same time revealing more nuanced differences in the coping process relating to one’s own and to a friend’s symptoms.

Both Studies 1 and 2 were focused on hypothetical scenarios of symptoms of mental illness. In contrast, Study 3 was designed to understand the applicability of the hypothesised model in Study 2 to a sample of young people with lived-experience of mental illness. Study 3 was also designed to extract more nuanced and detailed findings on the meso and macrosystems as a result of the comparison between hypothetical and lived-experienced scenario. Furthermore, Study 3 built on Study 1 by including perceived severity of symptoms as a mediator between stigma and threat. Despite Study 3’s limitations, partial support was found for the applicability of the TTC when exploring young people’s actual support seeking behaviours. This study offered initial support for the relevance of stigma, threat, and perceived severity of symptoms among young people with lived experience of mental illness, but mainly for when dealing with a friend’s symptoms of mental illness (as demonstrated by the support for the mediation hypothesis).

This chapter will now discuss the key findings of the entire thesis, how these fit with previous research, and what the implications for research and practice are. Following this, the strengths and limitations will be acknowledged and suggestions for future research will be given. Finally, personal reflections about the PhD process as a whole will be presented.

10.1. Key Findings

10.1.1. Stigma, Trust, and Threat Influenced Support Seeking for Self and for a Friend's Symptoms of Mental Illness Differently

Through the use of different methodologies, this thesis provided evidence of the effects of stigma, trust, and threat on support seeking. The present thesis also provided evidence for the different role that each of these elements play when young people deal with their own or with a friend's symptoms of mental illness. Amongst other findings, Study 1 showed the importance of the macrosystem in the form of stigma on young people's support seeking behaviours, mainly for their own mental health problems. From this initial qualitative study there was a perception that high levels of stigma hindered young people's willingness to seek support due to fear of embarrassment or judgment from others. The interviews revealed that participants seemed to put more emphasis on the effects of public-stigma when dealing with symptoms of mental illness when compared to self-stigma. This was therefore further explored in Study 2.

Both self- and public-stigma were included in the model tested in Study 2 and hypothetical self-symptoms were associated with self-stigma, while public-stigma seems to play a more significant role when seeking support for a friend who disclosed symptoms. These results are reflective of Schnyder et al.'s (2017) systematic review which concluded that young people are less likely to seek support for their symptoms if they perceived higher levels of public-stigma. Further research also showed that higher levels of self-stigma reduces adolescents' support seeking behaviours (e.g., Heary et al., 2017; Talebi et al., 2016).

On the other hand, when a friend was the one experiencing symptoms, public-stigma played the most prominent role in support seeking behaviour; this was the case for both Studies 2 and 3. Linking these findings to the TTC, Lazarus and Folkman (1984) highlighted that one of the important components of the coping process is the personal relevance of the stressful event that the individual is exposed to. Thus, young people dealing with a friend's symptoms of mental illness might not consider these to be as relevant to their own wellbeing as would be the case when they are personally experiencing the same symptoms. During the primary appraisal process, a young person will assess the level of personal relevance of that situation (i.e., how this affects their wellbeing) (for a more detailed explanation see Chapter 2 section 2.3.1). Personal relevance is also linked with endorsing and internalising societal beliefs about mental illness (i.e., higher personal relevance is likely to mean a higher probability of reporting mental illness self-stigma). Thus, if a young person does not attribute personal relevance to a friend's disclosure of symptoms of mental illness during the primary appraisal process, then they may be more likely to report higher levels of public-stigma.

Study 1 showed that negative appraisals such as threat negatively affected support seeking when young people were dealing with either their own or a friend's mental health problems. As such, Study 2 explored the role of threat appraisals on support seeking in further detail and found that threat acted as a mediator between stigma and support seeking for young people dealing with their own hypothetical symptoms. Higher levels of self-stigma were associated with higher levels of threat, which were then associated with a higher support seeking. This is partially in line with previous research that stigma increases levels of threat (Link et al., 2004; Major & O'Brien, 2005; Yang et al., 2007). However, the current research contradicts literature suggesting that higher threat is linked to lower levels of support seeking (Eisenberg et al., 2009; Mojtabai, 2010; Vogel & Wester, 2003). Other research has also concluded that higher threat levels are associated with lower support seeking from professionals (Camara et al., 2017; Rickwood et al., 2015). This might be explained by a variety of factors, such as self- and public-stigma, or trust in sources of support (as explored in the published paper in Chapter 8). Furthermore, these results offer initial understanding for the possible role of threat being more relevant when young people are dealing with their own rather than when dealing with a friend's symptoms.

The mediation effect of threat on the relationship between stigma and support seeking was not present when a friend was experiencing symptoms, in either of the quantitative studies. This study suggests threat appraisals might *not* play as important a role in the coping process in regards to support seeking for a friend's symptoms of mental illness when compared to one's own symptoms. This is further supported by the observation in Study 2 that there were higher levels of threat reported in the Self condition than in the Friend condition. This could be a result of other variables playing a more significant role in support seeking for a friend's disclosure. For example, previous positive experiences of coping (Rickwood et al., 2015; Sears, 2020), mental health literacy (Kelly & Jorm, 2006; Lubman et al., 2017; Singh et al., 2019), or even other types of primary appraisals (e.g., challenge, harm/loss) could play a more relevant role than threat in the Friend condition. Later on in this chapter, suggestions for future research on relation to this issue will be presented.

Finally, moderation effects of trust were supported only in Study 2, Moderation effects were present in the context of a young person's own symptoms (i.e., trust moderated the relationship between threat and support seeking online). Overall, the results from this thesis show an association between support seeking, threat, and trust when young people respond to their own hypothetical symptoms of mental illness (i.e., Study 2). However, these associations were not present when responding to a friend's disclosures or their own symptoms in a lived-experienced sample responding (i.e., Study 3).

Given the limited body of research on support seeking by young people responding to a friend's disclosure of symptoms, it is difficult to attribute a reason for these findings. However, some possible avenues of research and explanation can be hypothesised. For example, the TTC suggests that one of the components in primary appraisals is the *relevance* of the experience for the individual (Lazarus, 1991a, 1999). This means that people will feel that more is at stake if they identify personal relevance in the experience and it may be the case that this is harder when a vignette methodology is used. Vignettes are a valuable tool to present controlled situations to participants (e.g., Leighton, 2010; Rickwood & Thomas, 2012), but might not provide the full context required for participants to gauge the full spectrum of what the real-life implications of experiencing symptoms might be (Hughes & Huby, 2004).

Mental health literacy is likely to play a significant role in the context of support seeking, especially when exploring the distinction between a young person's own symptoms and those of a friend. Recognition of symptoms of mental illness has been shown to influence young people's ability to support a friend (Kelly & Jorm, 2006; Lubman et al., 2017; Singh et al., 2019). So, if a young person does not recognise that a friend is in distress, they are unlikely to see any need to seek support for their friend.

Furthermore, it is important to consider whether teaching young people about symptoms, and educating them to be able to identify distress in others, is enough to allow for identification of mental illness and lead to personal relevance to be established. The problem might not be in the recognition of symptoms, but in the fact that without direct experience of mental illness a young people may never fully understand what a friend is experiencing.

At the same time, it is important to consider that the use of vignettes in Study 2 might have influenced young people's responses since there was no clear declaration of mental illness, and rather a description of relevant symptoms associated with either depression or anxiety. Leighton (2010) highlighted the need, when exploring the impact of mental health literacy on support seeking, to be focused more on the young person's ability to recognise symptoms than to correctly name a disorder. In this regard, the vignettes in this study might have been enough to lead young people to recognise symptoms of depression and anxiety, if their levels of mental health literacy were high. Finally, the role of mental health literacy could take up a form of a moderator where higher levels of literacy, influence the relationship between threat and support seeking from different sources when a friend discloses symptoms of mental illness. Thus, further research exploring this should be conducted.

Finally, both compassion and self-compassion could help explain these results given the role it has been shown to play in support seeking (Allen et al., 2010). López et al. (2018) concluded that compassion and self-compassion are two different constructs that do not correlate with each other. Additionally, in their research with adults, they concluded that individuals were more likely to show compassion to others than themselves (i.e., higher compassion levels and lower self-compassion). Thus, threat being a mediator for young people's own hypothetical symptoms and not for the friend's scenario, could show that young people are more likely to be compassionate towards others and not perceive friend's symptoms to be as threatening as they would their own symptoms.

10.1.2. Relevance of Different Sources of Support when Dealing with Symptoms of Mental Illness

This research concludes that different sources of support are influenced by different variables when young people are responding to symptoms of mental illness. Study 1 revealed that young people would ask for support if experiencing symptoms themselves from informal sources such as friends and parents. Meaning that, overall, the microsystem was shown to be the preferred system for young people when seeking support for symptoms of mental illness. When it came to a friend's symptoms, young people would refrain from discussions about these with other friends, but would still engage with their parents when seeking support. Study 2 further revealed that self-stigma was negatively associated with seeking support from parents when dealing with their own symptoms. Generally, this shows that young people, irrespective of who was experience the symptoms, tend to seek support from sources and active players in their microsystem.

Overall, existing research concludes that adolescents show a preference for informal sources of support such as parents/carers and friends (e.g., Leavey et al., 2011; Sears, 2020), and less support seeking from parents/carers who endorsed stereotypes and prejudice about mental illness (Yap et al., 2011b) which can result in young people fearing the consequences they will face in the family environment. For example, young people might fear that they will lose their independence if they anticipate the need for family members to provide constant support (Sheehan et al., 2017).

Study 2 provided valuable insight into the influence of threat on support seeking from parents and professionals. Threat could be integrated within the mesosystem as this is a result of the interaction between micro and exosystem. Higher levels of threat can affect young people's identity and self-esteem (Major & O'Brien, 2005). This has been linked with fears of being excluded from the community if symptoms are disclosed (Rubin et al., 2015). However, in this thesis, it is encouraging to see that young people are willing to seek help from professionals and parents if their appraisals of threat are high. This may indicate that work by practitioners, communities, and mental health organisations to encourage adolescents to disclose symptoms they experience, and to reduce stigma about disclosure, might be working and producing some positive change. In any case, further research is needed in order to better understand this effect and to investigate its reproducibility. On this note, contrary to what was expected, Study 3 did not show similar results regarding young people who reported experiencing symptoms themselves. Further research, with adequate statistical power, is needed to investigate this relationship in samples of young people with lived experience of mental illness.

One result from the microsystem that is worth noting is that when it comes to teachers and school staff, in Study 1 young people revealed that they were reluctant to seek support from this source for either their own or for a friend's mental illness. Similarly, in both quantitative studies, no significant paths were identified when considering teachers as a source of support. Research has also reported underuse of teachers as a source of support (Daniel et al., 2010). This is despite their value in providing support and of schools being a place for opportunities of developments of intervention and prevention programs (Berger et al., 2013; Vostanis et al., 2022). The Curriculum for Excellence in Scotland (CfE; Scottish Government [SG], 2019, p. 4) states that "it is important that children and young people feel that they can share their anxieties with an appropriate individual who has the skills, rapport, responsibility and the time to listen and to help, or can identify appropriate sources of support". In this context, it may be of concern that young people appear reluctant to approach school staff with their concerns.

The underuse of school staff could be due to a lack of confidence in teachers respecting their privacy and providing the necessary support for the situation. Considering the Ecological Systems Theory (Bronfenbrenner, 1979), the mesosystem, through the lack of trust in this source of support, is playing a role in young people selection of teachers and school staff as helpful sources. Yet, recent research indicates that teachers are one of the most sought-after sources of support when young people are seeking support from a mental health professional (Sadler et al., 2018). Thus, depending on the perception of need for support from professional services, young people might refrain from seeking support from teachers until they see a need for mental health services to be involved. Further to this, the results might be speaking for a greater need for investments in rapport building interventions and programmes in schools that aim to improve young people's levels of confidence and comfort when disclosing to teachers and school staff.

In Study 2, public-stigma was found to be negatively associated with support seeking from friends, parents, and professionals when dealing with a friend's disclosure of symptoms of mental illness. This means that both the meso and macrosystem seem to be having an impact on support seeking from the microsystem. Pattyn et al. (2014) have also shown that young people are less willing to seek support from parents/carers and friends when levels of public-stigma are high. The results from this thesis corroborate existing literature relating to professional support, where higher levels of public-stigma reduce support seeking from professionals (e.g., Aromaa et al., 2011; Schomerus et al., 2009; Yap et al., 2013). However, this thesis provides the additional insight that these effects are present when seeking support for a friend who discloses symptoms. As such, it is possible to conclude that public-stigma also has an important and possibly similar impact in young people seeking support for a friend's symptoms of mental illness.

Finally, when it comes to online sources of support, this thesis delivers mixed results. The relationship between public-stigma and support seeking was only present when seeking support online for a friend's symptoms of mental illness in Study 3. The use of online sources of support has been shown to be related to lower levels of stigma (Horgan & Sweeney, 2010; Mar et al., 2014; Neslund et al., 2016; Wetterlin et al., 2014) which corroborates the results reported in Study 3. Young people have reported that sharing feelings online without the fear of judgment and embarrassment from others is an important reason to go online for support (Liverpool et al., 2020).

Study 2 results revealed that trust could play a significant role as a moderator in the relationship between threat and seeking support using a digital form, again showing the role of the mesosystem when selecting a source of support. It is also true that young people in Study 1 reported high levels of scepticism when seeking support online, for both of the scenarios explored in this thesis (i.e., for their own, or for a friend's, symptoms). These results may support one another, and provide further insight into the variables that influence young people's support seeking online. Specifically, trustworthiness of sources has been identified as one relevant characteristic when consulting information online (e.g., Callahan & Inckle, 2012). Additionally, people also report that anonymity and confidentiality are advantages when using digital platforms (e.g., Callahan & Inckle, 2012; Pretorius et al., 2019). The internet may therefore be an alternative to other more conventional forms of support (e.g., mental health professionals in a face-to-face setting) (Frost et al., 2016), given that young people taking part in the research reported in this thesis have reported fears of confidentiality, and of trust being broken as a result of sharing of one's symptoms. This raises a question as to why participants fear confidentiality and anonymity might be broken if using more 'conventional' forms of seeking support. Future research should explore young people's conceptualisation and understanding of these concepts (i.e., confidentiality and anonymity) in the context of mental illness support in order to be able to address some of these concerns that participants in this study have highlighted.

10.1.3. Perceived Severity of Symptoms as an Influence when Seeking Support for Mental Illness

The importance and relevance of the perceived severity of symptoms was one of the main themes extracted from the interviews conducted in Study 1. When seeking support for symptoms of mental illness, young people reported that they would only seek help from a professional if they considered the symptoms to be 'severe'. This sparked a need to clarify what they meant by 'severe' and it was clear that they equated levels of threat with severity of symptoms by giving examples such as self-harming behaviours or suicidal thoughts. On the one hand, some research conducted by Leighton (2010) concluded that adolescents when presented with vignettes depicting depression symptoms characterise it as having low perceived severity. On the other hand, both the findings from this thesis and Leighton (2010) research contradicted most research suggesting that young people reporting higher severity of symptoms of mental illness tend to, overall, seek less help (Velasco et al., 2020). Thus, a further exploration of this relationship was needed.

Study 3 pursued this issue by considering the role of perceived severity of symptoms as a mediator in the relationship between stigma and threat. Only when a friend reported symptoms was there a positive correlation between perceived severity of symptoms and threat, and perceived severity of symptoms and self-stigma. That is, there was only support for the possible existence of mediation in that context. Existing literature partially corroborates these findings. Lazarus (1991a) concluded that the level of severity of symptoms is linked with the intensity attributed to the stressor. Thus, suggesting that, when a friend is experiencing symptoms of mental illness, young people may attribute higher levels of threat appraisals when they perceive severity of symptoms as also high.

The initial finding in Study 1 about a possible connection between perceived severity of symptoms and support seeking from professionals was not demonstrated in Study 3. This could be explained in part by some of the limitations described in Chapter 9 (section 9.5) pertaining to low sample size, but also there is a possibility that this association is more complex than initially hypothesised in this study. This thesis only considered young people support seeking behaviours initiated by the young person themselves and asked about sources of support as the end point and not as a vehicle for further support. Thus, it might be helpful to further explore and clarify in future studies the intent of the support being sought beyond the emotion- and problem-focused dichotomy initially proposed in this thesis.

10.2. Implications

10.2.1. Theory

The present thesis used the TTC and the Ecological Systems Theory as a framework to better understand support seeking in young people responding to symptoms of mental illness. All three studies applied key concepts and components of theorical approaches and demonstrates its applicability within the context of mental illness. Through examining the use of cognitive appraisals and coping strategies, as initially suggested by Lazarus and Folkman (1984), each study in this thesis offered evidence for the relevance of primary and secondary appraisals in the coping process. Additionally, using Bronfenbrenner’s (1979) framework of individual development based on system interaction, each study offered evidence on the relevance of a variety of systems when young people seek support for mental illness.

Within this thesis, the use of threat appraisals as a key component of the relationship between stigma and support seeking was only possible given the clear theoretical focus of the interviews conducted in Study 1. After the analysis of the qualitative data, it became evident that young people appraised hypothetical mental health problems (their own or of a friend's) as threating, through manifestation of stigma and fears of isolation. This provides insight into the utility of this theory when exploring young people's experiences while coping with the specific stressful events investigated here. This study was able to offer high-level support for the importance of appraisals and also provided evidence for how appraisals can be manifested by young people.

Of particular interest is the contribution of this thesis when it comes to demonstrating trust as a relevant secondary appraisal. Although the TTC does not explicitly refer to trust in its original model, this thesis provided evidence of the relevance in this particular context. It has been shown that exploring trust while evaluating the available sources and impact on wellbeing (i.e., secondary appraisal) has a significant impact when young people are seeking support for their own or for a friend's symptoms of mental illness.

Additionally, the role of perceived severity of symptoms became evident when exploring the data from Study 1. This offers further evidence of the applicability of the TTC in this context and of what other elements influence the coping process. The mediating role of threat on the relationship between stigma (i.e., both public- and self-stigma) and support seeking addressed in this thesis is only one way explore the impact of this element in the coping process.

10.2.2. Research

The research implications from this thesis concern methodological innovations and resources that can support future research. In the context of this thesis, an interview-schedule for the first study was developed and piloted. This provides researchers with a theory-based, semi-structured interview that can be further developed to include other elements of the coping process.

Four vignettes were developed and piloted for use in Study 2. These vignettes can be used by other researchers to explore other topics related to mental illness. For example, these could be used when exploring mental health literacy among young people. For both quantitative studies, a measure of trust in each of the five sources of social support was developed and piloted. Exploratory factor analysis supported a single factor structure for the measure and it demonstrated good internal reliability for each of the five sources of support. Thus, this scale is available to be used by other researchers in their own research projects. Future work is still needed to assess its psychometric characteristics. Assessing for reliability and validity of this measure in future research with young people would be relevant to assert the suitability of this measure when testing trust in sources of support.

All of these elements are freely available in the OSF. As covered in Chapter 3 (section 3.1), freely available resources not only improve transparency, reproducibility, and reduce questionable research practices (Munafò et al., 2017), these also allow for research to have a higher impact by reaching a wider audience. When discussing open science practices, it is worth stating that the pre-registration of Study 1 is also a contribution to research. This is because this study was qualitative and, as stated in Chapter 3 (section 3.1), at the time of the registration, there was a reduced focus on pre-registration of qualitative studies (Kern & Gleditsch, 2017; Piñeiro & Rosenblatt, 2016). OSF now includes a template for pre-registering qualitative studies and Study 1 can be used as an example of how to do a qualitative pre-registration.

10.2.3. Practice

This thesis provides evidence of the need to improve young people's awareness about when it is appropriate to seek support for their own or for a friend's symptoms of mental illness. This was indicated in Study 1 when young people reported that they would be likely to only seek support from a professional if they were experiencing symptoms that they considered to be severe. Participants from Study 1 also expressed that mental illness symptoms typical of depression and anxiety were not considered severe enough to merit seeking support from a health professional. This may indicate that there is a lost opportunity when it comes to prevention and early intervention in relation to these difficulties among young people. This finding is in line with existing policies put in place by the Scottish Government (2017c) as a result of their Mental Health Strategy (i.e., Action 8), to address and identify mental illness at the earliest point possible in order to offer young people the best chance to overcome their psychological distress and prevent escalation of the symptoms. Actions around offering complementary training to school staff have been proposed in order to build a multi-agency pathway that can act in multiple fronts to aid young people to overcome their psychological distress.

Furthermore, there may be a need to improve young people's mental health literacy. Study 1's findings revealed that young people equate severity with self-harming behaviours or suicidal thoughts. This may stem from a lack of understanding of how different symptoms evolve and affect young people's performance and overall development. School-based programmes that are focused on improving mental health literacy levels in young people have been shown to reduce stigma (e.g., Chisholm et al., 2015; Pinto-Foltz et al., 2011) and increase levels of support seeking (e.g., Burns & Rapee, 2006; Kelly et al., 2006). Thus, investments in mental health literacy provision that explore the definitions and symptoms related to the most common disorders in adolescence (as reported in Chapter 1 section 1.2.2) could be beneficial for young people in order to improve support seeking. These provisions could include discussions around when to seek support and the appropriateness of early intervention/ prevention as well as what sources are available, rather than looking for professional support only as a last resort. Additionally, the current findings and research implications are in line with efforts in the policy sector to improve health-related literacy. The current health literacy strategy, being implemented by the Scottish Government (2017b), focuses on improving the knowledge, understanding, and skills to maintain good health of the Scottish population.

The present thesis highlighted the underuse of teachers as a source of support. There might be a need for schools to further invest in bringing home the idea in young people's mind of the value of teachers when dealing with mental illness. This is in line with the need to keep the child and young person at the fore front of policies to ensure their wellbeing and positive development throughout their school years. Policies such as Getting it right for every child (GIRFEC; SG, 2017a), National Improvement Framework (NIF; SG, 2022), and the CfE (SG, 2019), have highlighted the importance to include wellbeing and mental health as actions to improve the existing provisions. All these policies have proposed steps in their agendas for staff in schools to adhere to in order to improve students' wellbeing and mental health.

The results from this thesis show that there is a need to invest more broadly in interventions that explore rapport building between students and school staff. Developing targeted interventions that frame school staff in general as avenues for help is only addressing part of the problem (i.e., availability of resources and information about where and from whom to seek support). Young people have demonstrated difficulties to seek support due to lack of trust and lack of confidence that confidentiality will not be broken. So, addressing these issues first through targeted interventions focusing on developing feelings of confidence and comfort in young people, might help to tackle the underuse of school staff and teachers as a source of support as a whole.

Additionally, the Mental Health Strategy (SG, 2017c), being implemented since 2017, aims to change service delivery to young people and children, as well as highlights key action points for schools to be implemented by 2027. Of main interest, supporting some of the results from this thesis, are action points 1 and 2, where the strategy states the following: Action 1: “Review Personal and Social Education (PSE), the role of pastoral guidance in local authority schools, and services for counselling for children and young people”, and Action 2: “Roll out improved mental health training for those who support young people in educational settings”. These highlight the need to invest in training and changes directed at initial points of contact of students in order to build confidence of staff to act appropriately in case a student discloses psychological distress. Furthermore, given the findings on the impact of trust on online support seeking, there is an opportunity to improve the digital content and training in this area might also be helpful so that young people have a better understanding about what is available to them. These changes could be made by working with the young people in order to create safe and trustworthy digital spaces that can aid their support seeking behaviours.

When it comes to the third sector, there is also valuable contributions from this thesis, especially when it comes to stigma. In Scotland, different anti-stigma campaigns have been taken forward aiming to reduce stigma in young people (e.g., *See Me*). This thesis provides further evidence for the need for further investment in these types of campaigns given the prominent impact of stigma (both self and public) on support seeking. However, this thesis also adds to the already existing knowledge by concluding that young people responding to a friend disclosure, are also influenced by stigma but also the singular impact of trust. A focus on responding to a friend’s disclosure when exploring possible aims of these interventions and campaigns could be beneficial so that specific elements hindering support seeking, such as fear of breaking a friend’s trust when disclosing to others and its consequences, can be addressed early on.

10.3. Strengths and Limitations

Strengths

This thesis explores a novel topic by aiming to provide evidence on how young people cope with their own or with a friend’s symptoms of mental illness. As previously stated in this thesis, this is an under researched area that has the potential to provide valuable evidence into support seeking behaviours and preferences. By exploring the role of different components of the TTC in both scenarios, this thesis provides a good starting point to further explore different elements that could be of value, particularly where young people are exposed to disclosures of mental illness from their friend(s). Furthermore, the investigation of all five sources of support in both conditions offers the ability to better understand what factors are actual at play when young people are coping with symptoms of mental illness. This thesis provided evidence on what variables are relevant to each source of support, and opened the discussion to explore which others might be more relevant when exploring the ones that did not yield the expected results and are under explored (i.e., teachers).

As it is evident from the previous section on implications for practice, this research has direct links with existing Scottish Government policies around mental health. Thus, the practical implication of these findings is a strength in itself. Throughout each of the three studies, open science practices were integrated. This approach was implemented to improve the transparency of the work and to increase how robust and reliable it is. These practices involved pre-registering Study 1 and using the Open Science Framework as a repository for data and materials used in two out of the three studies.

Furthermore, the use of both quantitative and qualitative methods allowed for a more nuanced understanding of which elements play a role in young people's support seeking and how these might interact with each other. Conducting a qualitative interview-based study prior to designing the quantitative part of the thesis allowed for a focused approached when designing the statistical model hypothesised in both Study 2 and 3. The use of qualitative approach prior to design of quantitative research, highlighted relevant variables such as stigma, trust, and threat as main elements when seeking support. Thus, Study 2 and 3 covered those elements in a way that allowed to assess how they influence each other, which was not possible during the interviews.

Limitations

One of the main limitations of this thesis regards the sample size in the final study. Study 3 was statistically underpowered and this impacted on the possibility of conducting the most appropriate, planned, analyses. Associated with this was the impact on the ability to directly compare effects with Study 2. Similarly, Study 2 was also under powered to detect specific moderation effects, raising the Type 2 error rate associated with those. Building on what was already discussed in Chapter 9 (section 9.5), the COVID-19 pandemic had a significant impact in this thesis. The majority of the impact was felt in the sample size of Study 3 where the analytic strategy had to be substantially restructured and replanned in a way that was most appropriate to the data gathered. The impact of the COVID-19 pandemic on a personal level is discussed in section 10.5 below.

Finally, both the use of self-report and cross-sectional data are also considered limitations. Reliance on self-report has been criticised due to the potential for inaccurate data with issues around interpretation of questions, social desirability (Gordon, 1987; Kuncel, & Borneman, 2007), and it increases common method variance (Podsakoff et al., 2003). This may limit the validity of the findings. However, when it comes to the coping literature, evidence suggests that rather than replacing the use of self-report with another method, one should aim to use a more ecologically sensitive approach that aids in the understanding of stress and the coping process (Lazarus, 2000). Thus, the focus should be on in-depth methods that are contextual and offer a longitudinal in design (Dewe & Trenberth, 2004). Research shows that despite some limitations, self-report can be appropriate in specific settings being that high levels of congruency between self-reported data and objective assessments have been found (Crockett et al., 1989). Thus, an option would be to use different sources of data in parallel to self-report (e.g., collecting data with the sources of support explored in this study).

Furthermore, the use of cross-sectional data is also a limitation given the lack of temporal element when analysing the statistical model proposed (Carlson & Morrison, 2009; Woodside, 2011). In addition to this, by using cross-sectional data it is not possible to make a causal inference about the associations described in this thesis (Wang & Cheng, 2020). Thus, for the current study it is not possible to infer if higher levels of stigma caused specific support seeking behaviours from the participants. This limits any conclusions coming from the findings.

10.4. Future Directions

Coping is a cyclical process (Lazarus & Folkman, 1984) and so longitudinal data will be an important future step when seeking to untangle causal relationships between variables. Through the use of longitudinal approaches, it is a possible to begin to identify the psychological mechanisms which would extend the present work. Building on what is proposed by this thesis, the utility of any particular source of support should also be explored. This thesis focused on the choice of source of support, while a factor that has also been proven to play a role in support seeking is young people’s previous positive support seeking experiences. Research has shown that young people that have a previous positive experience with a particular source of support are more likely to ask for support again if in need (Sears, 2020). A previous positive experience possibly means that young people could attribute an appraisal of challenge (i.e., positive outcome and something could be gained from it) if experiencing symptoms of mental illness again. Thus, including previous experience as a variable when exploring support seeking, and testing if appraisals of challenge are made, could be helpful to further comprehend the adapted coping model proposed in this thesis. Similarly, as suggested by several authors, the coping process is not only cyclical but highly complex (e.g., Cheng et al., 2014; Lazarus & Folkman, 1984). As such, research in this topic should explore the role of flexibility of coping strategies in order to assess how young people adapt as a result of previous experiences of coping.

Furthermore, when it comes to the TTC, future research should explore different forms of coping. Research could explore how the proposed model from Study 2 and 3 performs when exploring other forms of coping such as avoidance, self-blame, or distraction (e.g., Compas et al., 2001). Both overarching coping strategies explored in this thesis do not allow for further insight into what exactly young people do when seeking support. As described in Chapter 2 (section 2.3.2), there are a range of actions that could be included in both problem- and emotion-focused coping. For example, Turner et al. (2006) showed that greater levels of threat might be linked with seeking information to alleviate anxiety symptoms. Research has also concluded that avoidance coping is linked with higher levels of stress (Eisenbarth, 2012).

Additionally, it will be important to explore how different variables interact with support seeking according to the proposed model in this thesis. For example, self-related constructs such as self-efficacy, self-esteem, or self-compassion could play a role in the associations tested in this thesis. Feelings of control and self-efficacy have been shown to be linked with seeking health information (Lee et al., 2008). Similarly, higher levels of self-esteem have been shown to be associated with coping strategies such as planning or problem solving (Griva & Anagnostopoulos, 2010; Heffer & Willoughby, 2017). Self-compassion has also been shown to play a role in support seeking behaviours. Research concluded that self-compassion could be seen as a coping strategy in itself and it is associated with positive adjustment and wellbeing (Allen & Leary, 2010). Neff et al. (2007) also reported that self-compassion is a strategy used by individuals that regularly use active coping. At the same time, self-compassion has been shown to moderate the relationship between public- and self-stigma associated with help-seeking (Heath et al., 2018). Thus, exploring the link of self-compassion within the context of support seeking for the model tested in this thesis and exploring how this self-related construct influences support seeking after a friend's disclosure could be beneficial for a better understanding of young people's support seeking behaviours.

Exploring different roles and forms of threat could be considered by also further exploring the place of perceived severity of symptoms in the coping process. Thus, exploring specific coping strategies other than emotion-and problem-focused might yield detailed results that could later inform the development of prevention and intervention strategies that are targeted at young people's needs. For example, if young people report using avoidance as a coping strategy, efforts could be moved towards increasing young people's awareness about the importance of talking about their psychological distress.

Mental health literary has been mentioned previously as a possible explanation for some of the results in this thesis. It would have been interesting to explore the role of mental health literacy from the start by including it within both studies. This was not done because the possible role of literacy only became evident upon analysis of the results. Thus, future research should explore the key role that mental health literacy could have as a potential appraisal. Research has shown that mental health literacy influences young people's perceptions of the availability of support, as well as their ability to seek help (e.g., Gulliver et al., 2010; Velasco et al., 2020). As such, exploring the role that mental health literacy would play as an appraisal (in a similar way as stigma has been included in this thesis) could offer further insights into future directions of intentions and actions needed to better support young people support seeking.

In addition to what has been addressed in this thesis, exploring the impact of a friend's disclosure on a young person's mental health and wellbeing entails further exploration. Research in the field of bereavement by suicide has explored the consequences for young people's mental health and wellbeing when a close friend dies by suicide (Andriessen et al., 2015; Pitman et al., 2014). Hence, exploring how a disclosure of mental illness affects (or not) a young person, and how they cope with that situation, could lead to interventions providing more targeted support for young people who are dealing with a friend's disclosure of mental illness. Given that most of the existing research explores these topics considering only the young person's symptoms, there is still a lot that is unknown when it comes to the coping process when responding to a friend's disclosure. Building from this thesis, exploring the role of different primary appraisals (e.g., challenge) and alternative coping strategies will provide further guidance when developing mental health programmes and strategies to be implemented at schools (like the ones mentioned earlier in this chapter).

Finally, and given the clear focus of this research on how young people respond to symptoms of mental illness, future research should explore the involvement of young people as active participants throughout the research process, and not just as participants. It is worth mentioning that in this thesis participatory research was not implemented due to limitations in funding and time. However, given the exploratory nature of Study 1 for example, the inclusion and active participation of young people in this research would have been helpful to get a better understanding of how the relationship between variables might work when considering disclosures from a friend. In general, by including young people as active collaborators alongside the researchers, there is the opportunity to develop a better understanding of the mechanisms through which different relationships are established. Including young people in research allows for advances in knowledge and practice to be achieved by focusing directly on young people's needs and experiences (Belone et al., 2016).

10.5. Personal Reflections

This section will include a detailed reflection about some of the challenges I encountered as a researcher, how I overcame some of them, and what I have learned during the PhD. It includes personal reflection aiming to explore my positionality as a researcher in relation to the entire PhD process.

In Chapter 3 (section 3.2.5), I cited a study by Stubb et al. (2012) where they suggested that students differ in the meaning they attribute to their PhD work: either as a process or a product. I interpret my work more as a process rather than a product. This is due to all the professional development that occurred alongside the research part of the PhD. Throughout my journey, I was involved in different activities such as teaching, writing a blog post, presenting at webinars, organising/participating in statistical workshops, and working as a research assistant in the Education department. These, and many other activities, allowed me to develop important skills that I will be using throughout my professional career. For example, I was involved in organising a two-day workshop on Multilevel modelling with three of my departmental PhD colleagues. This stemmed from our need to learn about this complex statistical analysis and as a way to enhance our teamwork skills. We were successful in planning, organising, and delivering this workshop. We collaboratively applied for funding for the workshop and were successful in winning two different sources of funding. Attendees told us that they thought the workshop was very well planned and organised. I believe this was a very valuable experience as it helped me develop my organisational skills and team work.

Stubb et al. (2012) also provided some evidence about the impact of PhD work on each student's wellbeing. I believe that given the topic of this thesis, some reflection about the impact that this PhD had on my own wellbeing and mental health is of relevance. During the PhD process, there were moments of high levels of stress and anxiety. While characteristic of many professions, these needed to be addressed given the pressure a PhD student is under while conducting research and attending to all other elements of their professional development. From my experience it became evident that, in order to succeed, a PhD student needs to be able to manage their anxiety and stress levels extremely well or they will hinder their productivity and, ultimately, not achieve their goals.

I had difficulties managing my stress and anxiety throughout my PhD. These difficulties became more evident when the COVID-19 pandemic started, and my initial PhD plans had to be altered (mainly, as reported in Chapter 9 section 9.2.5). My high levels of anxiety and stress during this period had a clear impact on productivity and concentration, especially during the final stage of the PhD. This is not surprising as it has been shown in the literature that when stress and anxiety levels of doctoral students are high, they can affect their motivation and ability to perform (Litalien et al., 2015). While writing up, stress and anxiety were caused by both the pressure of time and the need to balance work and thesis writing. This was coupled with the inherent pressures and anxieties caused by the COVID-19 pandemic (e.g., Armour et al., 2021; Silva Junior et al., 2020). The timely completion of my PhD was affected due to these difficulties.

However, I believe that the support from the supervision team and my personal relationships helped me overcome some of the more stressful times during the PhD. These came into play especially when thinking back to the different stages of research and the intrinsic ‘imposter syndrome’ (i.e., doubting my own abilities and feeling like a fraud) that many PhD students can relate to (e.g., Lau, 2019; Sverdlik et al., 2020). Leaning on other PhD colleagues, and my supervisory team, by sharing my worries and doubts helped me to overcome my own self-doubt in my abilities to complete each task, and ultimately, a PhD.

In Chapter 3 (section 3.2.5), I also provided a brief context about my personal circumstances prior to starting my PhD journey. These are relevant when I start to reflect on how the research process developed, and the impact that my personal experiences had on the different phases of each of the studies in this thesis. I was interested in studying this topic given my previous experience as an intern in a public school. As one of the psychologists in that school, I accompanied several adolescents that expressed difficulties with symptoms of mental illness. Their experiences, and how they reported some of their responses to the symptoms and the challenges they faced when seeking support, inspired me to think about what sources of support were available and how the process of support seeking unfolded. The other main element of this thesis (i.e., responding to a friend’s disclosure of symptoms), came later. Once I started to study this topic in more detail, I realised that we as communities (and even me during my internship) encourage young people to disclose their symptoms. However, we do not explore the consequences of this disclosure, especially when disclosure is to another young person. Thus, my motivation to explore the topic in this thesis stemmed from my knowledge of the topic from both a practice and academic (i.e., higher education in Psychology) point of view.

One of the elements described in Chapter 3 (section 3.2.5) about the positionality of the researcher refers to the insider versus outsider stance of the researcher in regards to the research and participants (Berger, 2015; Mason-Bish, 2019). My personal knowledge and background were specific to the Portuguese context, and so a lot of my initial preparation (particularly regarding Study 1) was focused on my understanding of the concepts and support available for young people within that context. This gave me, on some level, an outsider position, although my knowledge about some of the mental health concepts explored was universal (i.e., insider) (Creswell, 2007; Creswell & Poth, 2017). Throughout the design and planning of this first study, I researched the Scottish context to find out more about existing mental health policies and prevalence of mental illness in young people within the UK. In this regard, I believe the qualitative nature of Study 1 was a good initial study to give me the ability to better understand recruitment, data collection, and the context in which I was working in. If I was to repeat the entire research in this thesis today, I believe I would be more confident from the start given that my knowledge about the Scottish context has improved throughout my PhD journey.

10.6. Concluding Remarks

To conclude, this thesis provided evidence on differences of young people's support seeking behaviours when dealing their own, or with a friend's, poor mental health and symptoms of mental illness. This thesis showed that different variables influence young people's support seeking and responses to poor mental health and mental illness depending on whether they themselves experience symptomatology or whether this is disclosed to them by a friend. The TTC provided an appropriate theoretical framework within which the investigation of the different components of coping and appraisals could be explored. This framework was flexible enough to also accommodate other important variables (trust, stigma) that emerged during the study.

Furthermore, it was possible to integrate both stigma and trust within the TTC. The current thesis offers evidence on the relevance of looking at support seeking through the lens of the TTC and the possibilities of this theory when it comes to providing alternatives to improve support for young people dealing with symptoms of mental illness. Though exploring other components of the coping process in more depth would be helpful moving forward (e.g., more extensive list of coping strategies, the role of other primary appraisals), this thesis makes a significant contribution by providing evidence of the mechanisms through which coping is influence by both public- and self-stigma. This thesis provided evidence as to the negative effect that both these types of stigma can play in the coping process. Adding to this, the current thesis offers evidence of buffering role of trust in sources of support in the coping process.

The novelty of this research revolves around the results relating to when young people cope with a disclosure of a friend's symptoms of mental illness. Further research is needed for this group though the present thesis provides initial evidence on coping differences and potential key relevant factors during the coping process. Testing other statistical models by including other possible relevant variables after a friend's disclosure, could lead to more adequate support to young people being offered, and a better understanding of what young people consider when seeking support following a friend's disclosure.

Overall, this thesis contributes to the knowledge about young people's support seeking behaviours and which elements influence the coping process. At the same time, this thesis also provides insight into the difference between hypothetical scenarios and lived-experiences. This distinction allows us to attribute some meaning to the differences between intentions to seek support and actual support seeking. Mainly, stigma, trust, and threat were shown to be three key elements for young people seeking support for both their own and for a friend's symptoms.

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Appendices

Appendix 1

Study 1 - Participant Information Sheet for parents

Participant Information Sheet for Parents

Title of the study: How young people understand and deal with mental health problems.

Introduction

My name is Sofia Pimenta I am a PhD student at the University of Strathclyde. My supervisor is Dr Simon Hunter in the School of Psychological Sciences and Health.

What is the purpose of this investigation?

The purpose of this investigation is to examine how young people understand and deal with mental health problems. I am interested in understanding what young people consider to be a mental health problem. I am also interested in the decisions and thoughts behind dealing with a mental health problem.

Do your child have to take part?

Participation in this research is completely voluntary and your child does not have to take part. Even if you give consent, your child can still decide that they do not want to participate. If you decide that you would like to allow your child to take part, they will be asked to take part in an interview with Sofia. If you prefer that they do not take part, then you have the right to withhold your consent without telling us why. Finally, even if your child takes part, you (and they) will still have the right to withdraw their data if you change your mind at a later date.

What will your child do in the project?

If you decide that you would like your child to take part, they will be invited to participate in an interview with the researcher. During the interview they will be asked (i) what their understanding of a mental health problem is, and (ii) how they would deal with a mental health problem, either their own or a friend's. This interview will be audio recorded and it is expected to last no more than 40 minutes.

Why have your child been invited to take part?

Your child has been invited to take part because they are an English-speaking young person between the ages of 11 and 14.

What are the potential risks to your child taking part?

As described above, the questions will relate to how your child understands mental health and to what they would do to deal with symptoms of mental health problems (either personal symptoms or those of a friend). Although no young person will be asked anything about their own actual experiences, it is possible that sensitive, personal information may be revealed to the researcher. In the event of participants revealing any information that can be consider harmful to themselves or others, the researcher will stop the interview and notify parents/guardians about this to safeguard the participant as well as providing information about where to go for help and support. Relevant mental health service providers may be alerted to assure the safety of the child if there is a need to do so. Finally, if any young person becomes upset for any reason during the interview it will be stopped and school staff will be alerted to this.

What happens to the information in the project?

All data collected will be stored so that it is pseudo-anonymous (i.e., it will not be possible to identify any individual participant from the audio recordings alone). Only the named researchers on this form will have access to the data. All the consent forms will be archived so that only the named researchers will have access to them. All of the consent forms will be destroyed after 5 years. Audio recordings will be kept on password protected computers before being destroyed. The interviews will also be transcribed and the audio recordings will be deleted shortly after.

The transcripts will be included in Sofia's PhD submission, and may be kept in a public repository for others to access – no young person will be identifiable in any of these transcripts.

The University of Strathclyde is registered with the Information Commissioner's Office who implements the Data Protection Act 2018. All personal data on participants will be processed in accordance with the provisions of the Data Protection Act 2018.

Thank you for reading this information – please ask any questions if you are unsure about what is written here.
Please also read our Privacy Notice for Research Participants (attached).

What happens next?
Please complete the attached consent form to indicate whether you DO or DO NOT wish your child to participate, and return the consent form to the school. Subsequently, your child will be given details of the study and asked if they wish to take part. If they do want to take part, then they will also be asked to sign a consent form before the interview takes place.

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This investigation was granted ethical approval by the School of Psychological Sciences and Health Ethics Committee at the University of Strathclyde.
If you have any questions/concerns, during or after the investigation, or wish to talk to an independent person to ask any questions or further information, please contact:

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Appendix 2

Study 1 - Participant Information Sheet for participants

Participant Information Sheet

Title of the study: How young people understand and deal with mental health problems.

Introduction
My name is Sofia Pimenta I am a PhD student at the University of Strathclyde. My supervisor is Dr. Simon Hunter in the School of Psychological Sciences and Health.

What is the purpose of this investigation?
The purpose of this investigation is to examine how young people understand and deal with mental health problems. I am interested in understanding what young people consider to be a mental health problem. I am also interested in the decisions and thoughts behind dealing with a mental health problem.

Do you have to take part?
Participation in this research is completely voluntary and you do not have to take part. If you decide to take part, you will be asked to take part in an interview with Sofia. If you prefer not to take part, then you have the right to do so without telling us why. Finally, even if you take part, you will still have the right to withdraw the data if you change your mind at a later date.

What will you do in the project?
If you decide to take part, you will be asked to participate in an interview with the researcher. During the interview you will be asked (i) what your understanding of mental health problems is, and (ii) how you would deal with a mental health problem, either your own or a friend's. This interview will be audio recorded and is expected to last no more than 40 minutes.

Why have you been invited to take part?
You have been invited to take part because you are an English-speaking young person between the ages of 11 and 14.

What are the potential risks to you in taking part?
As described above, the questions will relate to how you understand mental health and what you would do to deal with symptoms of mental health problems (either personal symptoms or those of a friend). You will not be asked about any actual experiences that you may have had with mental health issues. However, if you reveal any personal information that can be considered harmful, Sofia will inform your parents/guardians and/or other relevant mental health service providers about this to safeguard you. If you are upset for any reason during the interview it will be stopped and school staff will be alerted to this. If no personal information is revealed by you then what you say in the interview will remain completely confidential (i.e., no information that identifies you will be made public).

What happens to the information in the project?
All data collected will be stored so that it is pseudo-anonymous (i.e., it will not be possible to identify any individual participant from the audio recordings alone). Only the named researchers on this form will have access to the data. All the consent forms will be archived so that only the named researchers will have access to them. All of the consent forms will be destroyed after 5 years. Audio recordings will be kept on password protected computers before being destroyed. The interviews will also be transcribed, and the audio recordings will be deleted shortly after that. The transcripts will be included in Sofia's PhD submission, and may be kept in a public repository for others to access – no young person will be identifiable in any of these transcripts.

The University of Strathclyde is registered with the Information Commissioner's Office who implements the Data Protection Act 2018. All personal data on participants will be processed in accordance with the provisions of the Data Protection Act 2018.

Thank you for reading this information – please ask any questions if you are unsure about what is written here.
Please also read our Privacy Notice for Research Participants (attached).

What happens next?
If you are happy to continue with the research, please sign the consent form attached to this information sheet.

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Appendix 3

Study 1 – Consent form for parents

Parental Consent Form

Title of Study: How young people understand and deal with mental health problems.

- I confirm that I have read and understood the information sheet for the above project and the researcher has answered any queries to my satisfaction.

- I confirm that I have read and understood the Privacy Notice for Participants in Research Projects and understand how my personal information will be used and what will happen to it (i.e., how it will be stored and for how long).

- I understand that my child's participation is voluntary and that I am free to withdraw my child, and my child can withdraw from the project at any time, without having to give a reason and without any consequences.

- I understand that I can request the withdrawal from the study of some personal information and that whenever possible researchers will comply with my request. This includes the following personal data:
    - audio recordings of interviews that identify my child.

- I understand that any information recorded in the investigation will remain confidential and no information that identifies me or my child will be made publicly available.

- I understand that the interview will be confidential and that I will not have access to my child's interview. However, if my child discloses anything of concern I will be notified by the research team. If necessary, relevant mental health service providers will be alerted to assure the safety of my child.

- I understand that the interview will be audio-recorded.

- I consent to my child being a participant in the project.

Name of
Child:____
(please print)

Print Name(Parent/Guardian):	Hereby agree to my child taking part in the above project.
Signature of Parent/Guardian:	Date

Appendix 4

Study 1 – Consent form for participants

Participant Consent Form

Title of the study: How young people understand and deal with mental health problems*.*

- I confirm that I have read and understood the information sheet for this project and the researcher has answered any questions I have.
- I confirm that I have read and understood the Privacy Notice for Participants in Research Projects and understand how my personal information will be used and what will happen to it (i.e., how it will be stored and for how long).
- I understand that my participation is voluntary and that I am free to withdraw from the project at any time, without having to give a reason and without any consequences.
- I understand that because the study is pseudo-anonymous, I can request the withdrawal from the study of some personal information and that whenever possible researchers will comply with my request. This includes the following personal data:
    - ➢ audio recordings of interviews that identify me.
- I understand that anything I report in the interview will remain confidential and no information that identifies me will be made publicly available.
- I understand that if I disclose anything considered harmful, the researcher will report that to my parent/guardian and/or, if necessary, to relevant mental health service providers to assure my safety.
- I understand that the interview will be audio-recorded.
- I consent to being a participant in this research.

(PRINT NAME)	Hereby agree to take part in the above project
Signature of Participant:	Date

Appendix 5

Study 1 – Debrief for participants

Debrief Form

Title of the study: How young people understand and deal with mental health problems.

<u>Thank you for taking the time to participate in this study.</u> Our research focuses on how young people understand and deal with mental health problems. Young people experiencing mental health problems are sometimes unsure about where they can get the best help. For example, some young people may not know who to turn to or what to search for online – this can be difficult for adults too! We hope to improve the quality of support being given to young people experiencing mental health problems by understanding more clearly what young people do to get help.

If you would like support, information or help for yourself, or if you are worried about a friend, you have some resources available to help you. If possible, you should always talk to a trusted adult such as:

- Parent/Guardian,
- Carer,
- Teacher,
- School counsellor,
- GP, if you feel that you are experiencing some serious symptoms.

There are some really good online resources that could help you after talking to a trusted adult. For example:

- *Young Minds*: an organisation focused on providing good mental health care to young people and working to empower young people. https://youngminds.org.uk/
- *Childline*: that offers advice on a variety of subjects. They can be contacted all day any day, for free, on *0800 1111*. If you phone, it won't even show up on your bill. You can also see their resources online, and chat to a counsellor online too. https://www.childline.org.uk/

If you have any questions about the study or your data, then please feel free to contact the researchers. Or if you wish to talk to an independent person to ask any questions or further information, you can also contact the Chair of the Ethics Committee, Dr Diane Dixon (details below).

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Appendix 6

Study 2 - Opt-in Participant Information Sheet for parents

Participant Information Sheet for Parents

Title of the study: Help and support-seeking among young people responding to symptoms of poor mental health.

Introduction

My name is Sofia Pimenta I am a PhD student at the University of Strathclyde. My supervisors are Dr Simon Hunter and Dr Susan Rasmussen in the School of Psychological Sciences and Health.

What is the purpose of this investigation?

The purpose of this investigation is to examine how trust and stigma can influence young people's help-seeking behaviours when exposed to symptoms of a mental health problem.

Does your child have to take part?

Participation in this research is completely voluntary and your child does not have to take part if you do not wish them to do so (or if they themselves do not wish to). If you decide that your child can take part, they will be asked to complete an anonymous survey. If you prefer that your child do not take part, then you have the right to do so without telling us why. Also, if you decide that your child can take part, they can still decide if they want to take part in the research or not. However, once data has been collected it will not be possible to remove it from the study as the data will be anonymous.

What will your child do in the project?

If you decide that your child may take part, they will be asked to complete a survey which will include questions on: (i) their beliefs and opinions about mental health problems, (ii) the degree to which they trust people who they could turn to for help, and (iii) what they think they would do in a hypothetical situation where either they or a friend experience symptoms of depression or anxiety. This will take place in their school and should take no longer than 40 minutes to complete.

Why has your child been invited to take part?

Your child has been invited to take part because they are a young person in S1, S2 or S3.

What are the potential risks to your child if they take part?

As described above, the questions will relate to how your child might respond when experiencing symptoms of poor mental health, or when seeing a friend experience such symptoms. Your child will **not** be asked about any actual experiences that they may have had with mental health problems. If you would like support, information or help for your child or other young person you know, you have some resources available to help you. If possible, you should always encourage them to talk to a trusted adult (e.g., Parent/Guardian, Teacher, School counsellor, GP). There are also helpful resources online with relevant information about how to help young people dealing with mental health issues. For example, *Young Minds*, which is an organization focused on providing good mental health care to young people (https://youngminds.org.uk/). And *Childline,* this is an organization that can be contacted all day any day for free by phone on *0800 1111* (https://www.childline.org.uk/). Nevertheless, after participating your child will be given an information sheet with information about where to get support and help if they ever experience any of the discussed symptoms.

What happens to the information in the project?
All data collected will be anonymous and it will not be possible to identify any individual participant from this data.
Only the named researchers on this form will have access to the data. All data will be kept on password protected computers for 5 years after the study is completed before being destroyed.

The University of Strathclyde is registered with the Information Commissioner's Office who implements the Data Protection Act 2018. All personal data on participants will be processed in accordance with the provisions of the Data Protection Act 2018.

Thank you for reading this information – please ask any questions if you are unsure about what is written here.

What happens next?
If you are happy that your child take part in this research, please sign the consent form you have been given.

Researcher contact details:
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If you have any questions/concerns, during or after the investigation, or wish to talk to an independent person to ask any questions or further information, please contact:

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Appendix 7

Study 2 - Participant Information Sheet for participants

Participant Information Sheet

Title of the study: Help and support-seeking among young people responding to symptoms of poor mental health.

Introduction

My name is Sofia Pimenta I am a PhD student at the University of Strathclyde. My supervisors are Dr Simon Hunter and Dr Susan Rasmussen in the School of Psychological Sciences and Health.

What is the purpose of this investigation?

The purpose of this investigation is to examine how trust and stigma can influence young people's help-seeking behaviours when exposed to symptoms of a mental health problem.

Do you have to take part?

Participation in this research is completely voluntary and you do not have to take part if you do not wish to do so. If you decide to take part, you will be asked to complete an anonymous survey. If you prefer not to take part, then you have the right to do so without telling us why. However, once data has been collected it will not be possible to remove it from the study as the data will be anonymous.

What will you do in the project?

If you decide to take part, you will be asked to complete a survey which will include questions on: (i) your beliefs and opinions about mental health problems, (ii) the degree to which you trust people who you could turn to for help, and (iii) what you think you would do in a hypothetical situation where you or a friend experience symptoms of depression or anxiety. This will take place in your school and should take no longer than 40 minutes to complete.

Why have you been invited to take part?

You have been invited to take part because you are a young person in S1, S2 or S3.

What are the potential risks to you in taking part?

As described above, the questions will relate to how you might respond when experiencing symptoms of poor mental health, or when seeing a friend experience such symptoms. You will **not** be asked about any actual experiences that you may have had with mental health problems. If you would like support, information or help for yourself or a friend, you have some resources available to help you. If possible, you should always talk to a trusted adult (e.g., Parent/Guardian, Teacher, School counsellor, GP). There are also helpful resources online for young people. For example, *Young Minds*, which is an organization focused on providing good mental health care to young people (https://youngminds.org.uk/). And *Childline,* this is an organization that can be contacted all day any day for free by phone on *0800 1111* (https://www.childline.org.uk/). Still, after taking part you will get an information sheet giving advice about where to get support and help if you ever experience any of the discussed symptoms.

What happens to the information in the project?

All data collected will be anonymous and it will not be possible to identify any individual participant from this data. Only the named researchers on this form will have access to the data.

All data will be kept on password protected computers for 5 years after the study is completed before being destroyed.

The University of Strathclyde is registered with the Information Commissioner's Office who implements the Data Protection Act 2018. All personal data on participants will be processed in accordance with the provisions of the Data Protection Act 2018.

Thank you for reading this information – please ask any questions if you are unsure about what is written here.

What happens next?
If you are happy to be involved in this study, please log-in to the survey as instructed by Sofia. You will be asked to give your consent online and can then complete the survey.

LINK SURVEY: tinyurl.com/studymentalhealth

Researcher contact details:
Sofia Milheiro Pimenta
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Appendix 8

Study 2 – Opt-in consent form for parents

Parental Consent Form

Title of the study: Help and support-seeking among young people responding to symptoms of poor mental health.

- I confirm that I have read and understood the Parental Information Sheet for the above project and the researcher has answered any queries to my satisfaction.

- I confirm that I have read and understood the Privacy Notice for Participants in Research Projects and understand how my personal information will be used and what will happen to it (i.e., how it will be stored and for how long).

- I understand that my child's participation is voluntary and that my child is free to withdraw from the project at any time, up to the point of completion, without having to give a reason and without any consequences.

- I understand that anonymised data (i.e., data that do not identify my child) cannot be withdrawn once they have been included in the study.

- I understand that any information recorded in the research will remain confidential and no information that identifies me or my child will be made publicly available.

- I consent to my child being a participant in the project.

(PRINT NAME)	
Signature of Parent:	Date

Appendix 9

Study 2 – Consent form for participants

Participant Consent Form

Title of the study: Help and support-seeking among young people responding to symptoms of poor mental health.

- I confirm that I have read and understood the Participant Information Sheet for the above project and the researcher has answered any questions I have.

- I confirm that I have read and understood the Privacy Notice for Participants in Research Projects and understand how my personal information will be used and what will happen to it (i.e., how it will be stored and for how long).

- I understand that taking part is voluntary (that is, I do not have to take part if I don't want to) and that I am free to withdraw at any time, up to the point of completion, without having to give a reason and without any consequences.

- I understand that anonymised data (i.e., data that do not identify me personally) cannot be withdrawn once they have been included in the study.

- I understand that any information recorded in the research will remain confidential and no information that identifies me or my child will be made publicly available.

- I consent to taking part in this project.

(PRINT NAME)	
Signature of Participant:	Date

[For the online version, participants were asked to give consent by answering Yes or No to the previous statements.]

Appendix 10

Study 2 – Debrief for participants

Debrief Form

Title of the study: Help and support-seeking among young people responding to symptoms of poor mental health.

Thank you for taking part in this study. Our research focuses on how trust and our ideas about mental health might influence how young people get help when they or a friend experience symptoms of poor mental health. Young people experiencing mental health problems are sometimes unsure about where they can get the best help. For example, some young people may not know who to turn to or what to search for online – this can be difficult for adults too! We hope to improve the quality of support given to young people experiencing mental health problems by more clearly understanding what young people do to get help for themselves and their friends.

If you would like support, information, or help for yourself, or if you are worried about a friend, you have some resources available to help you. If possible, you should always talk to a trusted adult such as:

- Parent/Guardian,
- Carer,
- Teacher,
- School counsellor,
- GP, if you feel that you are experiencing some serious symptoms.

There are also some really helpful online resources for young people too, such as:

- *Young Minds*: an organisation focused on providing good mental health care to young people and working to empower young people. https://youngminds.org.uk/
- *Childline*: that offers advice on a variety of subjects. They can be contacted all day any day, for free, on*0800 1111*. If you phone, it won't even show up on your bill. You can also see their resources online, and chat to a counsellor online too. https://www.childline.org.uk/

If you have any questions about the study or your data, then please feel free to contact the researchers:

Sofia Milheiro Pimenta
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Appendix 11

Study 2 – Opt-out Participant Information Sheet for parents

Participant Information Sheet for Parents

Title of the study: Help and support-seeking among young people responding to symptoms of poor mental health.

Introduction

My name is Sofia Pimenta I am a PhD student at the University of Strathclyde. My supervisor are Dr Simon Hunter and Dr Susan Rasmussen in the School of Psychological Sciences and Health.

What is the purpose of this investigation?

The purpose of this investigation is to examine how trust and stigma can influence young people's help-seeking behaviours when exposed to symptoms of a mental health problem.

Does your child have to take part?

Participation in this research is completely voluntary and your child does not have to take part if you do not wish them to do so (or if they themselves do not wish to). If you decide that your child can take part, they will be asked to complete an anonymous survey. If you prefer that your child do not take part, then you have the right to do so without telling us why. Also, if you decide that your child can take part, they can still decide if they want to take part in the research or not. However, once data has been collected it will not be possible to remove it from the study as the data will be anonymous.

What will your child do in the project?

If you decide that your child may take part, they will be asked to complete a survey which will include questions on: (i) their beliefs and opinions about mental health problems, (ii) the degree to which they trust people who they could turn to for help, and (iii) what they think they would do in a hypothetical situation where either they or a friend experience symptoms of depression or anxiety. This will take place in their school and should take no longer than 40 minutes to complete.

Why has your child been invited to take part?

Your child has been invited to take part because they are a young person in S1, S2, or S3.

What are the potential risks to your child if they take part?

As described above, the questions will relate to how your child might respond when experiencing symptoms of poor mental health, or when seeing a friend experience such symptoms. Your child will **not** be asked about any actual experiences that they may have had with mental health problems. If you would like support, information or help for your child or other young person you know, you have some resources available to help you. If possible, you should always encourage them to talk to a trusted adult (e.g., Parent/Guardian, Teacher, School counsellor, GP). There are also helpful resources online with relevant information about how to help young people dealing with mental health issues. For example, *Young Minds*, which is an organization focused on providing good mental health care to young people (https://youngminds.org.uk/). And *Childline,* this is an organization that can be contacted all day any day for free by phone on *0800 1111* (https://www.childline.org.uk/). Nevertheless, after participating your child will be given an information sheet with information about where to get support and help if they ever experience any of the discussed symptoms.

What happens to the information in the project?
All data collected will be anonymous and it will not be possible to identify any individual participant from this data. Only the named researchers on this form will have access to the data. All data will be kept on password protected computers for 5 years after the study is completed before being destroyed.

The University of Strathclyde is registered with the Information Commissioner's Office who implements the Data Protection Act 2018. All personal data on participants will be processed in accordance with the provisions of the Data Protection Act 2018.

Thank you for reading this information – please ask any questions if you are unsure about what is written here.

What happens next?
If you **DO NOT** want your child to take part in this research, please sign the consent form you have given and return it, within one week, to the school. In case of absence of a response from you, we will assume that you are happy that your child is involved in the project.

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This investigation was granted ethical approval by the School of Psychological Sciences and Health Ethics Committee at the University of Strathclyde.

If you have any questions/concerns, during or after the investigation, or wish to talk to an independent person to ask any questions or further information, please contact:

Convenor of Ethics Committee
University of Strathclyde
Graham Hills Building
50 George Street
Glasgow G1 1QE
Phone: 0141 548 2575
Email: hass-psh-ethics@strath.ac.uk

Appendix 12

Study 2 – Opt-out consent form for parents

Parental Opt-out form

Title of the study: Help and support-seeking among young people responding to symptoms of poor mental health.

- I confirm that I have read and understood the Parental Information Sheet for the above project and the researcher has answered any queries to my satisfaction.

- I **DO NOT CONSENT** to my child being a participant in the project.

(PRINT NAME)	
Signature of Participant:	Date:

Please remember that this form should only be returned to your child's school

if you do NOT wish them to take part in this research project.

Appendix 13

Study 3 - Participant Information Sheet for parents

Participant Information Sheet for Parents

Title of the study: "I feel upset": How young people cope with mental health problems.

Introduction

My name is Sofia Pimenta and I am a PhD student at the University of Strathclyde. My supervisors are Dr Simon Hunter and Dr Susan Rasmussen in the School of Psychological Sciences and Health.

What is the purpose of this investigation?

The purpose of this investigation is to examine how trust and stigma can influence young people's help-seeking behaviours when experiencing symptoms of mental health problems or when a friend reports experiencing symptoms of mental health problems. We are interested in beliefs and attitudes towards mental health problems from both young people who have experience mental health problems and young people who have not experience it. Your child's school has agreed to let pupils take part in this research if they and their parents/Guardians consent.

Does your child have to take part?

Participation in this research is completely voluntary and your child does not have to take part if you do not wish them to do so (or if they themselves do not wish to). If you decide that your child can take part, they will be asked to complete an anonymous online survey. If you prefer that your child do not take part, then you have the right to do so without telling us why. Also, if you decide that your child can take part, they can still decide if they want to take part in the research or not. However, once your child has completed the questionnaire, you won't be able to remove it from the study as the data will be anonymous. Finally, if you have any concerns that your child is not capable of providing their own consent to take part, then please feel free to decline their participation.

What will your child do in the project?

If you decide that your child may take part, they will be asked to complete a survey which will include questions asking about:

(i) their feelings about people who experience mental health difficulties;

(ii) how much they feel they can trust different people in their social network;

(iii) whether they have experienced any common symptoms of mental health difficulty, and/or whether a friend has discussed their own mental health difficulties with them;

(iv) depending on their reported experienced, they will then be asked to report what they did if they have experienced any symptoms <u>or</u> what they did if a friend discussed symptoms with them <u>or</u> what they would do in a hypothetical situation where they or a friend experienced symptoms of depression or anxiety.

This will take place in their school and should take no longer than 40 minutes to complete. They will be invited to take part using their own mobile device if they own one and take it to school (e.g., smartphone) or a device (a tablet) which can be supplied to them by the researcher.

Why has your child been invited to take part?

Your child has been invited to take part because they are a young person in S1, S2 or S3.

What are the potential risks to your child if they take part?

As described above, the questions will relate to symptoms typical of mental health problems that young people may have experienced such as sadness, difficulty concentrating, and sleep disturbance. The most challenging items are "*Thought about ending your life*" and "*Self-harming (i.e. hurting yourself on purpose)*". These items have been included in this survey because they are relevant when studying depression and anxiety in young people and because they are key priority areas for the Scottish Government. All young people will be made aware of the contents of the survey and can refuse to take part if they so wish. If you want your child to take part, they will be given a support sheet with information about where to get support if they ever experience any of the symptoms presented in the survey *[in the online version, parents will have the option to download the debrief sheet shown to participants].* In there they will have access to information like who they should talk to, online resources as well as a direct point of contact in their school to talk to someone if they feel that they need to.

What happens to the information in the project?
All data collected will be anonymous and this means that the researchers cannot find out who has said what from this data. This can help your child to be as honest as possible, but it is important to realise that no one will seek out your children to discuss anything they say in the survey – this is why the Debrief sheet gives clear avenues for support should they feel they need it. Any datasets with school or education authority identifiers will be kept on password protected computers and a dataset with no identifiers will be made available to other researchers. Parental consent forms will be kept for 5 years after the study is completed before being destroyed.

The University of Strathclyde is registered with the Information Commissioner's Office who implements the Data Protection Act 2018. All personal data on participants will be processed in accordance with the provisions of the Data Protection Act 2018. You can read the University of Strathclyde's full privacy notice for participants in research by visiting this website https://tinyurl.com/UoS-GDPR. Alternatively, if you prefer a paper copy to be sent to you please contact the investigators (contact details below).

Thank you for reading this information – please ask any questions using the contact details below if you are unsure about what is written here or about what young people are being asked to do in during this study.

What happens next?
If you are happy that your child take part in this research, please sign the consent form you have been given and return it to your son/daughter's school *[highlighted section to be replaced in the online version by "Please complete the consent details below"]*.

Researcher contact details:
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Appendix 14

Study 3 - Participant Information Sheet for participants

Participant Information Sheet

Title of the study: "I feel upset": How young people cope with mental health problems.

Introduction

My name is Sofia Pimenta and I am a PhD student at the University of Strathclyde. My supervisors are Dr Simon Hunter and Dr Susan Rasmussen in the School of Psychological Sciences and Health.

What is this study about?

We want to find out more about what young people do when they have feelings and experiences that are sometimes experienced by people with mental health problems. We also hope to learn what young people do if a friend tells them they have had feelings that can be experienced by people with mental health problems. Finally, we want to find out if (i) how much trust you have in other people makes any difference to what you do in these situations and (ii) your beliefs about mental health problems make any difference to what you do in these situations. If you have never experienced any of these situations, we are still interested in what your beliefs and behaviours about it are. We will ask you to answer questions about how you would deal with this and what your thoughts might be if something like this ever happened to you.

Do you have to take part in this study?

Taking part in this study is completely voluntary (meaning you can choose whether to take part or not) and you do not have to do it if you do not wish to do so. If you decide to take part, you will be asked to complete an anonymous online survey. If you prefer not to take part, then you have the right to do so without telling us why. However, once you have completed the questionnaire, you won’t be able to remove it from the study as the information will be anonymous (see below for more on what this means).

What will you do in the study?

If you decide to take part, you will be asked to complete an online survey which will include questions on:

(i) your feelings about people who have mental health difficulties;

(ii) how much you feel you can trust different people in your life;

(iii) whether you have had any feelings or thoughts that can reflect a mental health difficulty, and/or whether a friend has discussed their own feelings or thoughts with you;

(iv) what you did if *you* have experienced any feelings or thoughts that can reflect a mental health difficulty or what you did if *a friend* told you about their feelings or thoughts that can reflect a mental health difficulty with you or what they *would* do if you or a friend experienced feelings or thoughts that could reflect a mental health difficulty.

This will take place in your school and should take no longer than 40 minutes. You will be asked to take part using your own mobile phone if you have one and have it in school, or on a tablet which can be supplied to you.

Why have you been invited to take part?

You have been invited to take part because you are a young person in S1, S2 or S3.

What things should you think about before deciding to take part?

In the survey, we ask you about feelings or thoughts that can reflect a mental health difficulty that you or a friend may have experienced such as sadness, difficulty concentrating, and sleep problems. The most challenging items that you need to know about are “*Thought about ending your life*” and “*Self-*

harming (i.e. hurting yourself on purpose)". These items were added because they are important when talking about the feelings of depression and anxiety that some young people can experience. These may be issues that you do not want to discuss and if so then you are free to decide that you do not want to take part in this study. You are also free to stop at any point during the survey, without telling us why. Finally, you are free to answer only the questions you feel comfortable with. You have been given a support sheet with information about where to get help and advice.

What happens to the information in the study?

All information collected will be anonymous – this means that we cannot find out who has said what. This can help you to be as honest as possible, but it is important to realise that no one will talk to you about anything you report in the survey so no one will be able to offer you help or support if you say you are having difficulties. Information will be kept on password protected computers when it contains information like your school name – later, it will be free for other researchers (e.g., other university students) to use but they will not be given any identifying information (such as your school name or any other personal details). Your guardian/parent consent forms will be kept for 5 years after the study is completed before being destroyed.

The University of Strathclyde is registered with the Information Commissioner's Office who implements the Data Protection Act 2018. All personal data on participants will be processed in accordance with the provisions of the Data Protection Act 2018.

Thank you for reading this information – please ask any questions if you are unsure about what is written here.

What happens next?

If you are happy to be involved in this study, please log-in to the survey as instructed by Sofia. You will be asked to give your consent online and can then complete the survey.

LINK FOR SURVEY: tinyurl.com/ifeelupset

Researcher contact details:
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Phone: 0141 548 2575

Sofia is a member of the Disclosure Scotland scheme, which means she has been approved to work with children and young people. This study has been granted ethical approval by the University of Strathclyde Ethics Committee.

If you have any questions or worries, during or after the study, or want to talk to an independent person to ask any questions or further information, please contact:

University Ethics Committee, University of Strathclyde, Email: ethics@strath.ac.uk

Appendix 15

Study 3 – Consent form for parents

Parental Consent Form

Title of the study: "I feel upset": How young people cope with mental health problems.

- I confirm that I have read and understood the Parental Information Sheet for the above project and the researcher has answered any queries to my satisfaction.
- I confirm that I have read and understood the Privacy Notice for Participants in Research Projects and understand how my personal information will be used and what will happen to it (i.e., how it will be stored and for how long).
- I understand that my child's participation is voluntary and that my child is free to withdraw from the project at any time, up to the point of completion, without having to give a reason and without any consequences.
- I understand that anonymised data (i.e., data that do not identify my child) cannot be withdrawn once they have been included in the study.
- I understand that any information recorded in the research will remain confidential and no information that identifies me or my child will be made publicly available.
- I consent to my child being a participant in the project.

Name of the child: ____

(PRINT NAME)	
Signature of Parent:	Date:

NOTE TO ETHICS – for online completion, parents will simply give the name of their child and their own name. No other electronic signature will be required.

Appendix 16

Study 3 – Consent form for participants

Participant Consent Form

Title of the study: "I feel upset": How young people cope with mental health problems.

- I confirm that I have read and understood the Participant Information Sheet for the above project and the researcher has answered any questions I have.

- I confirm that I understand the Privacy Notice for Participants in Research Projects and understand how my personal information will be used and what will happen to it (that is, how it will be stored and for how long).

- I understand that taking part in this study is voluntary (that is, I do not have to take part if I don't want to) and that I am free to withdraw at any time, until I have finished it, without having to give a reason and without any consequences.

- I understand that anonymised data (i.e., data that do not identify me personally) cannot be removed once they have been included in the study.

- I understand that any information recorded in the research will be confidential and no information that could identify me will be made publicly available.

- I consent to taking part in this project.

NOTE for Ethics Committee:

This will be completed online. Then young person will have to agree that they agree with the above and if they do so they will then be able to complete the online survey. If they do not consent they will not be able to take part.

Appendix 17

Study 3 – Debrief for participants

Debrief Form

Title of the study: "I feel upset": How young people cope with mental health problems.

Thank you for taking part in this study. Our research focuses on how trust and our ideas about mental health might influence how young people get help when they or a friend experience symptoms of mental health problems. When we talk about "Mental Health" it is useful to remember that everyone, young and old, has ups and downs and that we all have times when our mental health can be a challenge. Young people (and adults too!) experiencing mental health problems are sometimes unsure about where they can get the best help. We hope to improve the support and advice given to young people.

If you would like support, information, or help for yourself, or if you are worried about a friend, you have some resources available to help you. If possible, you should always talk to a trusted adult such as:

- Parent/Guardian,
- Carer,
- Teacher/ School counsellor. At your school, you can talk to **[INSERT NAME OF THE SCHOOL STAFF MEMBER] [TIMETABLE/ROOM NUMBER- IF THERE IS ONE]** if you are worried about anything that has been covered in today's survey.
- GP (your Doctor), if you feel that you are experiencing very upsetting feelings.

There are also some really helpful online resources for young people that can offer you support for your mental health, as well as if you're experiencing thoughts of suicide or if you need help supporting someone you're worried about:

- *Young Minds*: an organisation focused on providing good mental health care to young people and working to empower young people. This online resource gives information about what mental health is as well as explains what different mental health issues are. It also has a blog where other young people share their experiences with mental health. https://youngminds.org.uk/
- *Childline*: that offers advice on a variety of subjects (like bullying, relationships and sex, school work, family issues, and your feelings). They can be contacted all day any day, for free, on *0800 1111*. If you phone, it won't even show up on your bill. You can also see their resources online, and chat to a counsellor online too. https://www.childline.org.uk/
- *Papyrus (Prevention of Young Suicide):* is an organisation that gives confidential advice and support for young people who feel suicidal (HOPELineUK: 0800 068 41 41; Text: 07786 209 697). https://www.papyrus-uk.org/
- *Samaritans:* If you're in distress and need support, you can ring Samaritans for free at any time of the day or night (Freephone: 116 123 (24 hours)). https://www.samaritans.org/

If you have any questions about the study or your data, then please feel free to contact the researchers:

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Appendix 18

Study 1 – Final interview schedule after pilot changes (changes highlighted in bold).

Question	Elements
What do you think about when I say mental health problem?	1) Mental health definition
Probe: If you hear someone saying that they, or a friend, have a mental health problem, what do you think this means?	(extracting also information sources and establishing a definition for the rest of the interview)
Probe: Why do you think that’s what it means? What do you think helped you get to that definition?	
Thank you! So, now maybe I can tell you what I think a mental health problem is? For me, a mental health problem is:	
“When someone is having troubled thoughts, emotions, and behaviours. Or it can even be when a person is having trouble relating to people around him or her. Some examples of this could be depression or anxiety”	
Do you understand that definition?	
So, if it is okay with you, for the rest of the interview try to keep that definition in your mind, okay?	
Now, I would like for you to imagine that you are experiencing a mental health problem.	2) Appraisals (i.e., primary appraisal)
How would you feel about it?	
Probe: Can you think of anything good about having a MHP? Can you think of anything bad about having MHP?	
Probe: Can you think of anything changing in for example your school everyday life because you have a MHP? What about anything changing with your friends and the relationship that you have with them? Also, at home, with your family? Do you think that anything would change if you had a MHP? Why? (for every question)	
Probe: Would this be a big concern to you or not?	
And now if you were to think about acting about it, what do you think you would do?	3) Coping strategies
Why?	
Probe: Would you be trying to understand the problem? Trying to almost understand what the MHP you had means? Focus on symptoms and how to it develops and works.	
So, do you think that maybe you would be more focus on dealing with your emotions and feelings about having MHP? Focus on why do you feel like this and if it is normal to feel the way you feel.	
Would you feel confident doing that?	2) Appraisals
Probe: Why?	(i.e., secondary appraisal)
Probe: Do you think that you would be able to figure out what to do by yourself without help? How? Why?	
Probe: Do you think that you would be able to talk to someone that you know about this?	

You said earlier that you would **[WHAT PARTICIPANT SAID].** Can you tell me a little bit more about it? So, can you give me examples of what you would ask/search? Probe (Online): Do you have any idea where to go online for it? What search terms to use, or websites might you visit? **Probe: Would you be more focus on getting information about the problem (i.e., understanding what it is)? Would you try to get help? Why (for both)?** **(If answer "getting help") When getting help, you think that you would turn more for professional help or other sources of support?** Probe: Do you think you would have all the information/help/support you would need and want? Why? Probe: Do you think you would feel the need to go anywhere else?	How/ what coping strategies work (information; help; support) (subtheme of coping strategies)
Now, you have been thinking about yourself as I was asking you these questions. If now I ask you to think instead of being the one with a mental health problem, for example one of your friends is the one that it is experiencing it. Keeping in mind the definition that we talked about in the beginning **[recall the definition to the participant]:** How would you feel about it? Why? Probe: Can you think of anything positive/ negative [depending on what the first answer is] about it? **Probe: Can you think of anything good about having a MHP? Can you think of anything bad about having MHP?** **Probe: Can you think of anything changing in for example your school everyday life because you have a MHP? What about anything changing with your friends and the relationship that you have with them? Do you think that would happen? Also, at home, with your family? Do you think that anything would change if you had a MHP? Why? (for every question)** Probe: Would this be a big concern to you or not? And now if you were to think about acting about it, what do you think you would do? **Probe: Would you be trying to understand the problem? Trying to almost understand what the MHP you had means? So, do you think that maybe you would be more focus on dealing with your emotions and feelings about having MHP?** Would you feel confident doing that? **Probe:** Why? **Probe: Do you think that you would be able to figure out what to do by yourself without help? How? Why?** **Probe: Do you think that you would be able to talk to someone that you know about this?** You said earlier that you would **[WHAT PARTICIPANT SAID].** Can you tell me a little bit more about it? So, can you give me examples of what you would ask/search?	Differences between coping for self and others in all the previous themes.

Probe (Online): Do you have any idea where to go online for it? What search terms to use, or websites might you visit?

Probe: Would you be more focus on getting information about the problem (i.e., understanding what it is)? Would you try to get help? Why (for both)?

(If answer "getting help") When getting help, you think that you would turn more for professional help or other sources of support?

Probe: Do you think you would have all the information/help/support you would need and want? Why?

Probe: Do you think you would feel the need to go anywhere else?

Appendix 19

Study 2 – Final survey

ABOUT YOU

Age (in years):

Gender: Male (boy) ☐ Female (girl) ☐ Prefer not to say ☐

What is your nationality? For example, you might be British or Polish or Indian.
____

What is your ethnic identity? For example, you might be British or Scottish or Scottish-Pakistani. ______________________________

BELIEFS ABOUT MENTAL HEALTH PROBLEMS

You will find below a list of sentences regarding mental health problems. By "mental health problem" we mean *when someone is having troubled thoughts, emotions, and behaviours. This can sometimes be shown by having trouble relating to people around him or her. Some examples of this could be depression or anxiety*.

For each sentence check off the answer that best suits you by putting an "**X**" in the appropriate square. Answer all the questions without exception.

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Most adolescents my age will tease/harass others if they know he/she is receiving mental health treatment.					
Most people believe that teens with emotional and behavioural problems are just as intelligent as other teens.					
Most adolescents look down on other adolescents receiving mental health treatment.					
Most believe that an adolescent with emotional or behavioural issues is dangerous.					
Many people are afraid of teens who are getting mental health treatment.					
People believe that adolescents with emotional or behavioural problems are to blame for their problems.					

Most teens would not want to hang out with somebody that has emotional/behaviour issues.					
Most believe that an adolescent with emotional or behaviour issues cannot be trusted.					
Most people believe that adolescents with emotional or behavioural problems will never get better.					
Most people believe that adolescents with mental health issues can't get good grades in school.					
Most believe that adolescents with emotional or behavioural problems cannot take care of themselves.					
Teachers and other school staff tend to give adolescents with emotional or behavioural problems a hard time.					
Most employers will not hire an adolescent with emotional or behaviour issues.					
Most people will not date someone who has mental health issues.					

If you had a mental health problem…	Almost Never	Sometimes	About half the times	Frequently	Very often
How often would you feel different from other adolescents your age?					
How often would you feel people may not like you if they knew?					
How often would you feel people will not want to be friends with you?					
How often would you worry that other people are uncomfortable with you?					
How often would you feel embarrassed about it?					

TRUST

Next you will see several of statements about your close friends, parents, teachers, mental health professionals, and online information. Please read each sentence carefully and place an "**X**" in the answer that best suits your thoughts.

Think of your friends…	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
I have friends that I can trust to keep a secret.					

I have friends that I can trust to keep their promises.					
My friends keep secrets from me.					
My friends are honest about what they are thinking.					
I believe that my friends know how to help me.					
My friends try to understand me.					

Think of your parents…	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
I trust my parents to keep a secret.					
I trust my parents to keep their promises					
My parents keep secrets from me.					
My parents are honest about what they are thinking					
I believe that my parents know how to help me					
My parents try to understand me					

Think of your teachers…	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
I trust my teachers to keep a secret.					
I trust my teachers to keep their promises					
My teachers tell me everything I need to know					
My teachers are honest about what they are thinking					
I believe that my teachers know how to help me					
My teachers try to understand me					

Think of a professional (e.g., GP, psychologist)…	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
I trust a professional to keep a secret.					
I trust a professional to keep their promises					
Professionals tell me everything I need to know					
Professionals are honest about what they are thinking					
I believe that professionals know how to help me					
Professionals try to understand me					

Think of interactions online…	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
I trust people online to keep a secret.					
I trust people online to keep their promises					
Online information tells me everything I need to know					
People online are honest about what they are thinking					
I believe that people online know how to help me					
People online try to understand me					

NOTE TO ETHICS: Next there are 4 vignettes, though each child will only be presented with 2 in total. These will relate to their own hypothetical symptoms of mental health problems **or** to a friend's symptoms. Participants will be asked to appraise the situation and assess how they would cope with it.

SELF

WHAT I WOULD DO

Below are descriptions of two different situations. Imagine you are experiencing these situations, and think about how you might react to it. There are no right or wrong answers.

Situation 1. You have been feeling unusually sad and in a low mood for the last few weeks, and nothing special has happened to trigger this. You are tired all the time and you have trouble sleeping nearly every night. Also, your appetite has changed and you have lost some weight. In school, you are having some difficulties concentrating and your results are not as good as they normally are.

In this situation, you would…	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
… be frightened					
… think that things can only get worse					
… think that things would not go well					
… have a lot to lose					
… be worried					
… not feel stressed					

HOW WOULD YOU DEAL WITH THIS SITUATION?

Thinking about your parents or guardians. Would you…

	No	Probably not	Maybe	Probably yes	Yes
Get emotional support from them					
Get comfort and understanding from them					
Try to get advice or help about what to do from them					
Get help and advice from them					

Thinking about school staff (e.g., teachers, support staff). Would you…

	No	Probably not	Maybe	Probably yes	Yes
Get comfort and understanding from them					
Get emotional support from them					
Get help and advice from them					
Try to get advice or help about what to do from them					

Thinking about your friends. Would you…

	No	Probably not	Maybe	Probably yes	Yes
Get help and advice from them					
Try to get advice or help about what to do from them					
Get comfort and understanding from them					
Get emotional support from them					

Thinking about professionals (e.g., GP, psychologist). Would you…

	No	Probably not	Maybe	Probably yes	Yes
Get comfort and understanding from them					
Try to get advice or help about what to do from them					
Get emotional support from them					
Get help and advice from them					

Thinking about going online. Would you…

	No	Probably not	Maybe	Probably yes	Yes
Try to get advice or help about what to do from a website					
Get help and advice from someone you don't know					
Get emotional support from someone you don't know					
Get comfort and understanding from someone you don't know					

Situation 2. You have always felt shy and self-conscious around others, and never felt that you knew what to say or how to act. Lately, you started to feel physically tense, nervous, sick, and flushed, even during breaks from classes. You often replay these situations in your head in a very self-critical way. You are sometimes described by others as "odd" or "a loner", also you avoid almost all social situations.

In this situation, would you…	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
… be frightened					
… think that things can only get worse					
… think that things would not go well					
… have a lot to lose					
… be worried					
… not feel stressed					

HOW WOULD YOU DEAL WITH THIS SITUATION?

Thinking about your friends. Would you…

	No	Probably not	Maybe	Probably yes	Yes
Get comfort and understanding from them					
Get emotional support from them					
Try to get advice or help about what to do from them					
Get help and advice from them					

Thinking about parents/guardians. Would you…

	No	Probably not	Maybe	Probably yes	Yes
Try to get advice or help about what to do from them					
Get emotional support from them					
Get comfort and understanding from them					
Get help and advice from them					

Thinking about going online. Would you…

	No	Probably not	Maybe	Probably yes	Yes
Get emotional support from someone you don’t know					
Get comfort and understanding from someone you don’t know					
Get help and advice from someone you don’t know					
Try to get advice or help about what to do from a website					

Thinking about school staff (e.g., teachers, support staff). Would you…

	No	Probably not	Maybe	Probably yes	Yes
Try to get advice or help about what to do from them					
Get comfort and understanding from them					
Get emotional support from them					
Get help and advice from them					

Thinking about professionals (e.g., GP, psychologist). Would you…

	No	Probably not	Maybe	Probably yes	Yes
Get help and advice from them					
Get emotional support from them					
Try to get advice or help about what to do from them					
Get comfort and understanding from them					

THANK YOU FOR TAKING PART IN THIS SURVEY

FRIEND

WHAT I WOULD DO

Below are descriptions of two different situations. Imagine you are experiencing these situations, and think about how you might react to it. There are no right or wrong answers.

Situation 1. A friend has been feeling unusually sad and in a low mood for the last few weeks, and nothing special has happened to trigger this. They are tired all the time and have trouble sleeping nearly every night. Also, their appetite has changed and they have lost some weight. In school, they are having some difficulties concentrating and their results are not as good as they normally are.

In this situation, you would…	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
… be frightened					
… think that things can only get worse					
… think that things would not go well					
… have a lot to lose					
… be worried					
… not feel stressed					

HOW WOULD YOU DEAL WITH THIS SITUATION?

Thinking about your school (e.g., teachers, support staff). Would you…

	No	Probably not	Maybe	Probably yes	Yes
Get emotional support from them					
Try to get advice or help about what to do from them					
Get help and advice from them					
Get comfort and understanding from them					

Thinking about professionals (e.g., GP, psychologist). Would you…

	No	Probably not	Maybe	Probably yes	Yes
Get comfort and understanding from them					
Try to get advice or help about what to do from them					
Get help and advice from them					
Get emotional support from them					

Thinking about going online. Would you…

	No	Probably not	Maybe	Probably yes	Yes
Get help and advice from someone you don't know					
Get comfort and understanding from someone you don't know					
Get emotional support from someone you don't know					
Try to get advice or help about what to do from a website					

Thinking about your parents. Would you…

	No	Probably not	Maybe	Probably yes	Yes
Try to get advice or help about what to do from them					
Get emotional support from them					
Get help and advice from them					
Get comfort and understanding from them					

Thinking about your friends. Would you…

	No	Probably not	Maybe	Probably yes	Yes
Get help and advice from them					
Get emotional support from them					
Get comfort and understanding from them					
Try to get advice or help about what to do from them					

Situation 2. A friend of yours was always shy and self-conscious around others, and never feels that they know what to say or how to act. Lately, they started to feel physically tense, nervous, sick, and flushed, even during breaks from classes. They will often replay these situations in their head in a very self-critical way, and they have mentioned this to you before. Sometimes they are described by others as "odd" or "a loner". They avoid almost all social situations.

In this situation, you would…	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
… be frightened					
… think that things can only get worse					

… think that things would not go well					
… have a lot to lose					
… be worried					
… not feel stressed					

HOW WOULD YOU DEAL WITH THIS SITUATION?

Thinking about your going online. Would you…

	No	Probably not	Maybe	Probably yes	Yes
Try to get advice or help about what to do from a website					
Get help and advice from someone you don't know					
Get comfort and understanding from someone you don't know					
Get emotional support from someone you don't know					

Thinking about your friends. Would you…

	No	Probably not	Maybe	Probably yes	Yes
Get emotional support from them					
Get help and advice from them					
Get comfort and understanding from them					
Try to get advice or help about what to do from them					

Thinking about your parents. Would you…

	No	Probably not	Maybe	Probably yes	Yes
Get comfort and understanding from them					
Get help and advice from them					
Try to get advice or help about what to do from them					
Get emotional support from them					

Thinking about professionals (e.g., GP, psychologist). Would you…

	No	Probably not	Maybe	Probably yes	Yes
Get help and advice from them					

Try to get advice or help about what to do from them					
Get emotional support from them					
Get comfort and understanding from them					

Thinking about school staff (e.g., teachers, support staff). Would you…

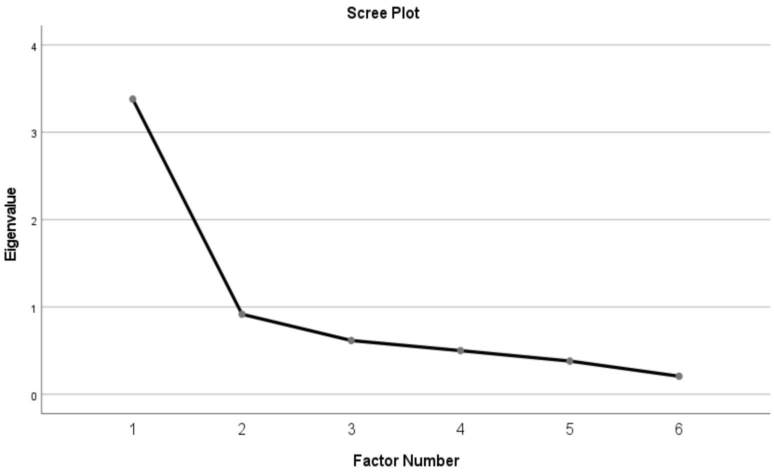
	No	Probably not	Maybe	Probably yes	Yes
Get emotional support from them					
Try to get advice or help about what to do from them					
Get comfort and understanding from them					
Get help and advice from them					

THANK YOU FOR TAKING PART IN THIS SURVEY

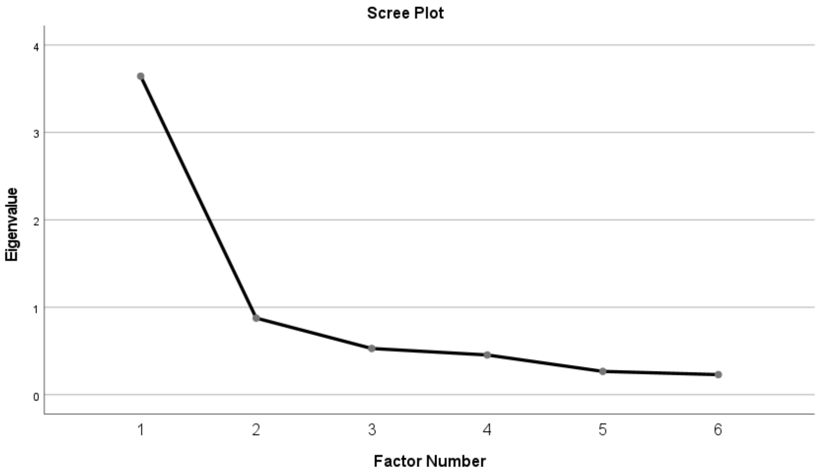
Appendix 20

Exploratory factor analysis – scree plots for each of the five sources of support

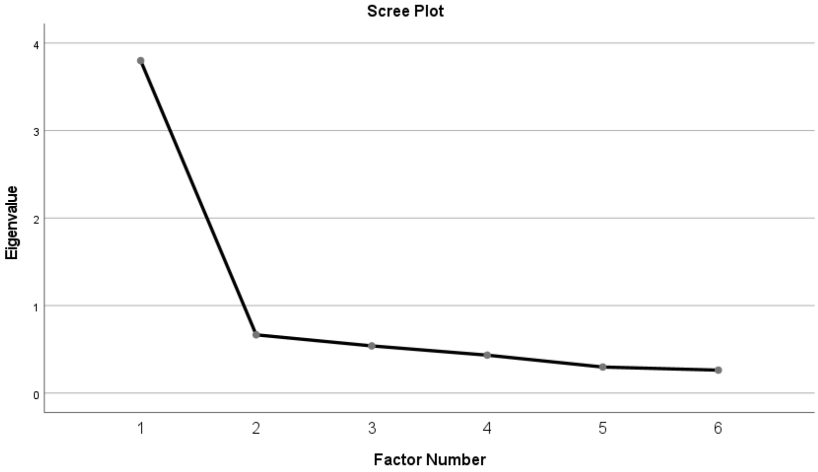
20.1. Support seeking from Friends



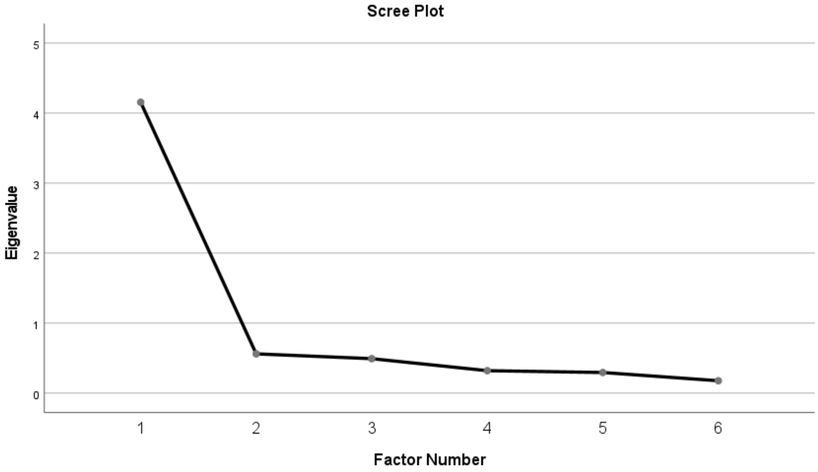
20.2. Support seeking from Parents



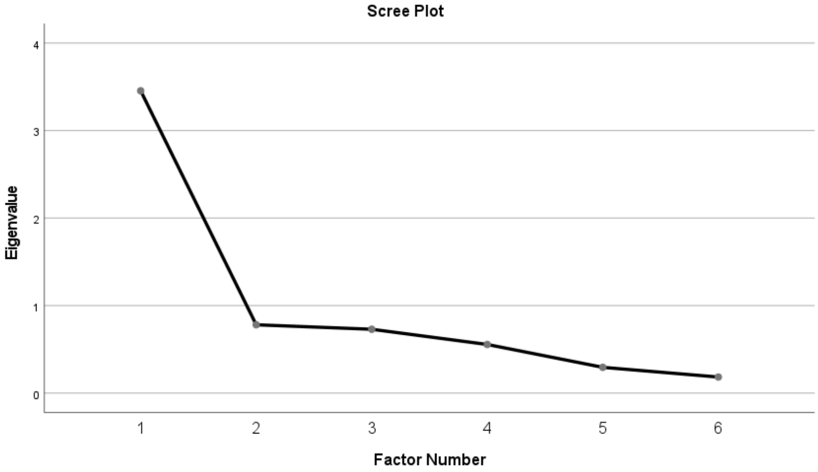
20.3. Support seeking from Teachers



20.4. Support seeking from Professionals



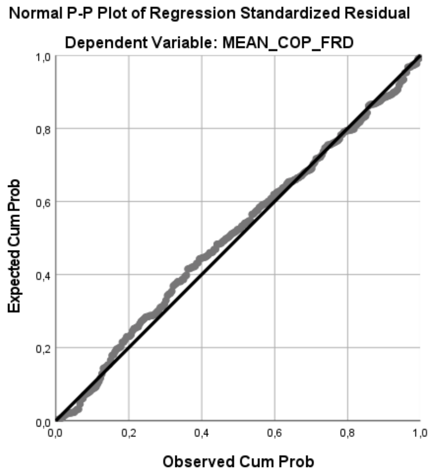
20.5. Support seeking Online



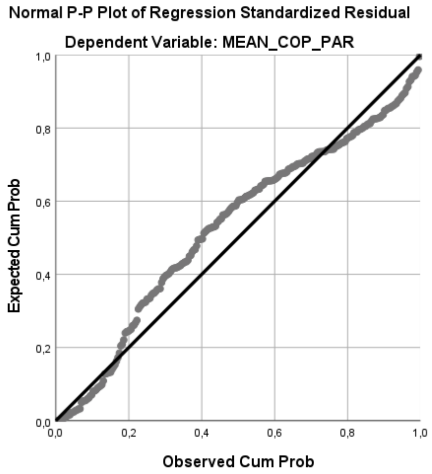
Appendix 21

P-P plots for assumption testing prior to path analysis for the five sources of support - outputs

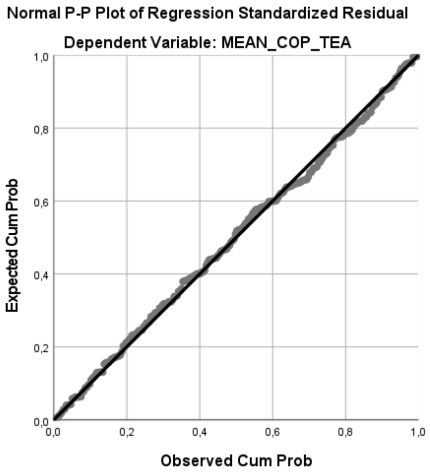
21.1. Support seeking from Friends



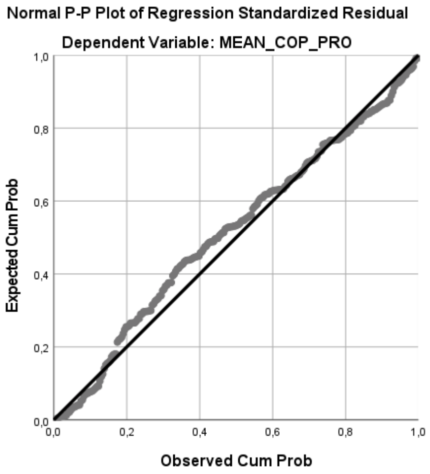
21.2. Support seeking from Parents



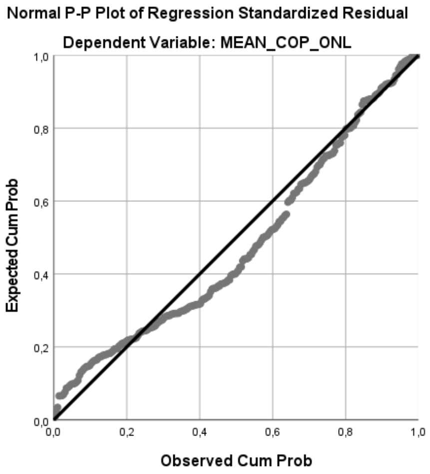
21.3. Support seeking from Teachers



21.4. Support seeking from Professionals



21.5. Support seeking Online



Appendix 22

Study 3 – Final survey

ABOUT YOU

Age (in years): ______

Gender: Male (boy) ☐ Female (girl) ☐ Not listed (add) ☐ Prefer not to say ☐

What is your nationality? For example, you might be British or Polish or Indian.

____

What is your ethnic identity? For example, you might be British or Scottish or Scottish-Pakistani.

____

TRUST

Next you will see several statements about your close friends, parents, teachers, mental health professionals, and online information. Please read each sentence carefully and place an “**X**” in the answer that best suits your thoughts.

Think of your friends…	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
I have friends who I can trust to keep a secret.					
I have friends who I can trust to keep their promises.					
My friends keep secrets from me.					
My friends are honest about what they are thinking.					
I believe that my friends know how to help me.					
My friends try to understand me.					

Think of your parents…	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
I trust my parents to keep a secret.					
I trust my parents to keep their promises.					
My parents keep secrets from me.					
My parents are honest about what they are thinking.					
I believe that my parents know how to help me.					
My parents try to understand me.					

Think of your teachers…	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
I trust my teachers to keep a secret.					
I trust my teachers to keep their promises.					
My teachers tell me everything I need to know.					
My teachers are honest about what they are thinking.					
I believe that my teachers know how to help me.					
My teachers try to understand me.					

Think of a professional (e.g., GP, psychologist)…	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
I trust a professional to keep a secret.					
I trust a professional to keep their promises.					

Think of a professional (e.g., GP, psychologist)…	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Professionals tell me everything I need to know.					
Professionals are honest about what they are thinking.					
I believe that professionals know how to help me.					
Professionals try to understand me.					

Think of interactions online…	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
I trust people online to keep a secret.					
I trust people online to keep their promises.					
Online information tells me everything I need to know.					
People online are honest about what they are thinking.					
I believe that people online know how to help me.					
People online try to understand me.					

BELIEFS ABOUT MENTAL HEALTH PROBLEMS

Below you have a list of sentences regarding mental health problems. For each sentence check off the answer that best suits you by putting an "**X**" in the appropriate square. Answer all the questions without exception.

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Most adolescents my age will tease/harass others if they know he/she is receiving mental health treatment.					

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
Most people believe that teens with emotional and behavioural problems are just as intelligent as other teens.					
Most adolescents look down on other adolescents receiving mental health treatment.					
Most believe that an adolescent with emotional or behavioural issues is dangerous.					
Many people are afraid of teens who are getting mental health treatment.					
People believe that adolescents with emotional or behavioural problems are to blame for their problems.					
Most teens would not want to hang out with somebody that has emotional/behaviour issues.					
Most believe that an adolescent with emotional or behaviour issues cannot be trusted.					
Most people believe that adolescents with emotional or behavioural problems will never get better.					
Most people believe that adolescents with mental health issues can’t get good grades in school.					
Most believe that adolescents with emotional or behavioural problems cannot take care of themselves.					
Teachers and other school staff tend to give adolescents with emotional or behavioural problems a hard time.					
Most employers will not hire an adolescent with emotional or behaviour issues.					
Most people will not date someone who has mental health issues.					

Think about the last two months. Have you had any thoughts or feelings that can be experienced by people who have a mental health problem? This might include sadness, difficulty concentrating, sleep problems, thought about ending your life, or self-harm (that is, hurting yourself on purpose)? Have any of your friends told you about thoughts or feelings like these?

☐ Both – I have had thoughts or feelings like these AND a friend has told me that they have too
☐ I have had thoughts or feelings like these
☐ A friend has told me that they have had thoughts or feelings like these
☐ Neither – I have NOT had thoughts or feelings like these AND no friends have told me that they are having them
☐ Prefer not to say

NOTE TO ETHICS: Next, there are three versions of this survey, though each child will only be presented with one of them. The three versions are:
(1) Relating to their own symptoms of mental health problems (answered by those who say they experienced their own symptoms)
(2) Relating to a friend's symptoms (answered by those who say they had a friend report symptoms to them)
(3) Relating to hypothetical symptoms of a friend (answered by those who say they neither experienced symptoms nor had a friend report symptoms to them)

Those young people who report "Both" will be randomised by class to complete either version (1) or version (2).

SELF

Now consider the following thought, feelings, and behaviours that can be experienced by people who have a mental health problem. If you have experienced any in the last two months, say how serious you thought they were. If you have not experienced any, then just choose N/A.

	N/A	Not serious	A little serious	Somewhat serious	Quite serious	Very serious
Worrying too much						
Difficulty concentrating						
Sleeping problems						
Being scared of, or avoiding, social situations						
Feeling very scared or embarrassed a lot						
Feeling sad						
Feeling hopeless						
Feeling moody						

	N/A	Not serious	A little serious	Somewhat serious	Quite serious	Very serious
Not being interested in everyday activities (e.g. school, hobbies)						
Having a lot less energy than usual						
Not feeling important to others						
Thought about ending your life						
Self-harming (i.e. hurting yourself on purpose)						

When you have thoughts, feelings, and/or behaviours like those listed above, do you…

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
… feel frightened					
… think that things can only get worse					
… think that things would not go well					
… think that you had a lot to lose					
… are worried					
… do not feel stressed					

Thinking about your mental health difficulties…	Almost Never	Sometimes	About half the time	Frequently	Very often
How often do you feel different from other kids your age because you have behaviour or emotional issues?					
How often do you feel people may not like you if they know you have emotional or behaviour issues?					
How often do you feel people will not want to be friends with you if they know you have emotional or behaviour issues?					
How often do you worry that other people are uncomfortable with you because of your mental health issues?					

Thinking about your mental health difficulties…	Almost Never	Sometimes	About half the time	Frequently	Very often
How often do you feel embarrassed about your emotional or behaviour issues?					

How have you dealt with these thoughts, feelings, and/or behaviours?

Thinking about your parents or guardians. Have you…

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
…been getting emotional support from them					
… been getting comfort and understanding from them					
… been trying to get advice or help about what to do from them					
… been getting help and advice from them					

Thinking about school staff (e.g., teachers, support staff). Have you…

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
… been getting comfort and understanding from them					
…been getting emotional support from them					
… been getting help and advice from them					
… been trying to get advice or help about what to do from them					

Thinking about your friends. Have you…

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
… been getting help and advice from them					
… been trying to get advice or help about what to do from them					

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
… been getting comfort and understanding from them					
…been getting emotional support from them					

Thinking about professionals (e.g., GP, psychologist). Have you…

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
… been getting comfort and understanding from them					
… been trying to get advice or help about what to do from them					
…been getting emotional support from them					
… been getting help and advice from them					

Thinking about going online. Have you…

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
… been trying to get advice or help about what to do from a website					
… been getting help and advice from someone you don’t know					
…been getting emotional support from someone you don’t know					
… been getting comfort and understanding from someone you don’t know					

THANK YOU FOR TAKING PART IN THIS SURVEY

FRIEND

You said earlier that a friend had told you about difficulties they had been experiencing. Now consider the following thought, feelings, and behaviours that can be experienced by people who have a mental health problem. If your friend said that they had experienced any of these in the last two months, say how serious you thought they were. If your friend did not report any to you, then just choose N/A.

	N/A	Not serious	A little serious	Somewhat serious	Quite serious	Very serious
Worrying too much						
Difficulty concentrating						
Sleeping problems						
Being scared of, or avoiding, social situations						
Feeling very scared or embarrassed a lot						
Feeling sad						
Feeling hopeless						
Feeling moody						
Not being interested in everyday activities (e.g. school, hobbies)						
Having a lot less energy than usual						
Not feeling important to others						
Thought about ending their life						
Self-harming (i.e. hurting yourself on purpose)						

When you think about the thoughts, feelings, and/or behaviours that you said earlier your friend told you about, you…

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
… feel frightened					
… think that things can only get worse					

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
… think that things would not go well					
… think that you had a lot to lose					
… are worried					
… do not feel stressed					

How have you dealt with your friend's thoughts, feelings, and/or behaviours?

Thinking about your school (e.g., teachers, support staff). Have you…

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
…been getting emotional support from them					
… been trying to get advice or help about what to do from them					
… been getting help and advice from them					
… been getting comfort and understanding from them					

Thinking about professionals (e.g., GP, psychologist). Have you…

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
… been getting comfort and understanding from them					
… been trying to get advice or help about what to do from them					
… been getting help and advice from them					
…been getting emotional support from them					

Thinking about going online. Have you…

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
… been getting help and advice from someone you don't know					
… been getting comfort and understanding from someone you don't know					
…been getting emotional support from someone you don't know					
… been trying to get advice or help about what to do from a website					

Thinking about your parents. Have you…

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
… been trying to get advice or help about what to do from them					
…been getting emotional support from them					
… been getting help and advice from them					
… been getting comfort and understanding from them					

Thinking about your friends. Have you…

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
… been getting help and advice from them					
…been getting emotional support from them					
… been getting comfort and understanding from them					
… been trying to get advice or help about what to do from them					

If you had a mental health problem…	Almost Never	Sometimes	About half the time	Frequently	Very often
How often would you feel different from other adolescents your age?					
How often would you feel people may not like you if they knew?					
How often would you feel people will not want to be friends with you?					
How often would you worry that other people are uncomfortable with you?					
How often would you feel embarrassed about it?					

THANK YOU FOR TAKING PART IN THIS SURVEY

HYPOTHETICAL

The following thought, feelings, and behaviours that can be experienced by people who have a mental health problem. Imagine your friend told you that they had experienced these in the last two months - say for each how serious you think they would be.

	Not serious	A little serious	Somewhat serious	Quite serious	Very serious
Worrying too much					
Difficulty concentrating					
Sleeping problems					
Being scared of, or avoiding, social situations					
Feeling very scared or embarrassed a lot					
Feeling sad					
Feeling hopeless					
Feeling moody					
Not being interested in everyday activities (e.g. school, hobbies)					
Having a lot less energy than usual					
Not feeling important to others					
Thought about ending their life					
Self-harming (i.e. hurting yourself on purpose)					

If a friend of yours were to experience any of these thoughts, feelings and/or behaviours you would…

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
… feel frightened					
… think that things can only get worse					

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
… think that things would not go well					
… think that you had a lot to lose					
… be worried					
… not feel stressed					

If a friend ever experience any of these thoughts, feelings and/or behaviours, how would you deal with this?

Thinking about your parents or guardians. Would you…

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
Get emotional support from them					
Get comfort and understanding from them					
Try to get advice or help about what to do from them					
Get help and advice from them					

Thinking about school staff (e.g., teachers, support staff). Would you…

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
Get comfort and understanding from them					
Get emotional support from them					
Get help and advice from them					
Try to get advice or help about what to do from them					

Thinking about your friends. Would you…

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
Get help and advice from them					

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
Try to get advice or help about what to do from them					
Get comfort and understanding from them					
Get emotional support from them					

Thinking about professionals (e.g., GP, psychologist). Would you…

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
Get comfort and understanding from them					
Try to get advice or help about what to do from them					
Get emotional support from them					
Get help and advice from them					

Thinking about going online. Would you…

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
Try to get advice or help about what to do from a website					
Get help and advice from someone you don't know					
Get emotional support from someone you don't know					
Get comfort and understanding from someone you don't know					

If you had a mental health problem…	Almost Never	Sometimes	About half the time	Frequently	Very often
How often would you feel different from other adolescents your age?					
How often would you feel people may not like you if they knew?					
How often would you feel people will not want to be friends with you?					

If you had a mental health problem…	Almost Never	Sometimes	About half the time	Frequently	Very often
How often would you worry that other people are uncomfortable with you?					
How often would you feel embarrassed about it?					

THANK YOU FOR TAKING PART IN THIS SURVEY

Appendix 23

Study 3 – Spearman correlation matrix for the Self group

	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
1. Public-stigma	-															
2. Self-stigma	.22	-														
3. Threat	.58*	.59*	-													
4. Trust in friends	-.40	.14	.10	-												
5. Trust in parents	.24	-.27	-.05	-.09	-											
6. Trust in teachers	.17	.11	-.05	.25	.38	-										
7. Trust in professionals	-.42	.19	-.02	.45	-.12	.02	-									
8. Trust in online	-.02	-.10	-.29	.15	.32	.53*	.05	-								
9. SS friends	-.06	-.06	.02	.47	-.26	.41	-.10	-.02	-							
10. SS parents	-.30	-.26	-.42	.29	.21	.46	-.08	.19	.62*	-						
11. SS teachers	-.11	.20	.14	.28	-.02	**.77****	.11	.35	.45	.31	-					
12. SS professionals	-.14	.04	-.05	-.41	-.17	-.44	.15	.05	.12	.16	.45	-				
13. SS online	.10	.48	.42	.27	.03	.34	-.11	-.09	.04	-.09	.39	-.01	-			
14. Perceived severity of symptoms	.03	.60*	.25	.13	-.21	-.08	.03	-.44	.18	.13	.15	.35	.51	-		
15. Number of symptoms	.59*	.40	.56*	-.04	.28	.02	-.41	-.19	-.07	-.37	-.08	.03	.44	.30	-	
16. Gender	-.32	-.29	-.04	-.13	.11	-.20	.05	.25	-.35	.19	.15	.27	-.26	-.40	-.46	-
17. Age	.07	.63*	.32	.04	-.50	-.23	.36	-.19	-.14	-.28	-.10	.01	-.23	.29	-.01	.07

*p<.05; **p<.01

Note: SS - Support seeking

Appendix 24

Study 3 – Spearman correlation matrix for the Friend group

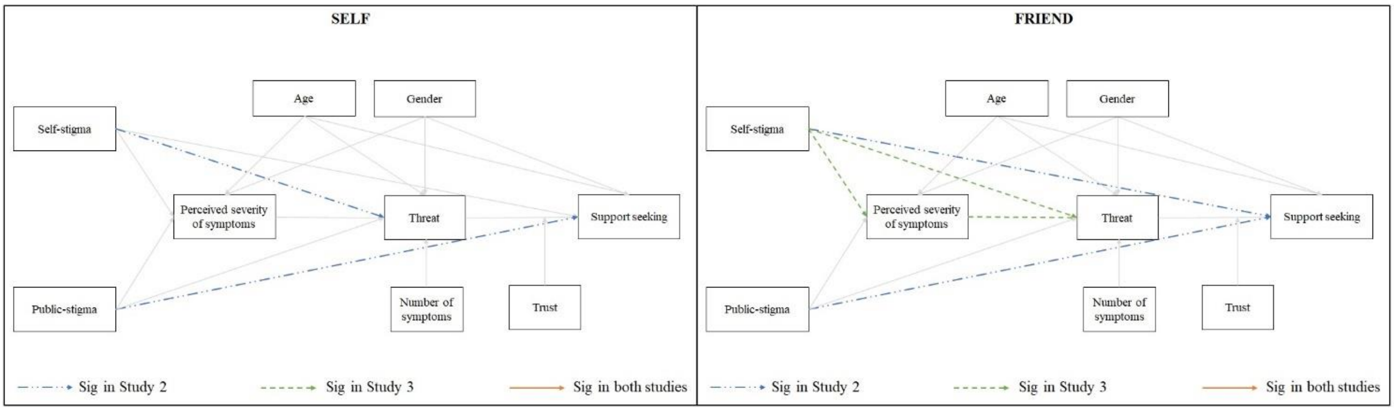
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
1. Public-stigma	-															
2. Self-stigma	**.61****	-														
3. Threat	.29	**.75****	-													
4. Trust in friends	-.24	**-.62****	**-.55****	-												
5. Trust in parents	-.25	**-.61****	**-.59****	**.77****	-											
6. Trust in teachers	.03	-.41	-.15	.23	.33	-										
7. Trust in professionals	-.30	-.36	-.15	.27	.41*	.42*	-									
8. Trust in online	.14	.10	-.15	-.09	-.10	.24	-.08	-								
9. SS friends	.05	.14	.20	.16	.05	-.11	-.16	-.05	-							
10. SS parents	.06	-.23	-.06	.17	.47*	.41	.28	-.27	.42	-						
11. SS teachers	.16	.02	.37	-.10	-.18	.54*	-.21	.20	.37	.27	-					
12. SS professionals	.04	.04	.35	-.07	.02	.20	.04	-.45*	.37	.40	.46*	-				
13. SS online	**.55****	.40	.40	**-.56****	-.48*	-.01	-.40	.04	.04	.06	.35	.24	-			
14. Perceived severity of symptoms	.40	**.67****	**.60****	- .37	- .29	-.04	.07	.26	.14	-.13	.09	.04	.17	-		
15. Number of symptoms	.23	.52*	.36	-.42*	-.22	-.41*	-.31	.07	.24	.03	-.02	.12	.10	.47*	-	
16. Gender	.16	-.12	.07	-.07	.03	.22	.14	.05	-.37	-.11	.04	-.21	.17	.24	-.28	-
17. Age	-.12	-.13	.04	.39	.07	.07	-.12	-.08	-.29	-.16	-.04	-.10	-.26	-.24	-.45*	.16

**p*<.05; ***p*<.01

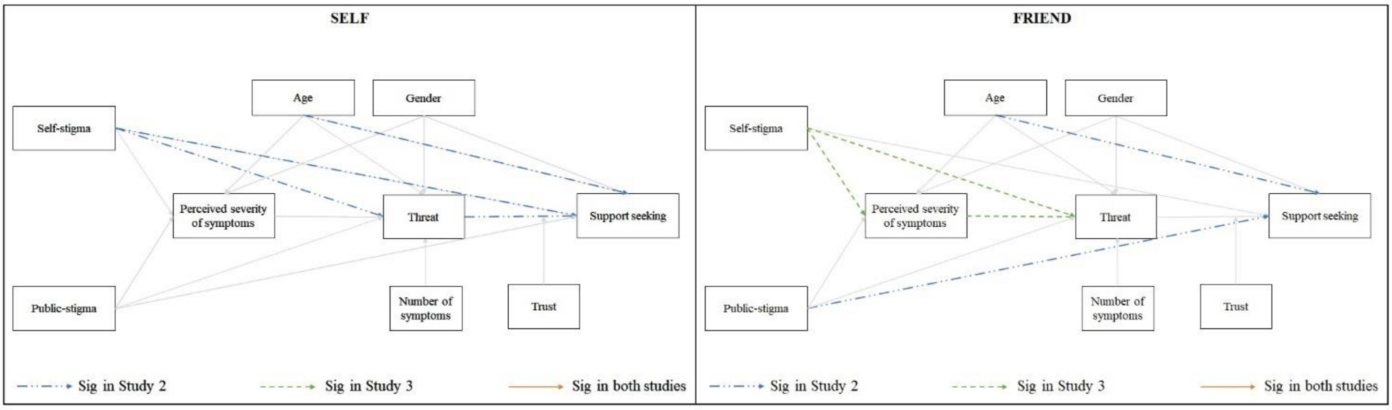
Note: SS - Support seeking

Appendix 25

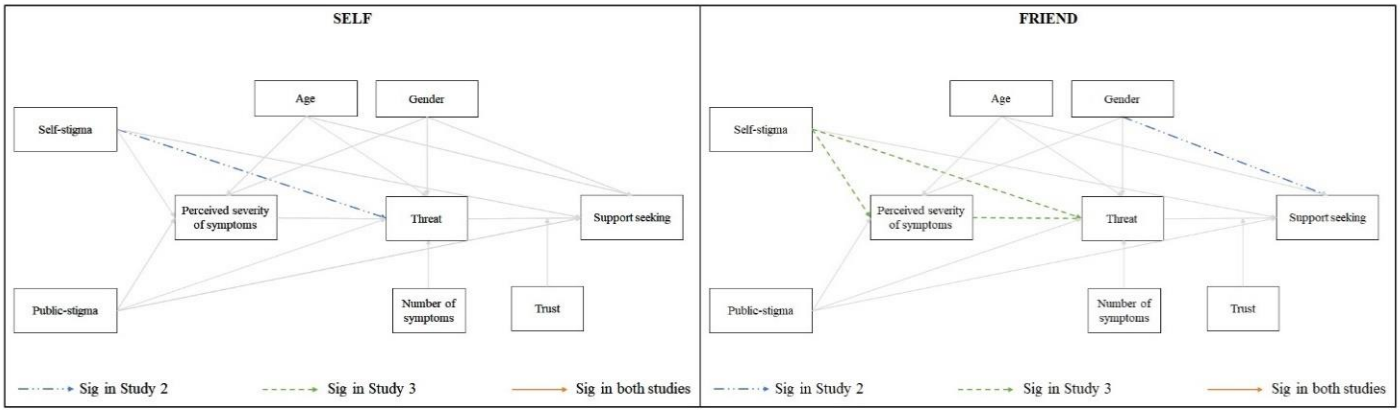
25.1. Study 3 – Path diagram for the friends model with significant paths for Study 2 and 3



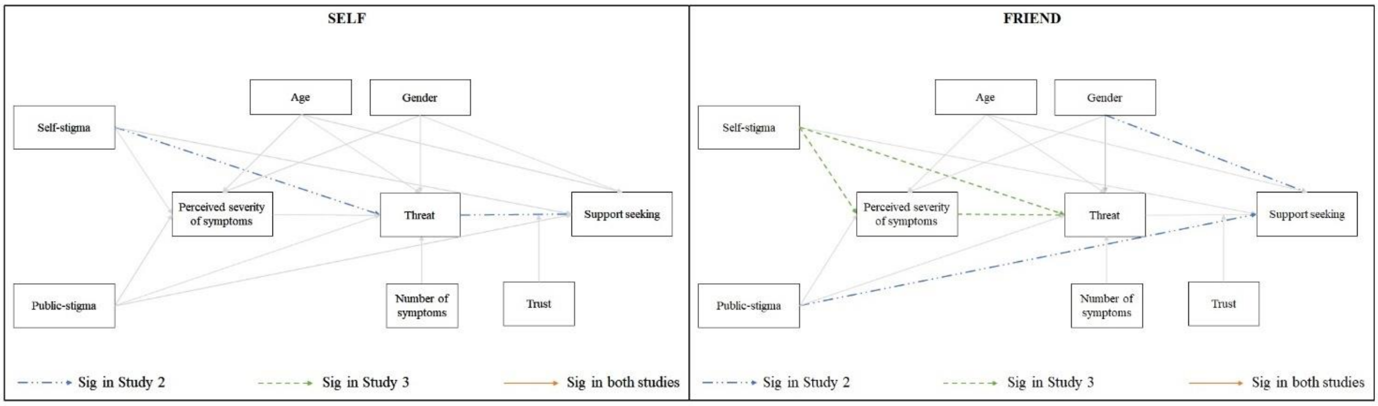
25.2. Study 3 – Path diagram for the parents model with significant paths for Study 2 and 3



25.3. Study 3 – Path diagram for the teachers model with significant paths for Study 2 and 3



25.4. Study 3 – Path diagram for the professionals model with significant paths for Study 2 and 3



25.5. Study 3 – Path diagram for the online model with significant paths for Study 2 and 3