# Irish Adolescents and Depression: A Study of Mental Health Literacy and Help-Seeking

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## Abstract

**Context:** This study was conducted to examine the mental health literacy and help-seeking behaviour of Irish adolescents in relation to depression. This is of interest because of the under-recognition of the disorder and the associated morbidity and mortality in this age group. **Objectives:** The aim of the study was to establish to what extent Irish adolescents are able to recognize depression in their peers and whether there is any differences between boys and girls abilities to do so. It also aimed to ascertain what help seeking behaviours students would recommend to their friends and whether students believe that they are likely to take a similar course of action themselves. If not, to examine their reasons for believing why it might be more difficult to obtain help for themselves than to give advice to their friends. **Design**: This was a cross sectional study which also included a nested qualitative study. A total of 363 students in four different kinds of Irish secondary schools in an urban area were approached to participate. Response rate of 32% was poor, resulting in a total of 120 students participating. A limitation is that the results only included an urban

sample and only included adolescents from mainstream schools. Also the numbers of boys and girls as separate samples were not large enough to consider statistically significant gender differences. **Results:** This study highlighted quite low levels of mental health literacy in relation to depression, It shows that both boys and girls were almost twice as likely to recognise depression in girls than in boys and that girls were better able to recognise depression in both a boy and a girl. Boys and girls were quite consistent in their choice of symptoms which would help them to recognise depression suggesting that they are using the same information. With respect to help-seeking Irish adolescents, even when aware of the need for formal help in depression, will turn to family and friends for help. **Conclusions:** There needs to be more of an emphasis on improving mental health literacy in Irish adolescents with particular consideration given to boys. Adolescents, their parents and all those in contact with them need to be aware of how to recognise adolescent depression and to facilitate onward referral for professional help when it is warranted.

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# CHAPTER 1

## INTRODUCTION

### 1.1 Adolescent Depression

The World Health Organisation (2004) is predicting that depression alone will be one of the greatest health problems worldwide by the year 2020. In 2001 the World Health Assembly observed "....mental health care has simply not received until now the level of visibility, commitment and resources that is warranted by the magnitude of the mental health burden. Only a very small percentage of national health budgets go on mental health." In response to this the WHO is currently focusing on psychosocial development and mental health as one of it's seven priority areas. According to the WHO "treating mental illness can be expensive but leaving mental illness untreated is a luxury that most nations can ill afford". In keeping with this the European Strategy for child and adolescent health and development (2005) listed mental health problems as an emerging threat to child, family and society. Bramesfield et al (2006) argue that

“when considering measures to decrease the burden of disease that is caused by depression, depressive disorders of adolescents and young adults are of increasing interest”.

## 1.2 What Constitutes Depression?

Most people will experience subjective depressed mood at some time in their lives. It can be associated with significant life events, such as trauma and bereavement as well as many physical illnesses. However it becomes abnormal when it is severe or persistent and when objective changes in mood or function are apparent. Typical features include:

- Low/ sad mood
- Loss of interest or pleasure
- Fatigue/Loss of energy
- Poor concentration
- Disturbed sleep
- Change in appetite or weight
- Agitation/ slowing of movement or speech
- Pessimism/hopelessness about the future
- Suicidal thoughts or acts

Risk factors for adolescents include family history of depression, negative life events such as loss, social stressors and co-existing alcohol or other drug misuse. Increasingly standardised criteria such as the ICD-10 and DSM-IV are being used in describing caseness although there is still some differences in the literature between those who refer to depression as a mental health problem and those who consider it to be a mental health disorder.

## 1.3 Burden of Disease

Current evidence suggests that mental health problems are the major disease burden for adolescents with prevalence rates of over 20% in 12-16 year olds (Burns and Rapee, 2006). Among these problems “adolescent depression remains arguably the

most concerning" both because it makes them more vulnerable to mental health problems in later life and puts them at greater risk of suicide and self harm.

Depression in adolescence is common but requires treatment, however most adolescents receive no treatment even though depressive disorders can be treated successfully with a combination of drug therapy and psychotherapy. Associated morbidity and mortality is very high. Eighty percent of adults in psychiatric hospitals have had a crisis by the age of eighteen and fifty percent by the age of fifteen. Main causes of mortality in adolescence are accidents and self-harm with an increase in suicide especially among young men. Approximately 90% of those people who complete suicide are suffering from mental illness, most commonly depression. There is a close relationship between depressive thinking about suicide, planning suicide and committing suicide.

## 1.4 Identification of Adolescent Depression

Early identification of adolescent depression makes sense from a public health perspective, as it is likely to lead to better outcomes such as decreased mortality from suicide. Identification and management of adolescent depression is important not just to alleviate their mental suffering but also because of school related risks. There is evidence to suggest that there is an increased likelihood of higher rates of absenteeism and below average academic performance in students with an identified mental health problem. This in turn could impact negatively on their further education and vocational opportunities and their economic participation in society as adults. Therefore it is of concern not just in the health domain but also in the educational domain and has considerable cost implications for the broader society.

## 1.5 Prevalence

Numerous epidemiological studies have looked at the prevalence of mental health disorders in adolescence in the developed world. A number of common themes emerge and these include:

Mental health disorders in early adolescence are much more common in boys than in girls. The prevalence rate in girls rises throughout adolescence so that by late adolescence female prevalence rates are significantly higher than for males. The rise is mainly accounted for by the increase in anxiety and depressive disorders in adolescence.

Mental health disorders in adolescence occur in all social classes but there are adolescents who are at greater risk by virtue of a broad range of factors. It is unusual for adolescents with mental health disorder to have a single discrete disorder. Co-morbidity is very common and contributes to much of the functional impairment associated with mental health disorders. Only a tiny proportion (between 5% and 10%) of young people with mental health disorders are in contact with helping agencies. There could be several reasons for this. It could partly be because young people are familiar with the feelings associated with depression and so they don't recognize it as a disease, similar to vague aches and pains associated with less serious physical conditions.
Language usage and terminology could also play a part. Adolescents themselves seem to rarely use the term depressed and so they would seem to be dependent on those who know them to recognise it.

Another reason for the low numbers receiving treatment could also be the lack of available services. Child and Adolescent Mental Health Services (CAMHS) are often both seen as, and are, the poor relation of other services in terms of resources. This in spite of the fact that long-term morbidity and mortality among young people with mental health problems is among the highest of any group of patients. Funding and resources appear not to have been increased in spite of the high morbidity and mortality evident to professionals and there could be a very real concern for some GP's that even if they have connected with their teenage patient and made an accurate diagnosis they could be faced with the frustration of inadequate resources or services for proper management and treatment of their young patient.

## 1. The Irish Context

This is a time of change within the Irish health service with current moves towards developing primary care services and targeting specific groups for health promotion under population health. Therefore it is an ideal time to develop a consensus about the most efficient, evidence based way of ensuring that there is an improvement in the recognition and treatment of adolescent depression. In Ireland however, unlike in many other countries, such work is being carried out in the context of a history of very poor service provision for adolescent mental health problems.

The UN Convention on the Rights of the Child (1992) enshrines the right to the highest standard of mental health yet this fundamental right has often been neglected. In February 2003 Amnesty International found that the Irish Government does not comply with its international human rights obligations in the provision of mental health services and it's Children's Report, September 2003 found that such services for children are severely under resourced in staff, funding and available therapies. It also concluded that service planning is hampered by a lack of data collection and little epidemiological research.

There have been only three major epidemiological studies of psychological disorders in children to date and these were conducted in the late 1980s. As noted in the recently published PAC document "Child Mental and Emotional Health" (HSE, 2006) these studies are now over fifteen years old and did not provide any information on adolescents which limits their usefulness for service planning purposes now. In light of this the HSE initiated a major epidemiological study of mental health problems in children in late 2004.

## 1.7 Caseness in the Irish Context

There is strong evidence to indicate that adolescent depression is as much a problem in Ireland as in other countries. Lynch et al 2004 conducted a prevalence survey of 720 Irish 12-15 year olds at risk for psychiatric disorders and suicide ideation in the Dublin area. They found that almost 20% of adolescents in this age group were at risk of having a mental health disorder. Of the 720 participants, 125 expressed suicidal intent and 45.7% expressed suicidal ideation. This study reported that 4.5% of 12-15

year olds in Dublin suffered from depression. This study also found that "suicide is now the leading cause of death in young men in the 15-24 year old age range". Martin et al (2005) screened 3,374 children aged 1.5 to 8 years. An overall prevalence rate of 17.5% were identified for mental health problems. Differences were identified according to age and rose to a high of 26% in secondary school children and to 34% in this age group in socio-economically deprived areas.

This study also found that some 10% of all 12-18 year olds had experienced suicide ideation in the previous 6 months and 7% had deliberately harmed themselves. The results of these studies suggest that the burden of disease for Irish adolescents is equally as concerning as it is in other countries.

According to the annual reports of the Health Research Board the number of admissions to hospital for psychiatric care was consistently higher for girls than for boys over the period 2001-2003. Since 2004, the trend has reversed, with more boys than girls being admitted to hospital for psychiatric care. In 2005 there were more boys (54.4%) admitted than girls and the most common reason for children being admitted to hospital was for depressive disorders (26.4%) This is of great concern as, although most depressive episodes in adolescence are short, outcome in terms of complete remission is not very favourable with one third likely to experience a further episode in the following four years, Lewinsohn and Clarke (1995)

The recently published "Vision for Change" (2006) recognises the need to prioritise the full range of mental health care to specialist mental health services for children and adolescents. It is adopting a health promotion-population health approach and "provides the context for progress in Ireland, underlining the need for capacity building through training, education and additional resources" Mc Nicholas (2006).

As adolescent depression has long term health, educational and vocational implications it could very well be that this is not something that can most profitably be addressed by primary health care services rather it might need a far more coordinated approach between health and education services for Irish adolescents. Lynch et al's (2004) study suggests that in-adequate service provision could be one of the main factors contributing to the under recognition of adolescent depression in Ireland. They demonstrated that the population of Irish adolescents examined

experienced significant mental health difficulties however…few had come to the attention of the appropriate child and adolescent psychiatric services. However they indicated that "screening programmes to identify adolescents with depression would be costly and there would be a need for service development to cope with the increased rate of referrals that would be generated. Child and adolescent mental health services in Ireland currently have long waiting lists, are extremely busy and cannot cope with their current caseload. Mental health promotion programmes in schools might be a more cost effective and, in the long term, beneficial use of scarce resources."

## 1.8 The Present Study

While a great deal of international research on the identification of adolescent depression in primary care settings has focused largely on improving its recognition by doctors, teachers and parents there has recently been considerable interest in looking at it from the perspective of the adolescents and it is this area that the current study intends to look at it in greater detail.
Jacobsen (2002) states that "as far as we are aware, there has been little research into teenagers understanding of psychological disorders and treatment. This is an important area in terms of recognizing their concerns and potential barriers to presentation, accessing help and accepting treatment".

Two key concepts in the approach of this study are Mental Health Literacy and Help-Seeking. The term "Mental Health Literacy" was coined in 1997 by Jorm et al. It refers to the knowledge, beliefs and abilities that support the recognition, management or prevention of mental health problems. In 1997 Jorm suggested that a high public level of mental health literacy would improve early recognition of and intervention in these disorders.

Hinson and Swanson (1993) defined help-seeking as seeking help from any source either informal: peers, parents, family members or formal sources such as counsellors and psychologists. Help-seeking is an important means of ensuring that adolescents obtain appropriate supports and interventions yet there are indications that it is an

area in which adolescents are especially weak. Cauce et al (2002) state that help-seeking cannot occur until a problem or mental health issue is identified and it is possible that adolescents do not look for help because of their lack of awareness of the extent of their difficulties. However there is also a lot of evidence to suggest that adolescents' feelings and attitudes can lead to them keeping their problem a secret (Miraudo and Pettigrew, 2002, Gould et al, 2004) Consequently they do not look for help and so their depression is not recognised as such and they receive no treatment.

A recent study in Australia, by Burns and Rapee (2005) looked at adolescent's mental health literacy, in particular their knowledge of depression and help-seeking behaviour. One of their findings was that adolescents do not consider doctors appropriate helpers for a depressed peer. They were far more inclined to recommend counsellors, friends or family and this could suggest that they see doctors as a place to go for physical health needs but not for mental health concerns. It was felt that a similar study with a cohort of Irish adolescents would be useful starting point to give some indication of the current state of their mental health literacy and help-seeking behaviour. As noted above there is a lack of Irish specific research in the area yet other related research (Lynch et al, 2004, Martin and Carr, 2006) suggests that the prevalence of mental health problems and depression in Irish adolescents is similar to that found in other countries highlighting a significant burden of disease in young people.

## 1.9 Aims of the research

This study has been informed by a detailed review of the literature and current thinking in the area of help-seeking and mental health literacy as well as by the work of Burns and Rapee (2006). No previous studies were found on mental health literacy in Irish teenagers and this study aimed to address this gap in our knowledge. It was an attempt to begin to examine the issues in Irish adolescents taking cognizance of relevant cultural issues and to add to the work of Burns and Rapee by obtaining qualitative information as to what they perceived some of the barriers to be to help-seeking. It was felt that there was a need for a study to demonstrate Irish adolescents current level of mental health literacy in relation to depression in order to provide

timely direction for improving the recognition and treatment of depression, especially in light of the recently demonstrated associated high levels of morbidity and mortality.

This study was aimed at determining to what extent Irish adolescents themselves are already able to recognize depression, and whether they are likely to take appropriate measures when they do. If we know more about the extent of their knowledge and help-seeking behaviour this can guide us, not only in service development and provision but, equally critically, it can provide us with direction in the education of our young people. This may ultimately prove more effective in preventing and reducing the current burden of disease associated with adolescent depression as well as minimising the negative impact on educational and vocational opportunities. It was hoped that findings from the study would provide recommendations with specific relevance for the Department of Education and Science as well as the Department and Health and Children.

**1.9a Objectives of the Study**

To establish to what extent Irish adolescents are able to recognize depression in their peers and to determine whether there is any differences between boys and girls abilities to do so.
To investigate which features or symptoms of depression are crucial in enabling them to identify this correctly.
To ascertain what help-seeking behaviours students would recommend to their friends and to determine whether students believe that they are likely to take a similar course of action themselves. If not, to examine their reasons for believing why it might be more difficult to obtain help for themselves than to give advice to their friends.

**1.9b Overview of study**

Students were selected from four second level schools in Dublin North Central which included a single sex boys school, a single sex girls school and two mixed sex schools, a mix which would be quite typical of schools in the area.

This area includes a mix of socioeconomic classes with pockets of severe deprivation as well as more affluent suburbs but with no rural population. Parents and students were invited to participate in the study and students with signed parent and students forms were given a questionnaire to complete in school.

# CHAPTER 2

# LITERATURE REVIEW

## 2.1 Identification of the relevant literature

In reviewing the literature for this study it was considered firstly in terms of: population, (adolescents) and both negative and positive outcome (depression, mental health disorders, emotional well-being and resilience). It was then considered in terms of education (mental health promotion, mental health literacy, mental health curriculum, school based educational programs) and intervention (help-seeking)

The following search terms were identified to produce as sensitive a search as possible, adolescence and depression, adolescence and mental health literacy, adolescence and help seeking, mental health literacy and depression. A Psychinfo and Medline database search of English language journals over the past 10 years, i.e. 1997-2007 was conducted. This time span was used as the term Mental Health Literacy was coined in 1997. This age range was chosen as once subjects are over eighteen the information can be included in the adult literature. Also this is typically the range found in Irish secondary schools and as the research was to take place in this setting it was felt that limiting the search to this age group would lead to more focused recommendations for the population. As this study was done in an Irish Context all epidemiological studies and a range of relevant policy documents relating to adolescent mental health were reviewed.

The review of the literature revealed that there has not been a great deal of research world wide on mental health literacy and adolescents and no study in this particular area in Ireland was identified.

Several key themes emerged from the literature review. These include the need to recognise adolescence as a developmental stage with particular health needs and the importance of identification and recognition of adolescent depression in reducing short and long term associated morbidity. Other themes which are pertinent is the body of evidence in relation to adolescent help seeking, and the emerging trends in

the health and education arenas such as mental health promotion and school based mental health curricula.

## 2.2 Adolescence as a Stage

There is increasing recognition that adolescents should be considered as a group having needs distinct from those of either adults or children. Adolescence is a time when patterns of health behaviour and use of services are developed and these tend to be continued during adult life. Health strategies must address the particular needs of adolescents particularly in relation to mental health and to date there has been a lack of specific people responsible for taking a lead in adolescent service provision in primary care networks. Approaches to health promotion in young people must also be appropriate for their stage of cognitive and social development as they may fail to appreciate the long term consequences of poor health or even regard it as someone else's problem. As noted by Christie and Viner (2005) a particular challenge is that parents are still largely responsible for all aspects of their health as a young person enters adolescence but by the end of adolescence health issues will be almost entirely the responsibility of the young person.

Adolescence is also a key period for children to develop patterns of emotional well being within the context of separating emotionally from their parents and developing stronger peer relationships. There is growing recognition that emotional health is equally important as physical health to a person's overall well being and that it has a significant impact on a person's quality of life and their contribution to society. There is strong and growing evidence for the fundamental inter-relationship between physical, mental and social health supporting a bio-psycho-social model. This is especially true in adolescence which has biological (puberty and sexual development) as well as psychological and social elements. Problems in adolescence in any of these areas can affect young peoples functioning in several areas of their lives- personal, social, behavioural, academic and vocational. The presence of a mental health disorder in adolescence can therefore interfere significantly with the accomplishment of the psychological tasks of adolescence and greatly increases the likelihood of long term adverse health and social consequences and thus can have lifelong implications.

Health services therefore must pay greater attention to the special needs of young people if they are to improve the emotional, psychological and physical health of the population as a whole.

## 2.3 Provision of Services to Adolescents

The key message in "Bridging the Gaps: Health Care for Adolescents" (The Royal College of Paediatrics and Child Health, June 2003) is that adolescent medicine is not so much about a particular set of diseases that afflict this age group, rather it is about the ways in which services are provided. Up until recently adolescents with mental health problems have mainly been referred to child and adolescent mental health services (CAMHS) but there is an increasing emphasis in many countries on developing primary care services.

Effective provision of such services requires coordination across different agencies. What is needed first is the co-ordination of services at strategic planning and delivery levels and secondly the coordination of services to meet the need of the individual adolescent. This has to be considered both within and between services and includes services provided by health, social, educational and legal services as well as voluntary bodies. There should be mechanisms for identifying local adolescent health needs and for monitoring the impact of local service provision in effectively meeting these needs.

The evidence on the effectiveness of health promotion for young people suggests that: simultaneous interventions at governmental, community, media, family and individual levels increase the chances of effectiveness of health promotion interventions. (Sweeting and West, 1996) There is also increasing research evidence that better mental health outcomes for adolescents may be achieved through early parenting interventions. (RCPCH, London 2002.)

Schools are seen by parents and children as important places for young people to obtain health information, advice and support. Pupils and parents value information given in school by health professionals who may have special knowledge, credibility

and skills different to those of teachers, who themselves value health support in helping young people, particularly those experiencing emotional, psychological and mental health problems.

However as noted by Michaud and Fombonne (2005) “The identification, treatment, and follow-up of mental health problems in young people can be complicated. Parents and teachers may dismiss problems as merely reflecting adolescent turmoil. Young people are often very reluctant to seek help, owing to developmental needs about being “normal” at the time when they are exploring identity issues and trying to engage with a peer group” They don't want to show themselves in an unfavourable light and may be embarrassed to admit that they are depressed, they see symptoms as a sign of weakness. However there is also evidence to suggest that there could be other factors at play apart from their personal embarrassment. For example in the Peer Relationship category of the Health Behaviour Survey of Children (HBSC, 2002) only slightly over 50% of Irish students reported that they find their peers to be kind and helpful and to accept them as they are.

## 2.4 Recognition of Adolescent Depression

In view of the increasing morbidity associated with adolescent depression there has been a great deal of research worldwide in looking at its’ recognition in primary care settings. Health professionals need to be able to recognize mental health problems in young people, and to be able to distinguish the normal self-limiting emotional reactions of teenager’s from disorders that are likely to have significant impact on their immediate or long-term future.

Although up to 50% of adolescents consult their general practitioner once a year only a small proportion consult for psychiatric symptoms, yet there is evidence that depressive disorders are present in a considerable proportion of them (Yates and Garralda, 2005).

The fact that few adolescents present their psychological distress for consultation indicates that they may not regard this aspect of their suffering as a valid reason for

presentation (Jacobsen 2002) This represents a great deal of missed opportunities for recognition and treatment and there is evidence that it is not just because they do not discuss it but neither do the doctors do anything about it. GP's often recognise that psychological factors are associated with the consultations and associated mood symptoms yet an Australian study showed firm evidence that the confidence, knowledge and skills of doctors in adolescent health contribute to barriers in delivering health care to youth. However there has also been some encouraging results in this area and a study by Gledhill et al (2003) showed that enhancing the GP consultation to include structured screening and specific management strategies for depression is feasible.

If teenagers are unlikely to talk to their doctors about psychological symptoms do they not recognize the difficulties and, if they do, who else are they likely to talk to? Bramesfield et al (2006) argue that "key persons, such as teachers should be educated to recognise early signs of depressive disorders to identify those at risk and to assist children and parents to find help. However Moor et al (2005) showed that training teachers in using a semi-structured clinical interview did not improve their ability to recognize their depressed pupils and so teachers might not be a reliable source of information for doctors. They concluded that "recognizing depressive illness in adolescence is one of the main public health challenges for adolescent mental health service and this study adds to the growing literature on the difficulties in achieving this".

Ani and Garralda, (2005) found that working with parents instead showed some promise and that although "studies continue to document the huge burden of unidentified and hence untreated psychopathology and associated psychosocial adversities among children attending primary care…. but expression of parental concern appears to provide important help in improving recognition. In relation to this Weissman et al (2004) suggests that, as many primary care clinicians see all members of a family, parents can give information about the mental health of their adolescents in their absence.

Deep unhappiness, disordered mood, disordered sleep, and feelings of helplessness and hopelessness are not a natural stage of adolescence and should not be lightly

dismissed when they are observed. Jacobsen concludes that a major gap at present is of awareness, and suggests that the notion of teenage turmoil indicating potential mental ill health should be made more of a priority for recognition and management by primary care. As mentioned earlier Jacobsen (2002) feels that teenagers understanding of psychological disorders and treatment is also an important area to look at in terms of recognizing their concerns and potential barriers to presentation, accessing help and accepting treatment.

## 2.5 Mental Health Literacy

An area which shows considerable promise in relation to this is "Mental Health Literacy". This term was coined in 1997 by Jorm et al. It refers to the knowledge, beliefs and abilities that support the recognition, management or prevention of mental health problems. In 2006 he reports that "since then the term has come into widespread use in Australia and it has appeared as a national goal in a number of policy documents."

A study by Goldney et al (2005) found that in Australian adults "there has been a significant increase in mental health literacy, at least as regards depression, in the South Australian community between 1998 and 2004". The prevalence of the belief that it was better to deal with depression alone declined from 27% to 12%. However, while there was an increased perception of the helpfulness of professional people there was no significant difference in recommendations about seeing a psychiatrist or psychologist and they noted "The lack of significant change in psychiatrists and/or psychologists being perceived as therapists of choice is of concern and suggests that community education about their expertise may be appropriate". Therefore mental health literacy improvements in adults do not necessarily equate with better treatment outcomes for those suffering from depression. It would seem that while there is a need to increase recognition and identification when it is necessary there is also a need to develop coping and problem solving skills.

While most of the research in this area to date has been done in Australia, other countries are following suit in policy development. The following definition from the BC Partners for Mental Health and Addictions Information in Canada service suggest

that they have a somewhat broader definition. They suggest that mental health literacy includes:

- the ability to recognize specific disorders
- knowing how to seek information on mental health
- knowledge of risk factors and causes, of self-care techniques, and of professional help available
- attitudes that promote recognition and appropriate help seeking

While relatively much has been written about adult mental health literacy, I have not been able to identify a large amount of work that has been done specifically with adolescents in mind and I have been unable to find any studies on the state of mental health literacy in Irish teenagers.

## 2.6 Help-Seeking

Apart from the fact that adolescents might not recognise their own depression other factors are also impacting on identifying it as their feelings and attitudes can lead to them keeping their problem a secret. According to "Mind Matters", a programme aimed at promoting the psycho-social health of young Australians, such feelings could include concerns about privacy as well as feelings of embarrassment, shame, pride of fear of stigma, pity, judgement and worrying about what others will think and consequently they do not look for help. A considerable amount of research has also looked at the barriers to help-seeking.

### 2.6a Trends in Help-Seeking

"Encouraging appropriate and effective early help-seeking for mental health problems has been recognised as essential for prevention and early detection" according to Wilson and Deane (2006). However they note that when dealing with teenagers "a major challenge is the well-established reluctance of young people to seek professional help". In an earlier study, Rickwood, Deane, Wilson and Ciarrochi, (2005) comment on several well-established health seeking trends. Firstly young people are more likely to seek help from informal sources and they prefer to talk to

their friends or family, who in turn can have a significant role in encouraging professional help-seeking. However this is not always the case and so adolescents miss out on getting the help they need, Tishby et al (2001). Secondly boys are much less likely than girls to seek help for mental health problems and this is largely explained by socialisation theories. Boys more commonly try to sort out their problems on their own or to suffer in silence. This reluctance increases during adolescence and is of particular concern because of the higher rate of completed suicides for males. There seems to be a high psychological price to pay because of negative attitudes to formal help-seeking and they suggest that "framing help-seeking as one of life's tools, and a sign of strength rather than weakness, is essential, along with actively reaching out to target males".

**2.6b Help Negation**

Rickwood (2006) notes that the help-negating effect of some of the most common mental health problems for young is of special relevance. "Rather than prompting help-seeking these problems actively reduce it." She reports on the findings of a large US study (Gould, Velting, Kleinman, Lucas, Thomas, and Chung, 2004) that "one third of adolescents with serious suicidal ideation, or depression… felt that people should be able to handle their own problems without outside help, and many reported that they would rather keep their distressed thinking to themselves." Wilson et al (2005) also found with Australian youth that the belief that you should handle problems yourself is one of several beliefs that negate help-seeking for adolescents.

**2.6c Barriers**

In terms of help-seeking behaviour Miraudo and Pettigrew (2002) suggested also that "the need to maintain an idealised version of self represents a barrier to achieving mental health as it is likely to result in the discounting of the less desirable real self that is experiencing a mental health problem. Internalised attitudes..... can act as barriers to positive mental health when they prevent adolescents from considering confiding in others an acceptable coping strategy". Consistent with this Gould et al (2004) in a study of high school students in New York State found that "approximately one third of at-risk students thought people should be able to handle

their own problems. In their study Miraudo and Pettigrew concluded that the significant barrier to developing and achieving positive mental health was “their lack of mental health literacy. In other words there is a need for adolescents to be made more aware of mental health issues and informed of ways to manage them”.

To date much of the research on young people's health issues have concentrated on negative and problematic aspects and on the “high risk” aspects of adolescence. More recently there has been a shift in focus to various skills or strategies used by adolescents to protect and promote their health and to enable them to overcome the risk factors and this is an area where a great deal of health and educational policy is now being aimed.

## 2.7 Population Health and Health Promotion

Current health service delivery in Ireland is framed within a Population Health model which focuses on maximising the health and social well being of the population. In the policy document “Quality and Fairness-A Health System for You” (Dept of Health and Children, 2001a) there is a lot of policy relating to health promotion in Ireland but no mention of mental health literacy per se. Health promotion includes not only the actions and attitudes of individuals but also the policies and activities of public bodies. Having a proactive approach to mental health can help us in our efforts to deal with life’s ups and downs.

According to the Health Strategy primary care is the appropriate setting to meet 90-95 per cent of all health and personal social service needs and needs to become the central focus of the health system. The aim of primary prevention is to stop problems from starting and to reduce risk factors for mental health problems and reinforce coping skills.

A comprehensive health program should be available to all young people which recognizes the fact that it is normal for adolescents to feel depressed from time to time and for this mood to last several days. Such normal behaviour can be distinguished from more serious problem by the duration, persistence, and impact of the symptoms.

As part of this program it will be important to remove the stigma associated with depression as this has been noted to prevent young people from seeking help.

The Health Strategy has promised a new action program around mental health and programs to promote positive attitudes to mental health. It has also stated that “Mental Health services for children and adolescents will be expanded through: Implementation of the recommendations of the First report of the Working Group on Child and Adolescent Psychiatric Services, (Dept of Health and Children) and: Development of mental health services to meet the needs of children aged between 16 and 18 (currently being reviewed by the Working Group on Child and Adolescent Psychiatric Services)” Up until now adolescents in this age range were not being seen by child and adolescent mental health teams and it is unclear to what extent this has impacted on the recognition and treatment of depression in these children in Ireland. However the Irish Government's 10-year blueprint for development of mental health services “A Vision for Change” has addressed this gap and adolescents in this age group should now be seen by local CAMHS teams as resources are being supplied.

## 2.8 Alcohol Use

A particular area that is of relevance to adolescent depression in the Irish context is the culture of intoxication in Ireland and Irish ambivalence towards the problem. It is generally well accepted that problematic drinking behaviour can result in significant behavioural problems and can impair adolescent’s psychological development. (Godeau et al, 2001) Some recent changes in young peoples drinking behaviour have been observed and they are considered to be problematic (Le Garrec, 2000), including:

More alcohol is being consumed by young people;

More girls drink and girls drink more alcohol:

Alcohol is being mixed with other substances;

Drunkenness is being seen as an end in itself.

The five drink threshold or binge drinking is considered problematic alcohol intake and anecdotal evidence would suggest that many Irish young people would not consider it to be so as they engage in this behaviour regularly with little discouragement from their peers and sometimes even their parents and teachers.. There has been a steady increase in teenage drinking in Ireland to the point where in the 2003 ESPAD survey (European schools project on Alcohol and Drugs Survey) Irish children reported the third highest level of binge drinking. Specifically Irish boys reported the 4$^{th}$ highest and Irish girls the 2$^{nd}$ highest level of binge drinking among all boys and girls. This is of great concern as alcohol is a major risk factor for social and physical harm, as well as disease. As mentioned earlier adolescence is the period of life in which lifestyle patterns are being adopted and there is a link between the age of initiation to alcohol and patterns of use and abuse in adulthood (De Witt et al, 2002).

Alcohol related offences are now the most common reason for Irish young people being referred to the Garda Juvenile Diversion Program. Also when Lynch et al (2004) compared those Irish adolescents diagnosed with an affective disorder (i.e. all the disorders which were depressive in nature) with those not diagnosed they found that affective disorders were associated with binge drinking. This can be a two way street for adolescents and we need to consider, both at individual and group levels, whether binge drinking is a result of a depressive disorder or a causative factor. In adolescence a developmental difficulty such as depression could lead to alcohol use but equally use of alcohol can reinforce an avoidant coping style and could lead to removal from school and reduce opportunities for developing better interpersonal and coping skills.

## 2.9 Education

Child and adolescent mental health problems are frequently first identified at school as parents with concerns about their children are likely to consult teachers and other student services as their first step in seeking help. As research evidence now suggests that developing mental health literacy rather than just improving psychological competencies could be the way forward in improving recognition and treatment of

adolescent depression, school based programs could be a key component in reducing the burden of disease and long term impact of adolescent depression. Developing a better knowledge about students mental health literacy should also provide direction about where to pitch intervention programmes.

The Department of Health and Children's (2000b) “The National Children's Strategy. Our Children-Their Lives” provides an integrated framework and the key policy context for child health initiatives. Part of the national goal of intensifying the promotion of health and well being included the introduction of a social, personal and health education programmes to all schools. To date this programme has only been delivered in the junior cycle, up until age 15 or 16, and there has not been a mental health component to this program A draft curriculum has now been prepared for all classes which will have a strong mental health component as well as a strong emphasis on problem solving and coping skills.

Mental Health education provides a dedicated space for students to examine factors that influence their mental health. Students can explore ways in which they can be more proactive in support of mental health, including an awareness of relevant support agencies. Efforts aimed at improving the mental health literacy of adolescents should not only increase the likelihood that adolescents will recognise depression when they need to but should also increase the opportunity for mental health promotion.

# CHAPTER 3
# RESEARCH METHODOLOGY

## 3.1 Introduction and Study Design

This was a cross sectional study aimed at estimating the level of mental health literacy in relation to depression in Irish adolescent boys and girls. It also included a nested qualitative study in the design which was aimed at determining themes as to whether, and why, these adolescents felt that it is easier to recommend help than look for it yourself. Ethics approval was sought and obtained from the ethics committee in University College, Dublin and the questionnaire was given to transition year students. The transition year program is for students in mid-adolescence who have completed the Junior Certificate cycle in the Irish secondary school system. Typically students are between 15-16 years old. This age range was chosen because, according to Nevin et al (2005), who quote Carr (in press) "middle adolescence-spanning the ages of 15 to 18- is an important period not only because the rates of substance abuse, conduct disorder and depression increase dramatically, but also because the rate of depression for girls rises to double that for boys during this developmental stage." It

was felt that this year is preferable to others as students are not under exam pressure and so any change in their classroom routine would not impact negatively on their academic work

## 3.2 Instrument

A modified and expanded version of the "Friend in Need" questionnaire used by Burns and Rapee (2006) was used with their permission. It was decided to use this questionnaire as it had been specifically developed to identify adolescent's knowledge and attitudes about mental health and help-seeking behaviour, however the scenarios and language used were modified to make it more relevant to Irish adolescents.

The questionnaire outlined 5 vignettes, which included descriptions of two teenagers who are experiencing depression (using ICD-10 and DSM criteria) and two teenagers who were coping with other life events and one who was suffering from anorexia. Questions on the vignettes were aimed at determining whether the adolescents were able to recognize their peers who are suffering from depression and at their preferred choice of available help.

In their study Burns and Rapee felt that a limitation was that the majority of research has relied on the use of brief written case vignettes and that it is unclear what extent this data can be translated into what actually is likely to happen in the real world. They argue that "it has been demonstrated that what depressed people believe will help and what they actually do are not necessarily the same (Jorm et al, 2000b) and that what people believe will help another person is not necessarily what they will do for themselves (Raviv, Sills, Raviv and Wilansky, 2000)." Nonetheless it was decided to continue to use this methodology in order to make comparisons with previous studies in this area as it was felt that it would still provide an insight into the student's knowledge of depression, i.e. their mental health literacy.

Further questions were added to determine whether the students believed that the advice that they give to others is different from what they would feel would be helpful for themselves. Mainly quantitative data was collected however some qualitative data

was obtained from most students in response to questions such as “Now imagine that instead of X the situation applied to you. Who would you be most likely to turn to?” Some students qualified their response with additional information such as “my parents and friend and if I still needed help a counsellor.”

A nested qualitative study was also included in the design which asked students to reflect on whether it might be easier to provide advice in relation to help seeking rather than looking for help themselves and to ascertain their reasons for their response. This was aimed at determining what barriers Irish adolescents might identify which could impact on their help-seeking behaviour.

Demographic information was obtained from the cover sheet of the questionnaire. This included the sex and age of the students and whether they lived in lone or two parent households. It also indicated the level of education their parents had achieved.

## 3.3 Subjects

Burns and Rapee (2005) identified several limitations in their study. One of these was that their data was collected from two privileged schools from restricted ethnic backgrounds, a sample which would, they felt, if anything reflect a higher level of mental health literacy. In an attempt to overcome this limitation a variety of schools in Dublin North Central were approached to participate in the study. It was hoped that this would provide a greater mix of students from all socioeconomic classes as Dublin North Central includes pockets of severe deprivation, large suburban housing estates and more affluent areas of private housing. It does not include a rural population. The present study was conducted in the same geographical area as Lynch’s (2004) study A further reason that these schools were used is that this is the area where the researcher works to provides a primary care psychology service and it was felt that this would be beneficial when it came to implementing any recommendations relating to service provision arising from the conclusions of the study. The students in this study attended a private, i.e. fee paying single sex boys school, a public single sex girls school, and two mixed sex comprehensive schools. Such a mix is quite typical of the range of schools in an urban Irish setting.

## 3.4 Sample Size

Table 3.1

Sample sizes required to achieve the specified precisions for a range of prevalences.

| Prevalence | Precision | Sample size |
|---|---|---|
| 50% | +/- 5% | 377 |
| | +/- 10% | 96 |
| 40% | +/- 5% | 363 |
| | +/- 10% | 92 |
| 30% | +/- 5% | 318 |
| | +/- 10% | 81 |
| 20% | +/- 5% | 243 |
| | +/- 10% | 62 |

A target sample size of 100 was chosen for this study based on consultation and the calculations shown. A 50% prevalence rate was chosen based on an average rate of recognition of depression between boys and girls in Burn's and Rapee's Australian study (2005) and in the absence of previous studies in this area with an Irish cohort.

It was decided to use four schools as there were approximately eighty students in each class, with the exception of the all boys school which was larger, and it was hoped that a final response of at least one hundred questionnaires would be obtained. It was difficult to estimate a reasonable response rate in advance of the study as many of the studies in the area which have been conducted largely in Australia report sample sizes but not response rate although there is considerable variation when they do so. Wilson et al (2005) report a response rate of 33% compared with a rate of 91% for girls and 60% percent for boys in Burns and Rapee's 2005 study. Swenson and Rose in the US reported a 70% percent response rate whereas Lynch et al in their Irish study set a

target response rate of 50% and excluded three schools from a potential eleven that did not reach this target, and their response rate from the remaining schools was 51%.

Another limitation identified by Burns and Rapee in their study was the different rates of participation between girls and boys, which makes the identified gender differences difficult to interpret. As we do not have information on mental health literacy to date in Irish adolescents it was felt that it could not be assume in advance that far less boys than girls will participate. However in the event that this would be the case a larger single sex boys school was included in an attempt to increase the potential number of questionnaires completed by boys.

## 3.5 Procedure

Initial contact was made with the school principal by a phone call, which was followed by emailing a copy of the principal's letter, parent and teacher consent forms and a copy of the research proposal. At this time three of the principals identified a key contact person in the school, in two cases this was the Transition Year Coordinator and in the third it was the School Guidance Counsellor. In the fourth school the principal co-ordinated the work. In consultation with the school principal and other designated staff information letters were sent out to parents and students and permission for participation was sought from both parents and students. The parent and student forms were sent home together with a blank envelope to return it in. However as Transition Year is a far less structured time than other years students do not typically have homework assignments and so many students did not even open their school bags in the evening and it was felt that this affected the response rate. Also as the consent forms were handed out on one day only any student who was absent on that day was excluded from the study.

The principals and teachers all recommended that the students should not have the form for longer than a few days as experience had taught them that allowing parents and students more time does not usually lead to an improved response. This was not

actually borne out in practice as the response rate was poorest in the boys school where the boys were only given the form for one night and the best response was obtained from the mixed sex school where the students were given several days to return the form.

However it was felt that the poor response rate in the boys school was also due to other factors. In this school the guidance counsellor asked that the researcher hand out the forms to the boys, whereas in all the other schools the forms were handed out by school staff and this resulted in a significantly higher response rate. It is felt that school students are probably more likely to comply with requests from a familiar adult than from a stranger and this had an impact on the response rate.

In keeping with this it is felt that the parental response rate might also have improved if there had been a letter from the school principal endorsing the study. Only those students whose parents had given their consent were allowed to participate. The students seemed agreeable to participating once their parents had signed the consent however there was no way of knowing if many more parents has signed the form and the student had decided not to hand it up. Similarly there was no way of ascertaining whether a larger number of students would have agreed to completing the questionnaire if they had obtained parental consent.

It had been proposed to the school that the questionnaire should be completed during a class period which is not a core subject area, i.e when the students would typically be engaged in activities which are not strictly academic in focus. The objective was that students would be in a familiar setting and should not feel singled out. However Transition Year programs typically involve schedules quite different to that of the rest of the school and so it proved difficult with work experience, community placements and class trips to even have the transition year students in the school. Also, even when they were attending school, students had less structured schedules, for example two of the schools were involved in musicals and students were actually less available to participate in the study than if they had been attending scheduled classes. One of the schools had an unscheduled penalty shootout in a soccer tournament on the day the students were completing the questionnaire at the time of their English class period and this reduced the numbers. As students were in a variety of activities

throughout the school it actually proved to be more efficient for the participating students from all classes to come to a spare classroom and complete the questionnaire under the supervision of the either the researcher or their teachers.

The students were informed that they were being asked to complete the questionnaire in order to look at some aspects of their knowledge of mental health problems and to determine who they or their friends were most likely to turn to if they were in need of help. The questionnaire was designed to be a familiar format for the students, with most questions requiring the students to tick boxes. This format would be familiar not just from schoolwork but also from popular magazines. Students either placed the completed questionnaire in a blank envelope on the researchers or teachers desk.

The teachers were offered an opportunity to have an educational session on adolescent depression and the importance of mental health literacy, which was to be delivered after the students had completed the questionnaire. Two schools, the girls school and one of the mixed schools, had already had a talk from "Aware", a voluntary organisation, whose aims are to assist those affected by depression. Their programme "Beat the Blues", is a depression awareness programme designed for senior classes in secondary schools. The boys school had recently had a researcher in from a local child and adolescent mental health team who had given some educational input. The second mixed school had two talks scheduled over the following few weeks and felt that the questionnaire would be a useful lead in activity, therefore none of the schools requested the educational session. Key findings and results of the study have been shared with all the schools that participated.

## 3.6 Ethical Issues

The main issues were of consent and confidentiality. The issue of consent was addressed by the use of consent forms for both adolescents and their parents. The issue of confidentiality was addressed by keeping the questionnaires anonymous. Also participants were assured that completed consent forms and questionnaires would be kept in a locked filing cabinet in the school of population health in UCD for a period of one year following the study. As there was a possibility that the questionnaire

might raise some concerns with some participants their teachers were informed that, should the need arise, any student who requested it would be offered an opportunity for consultation with the researcher, who is a registered clinical and educational psychologist.

## 3.7 Pilot Study

The questionnaire was piloted to four boys and six girls who did not attend the target schools. The pilot study was largely concerned with ensuring that students could comfortably finish the questionnaire within the allotted time of one class period and also to look at literacy issues  There was always a possibility that there would be some students who would be unable to complete the questionnaire due to literacy issues. However as this skill does have implications for improving mental health literacy in this population, it was decided that attempts would not be made to identify these students in advance. The questionnaire was piloted on two students who had previously been identified as having learning difficulties and these students had no difficulty with the readability level of the text. All students were able to complete the questionnaire within the time allowed  and seemed to have little difficultly in understanding what was expected of them. Some typographical errors were identified and changed.

## 3.8 Data Analysis

The data obtained was entered in to an SPSS package. Responses were coded according to the presence of identified key words to determine to what extent adolescents were able to recognize depression in their peers and to distinguish between depression and other life events. The features they identified in the scenarios as being key indicators as to the problem being experienced were also coded to highlight which symptoms were more salient to this group.

The qualitative responses to the nested study section of the questionnaire were analysed to identify a thematic framework. Responses were recorded verbatim and coded according to themes that emerged. A similar approach was also used to code additional and spontaneous responses to more open ended questions on the questionnaire.

### 3.7a Statistical Methods

Descriptive statistics were generated to characterise the sample and frequencies were reviewed to look at the ability of the students to recognise depression in their peers as well as their preferences with regard to help-seeking behaviour both for their friends and for themselves. Cross tabulations were used to look at gender differences.

# CHAPTER 4
# RESULTS

## 4.1 Introduction

The results of the study are presented here under the two main areas of investigation: Mental Health Literacy and Help-Seeking.

The first two objectives for the mental health literacy section of the study were a) to establish to what extent Irish adolescents are able to recognize depression in their peers, and b) to determine whether there is any differences between boys and girls abilities to do so. The third objective of this section of the study was to determine what symptoms were key in helping them decide what was the matter with their friend. The help-seeking section was designed to ascertain what help seeking behaviours students would recommend to their friends and whether they are likely to follow a similar course of action themselves. A nested qualitative study was included to look at whether adolescents believe that it is easier to give advice to a friend than to look for help themselves.

### 4.1a) Demographic Information

A total of 363 parent and student consent forms were delivered to the four schools who agreed to participate. Of the 363 forms sent home with students a total of 120 parents and student consent forms were returned, representing a response rate of 32%. The gender of the students and the type of schools they attended are summarised in Table 1

**Table 1. Gender and Type of School**

| | Type of School | | | | |
|---|---|---|---|---|---|
| Gender | Girls only | Boys only | Mixed Sex | Mixed Sex | Total |
| Male | 0 | 21 | 10 | 14 | 45 |
| Female | 30 | 0 | 30 | 15 | 75 |
| Total | 39 | 21 | 40 | 29 | 120 |

## 4.2 Mental Health Literacy Results

**4.2.a Recognition of depression**

The following tables summarise their open ended responses to the question "what, if anything, do you think is the matter with ….?" . The tables presents the most frequent "diagnoses" that the students came up with in response to this question.

**Table 2a**

**Depressed boy scenario (Dave)**

| | Parents Separating | Depression | Upset/ Hurt | Other | Missing |
|---|---|---|---|---|---|
| Male | 24 (48%) | 10 (22.2%) | 4 (8.8%) | 5 (11.1%) | 4 (8.8%) |
| Female | 30 (40%) | 28 (37.3%) | 5 (4.1%) | 5 (4.1%) | 7 (5.8%) |
| Total | 52 (43.3%) | 38 (31.7%) | 9 (7.5%) | 10 (8.3%) | 11 (9.2%) |

**Table 2b**

**Depressed Girl scenario (Aisling)**

| | Depression | Low self esteem | Upset Hurt | Exam Pressure | Other | Missing |
|---|---|---|---|---|---|---|
| Male | 24 (53%) | 5 (11.1%) | 3 (6.6%) | 1 (2.2%) | 9 (20%) | 3 (6.6%) |
| Female | 46 (61.3%) | 4 (5.3%) | 6 (8.%) | 5 (4.1%) | 8(10.6%) | 6 (8.%) |
| Total | 70 (58.3%) | 9 (7.5%) | 9 (7.5%) | 6 (5%) | 17(14.%) | 9 (7.5%) |

**Table 2c**

**Eating Disorder scenario (Jenny)**

| | Eating Disorder | Unhappy with Appearance | Low Self-Esteem | Other | Missing |
|---|---|---|---|---|---|
| Male | 22 (48%) | 14 (31.1%) | 2 (4.4%) | 4 (8.8%) | 3 (6.6%) |
| Female | 44 (58.6%) | 15 (20%) | 2 (2.6%) | 5 (4.1%) | 9 (12%) |
| Total | 66 (55%) | 29 (24.2%) | 4 (3.3%) | 9 (7.5%) | 12 (10%) |

**4.2c Key features or symptoms**

Students were asked what parts of the scenario were the strongest hints that the person was having emotional problems in order to determine whether there were key features or symptoms that assist adolescents in identifying depression in their friends. The following tables summarise those symptoms most frequently identified by the students. (N is greater than 120 as many students responded with more than one symptom. Percentages of the total responses are given.)

**Table 3a**

**Symptoms Dave, Depressed Boy**

| Symptom | Male | Female | Total |
|---|---|---|---|
| 1. Feeling constantly tired, no energy | 19 (23%) | 33(21.2%) | 52 (21.9%) |
| 2. Not interested in anything | 18 (22%) | 27 (17.4%) | 45 (18.9%) |
| 3. Finding it hard to sleep | 16 (19.5%) | 27 (17.4%) | 43 (18.1%) |
| 4. Not eating, losing weight | 13 (15.8%) | 29 (18.7%) | 42 (17.7%) |
| 5. Marks dropping in school | 11 (13.4%) | 14 (9%) | 25 (10.5%) |
| 6. Couldn't concentrate or think | 4 (4.9%) | 20 (12.9%) | 24 (10.1%) |
| 7. Couldn't do anything right | 1 (1.2%) | 5 (3.2%) | 6 (2.5%) |

**Table 3b Symptoms Aisling, Depressed Girl**

| Symptom | Male | Female | Total |
|---|---|---|---|
| 1. "I might as well be dead" | 26 (34.2%) | 49 (33.7%) | 75 (33.9%) |
| 2. "I'm a loser, good for nothing" | 19 (25%) | 37 (25.5%) | 56 (24.4%) |
| 3. "No-one would care if I wasn't here" | 13(17.1%) | 24 (16.5%) | 37 (16.7%) |
| 4. Often sad and tearful | 5 (6.5%) | 18 (12.5%) | 23 (10.4%) |
| 5. Lost her usual spark and energy | 7 (9.2%) | 11 (7.5%) | 18 (8.1%) |
| 6. Lost interest in things | 6 (7.8) | 6 (4.1%) | 12 (5.4%) |

## 4.3 Help-Seeking Results

Adolescents were offered a wide range of help seeking options to choose from and, in an attempt to gather as much valuable information as possible, they were not restricted to a couple of options. Many adolescents indicated that they would look for help from more than one source, therefore coding their responses proved difficult as twenty categories were needed in order to have exhaustive, mutually exclusive codes. Frequency charts were obtained for help seeking for each scenario and the highest ranking categories were chosen to compare the help seeking they felt that a friend would need and the help seeking they would want to engage in themselves.

**Table 4a Who do you think Dave needs help from?**

| Type of Help | Total N (%) | Male (%) | Female (%) |
|---|---|---|---|
| 1. School based formal help | 22 (18.3%) | 4 (8.8%) | 18 (24%) |
| 2.All available supports (Family, friends, school based and professional formal help) | 17 (14.2%) | 4 (8.8%) | 13 (17.3%) |
| 3.Family, friends and school based formal help | 15 (12.5%) | 6 (13.3%) | 9 (12%) |
| 4. Family and school | 12 (10.0%) | 4 (8.8%) | 8 (10.6%) |
| 5. Family and friends | 10 (8.3%) | 8 (17.7%) | 2 (2.6%) |

**Table 4b Who would you want to talk to in Dave's situation?**

| Type of Help | Total N (%) | Male (%) | Female (%) |
|---|---|---|---|
| 1. Family and friends | 22 (18.3%) | 8 (17.7%) | 14 (18.6%) |
| 2. Friends | 16 (13%) | 6 (13.3%) | 10 (13.3%) |
| 3. Parents | 15 (12.5%) | 7 (15.5%) | 8 (10.6%) |
| 4. School based formal help | 11 (9.2%) | 2 (4.4%) | 9 (12%) |
| 5.Friends and School based formal help | 9 (7.5%) | 2 (4.4%) | 7 (9.3%) |
| 6. No-one | 9 (7.5%) | 3 (6.6%) | 6 (8%) |

**Table 4c Who do you think Aisling needs help from?**

| Type of Help | Total N | Male (%) | Female (%) |
|---|---|---|---|

| | | | |
|---|---|---|---|
| 1. All available supports (Family, friends, school based and professional formal help) | 19 (15.8%) | 7 (15.5%) | 12 (16%) |
| 2. Family, friends and school based formal help | 17 (14.2%) | 5 (11%) | 12 (16%) |
| 3. School based and professional formal help | 11 (9.2%) | 4 (8.8%) | 7 (9.3%) |
| 4. Professional formal help | 11 (9.2%) | 9 (20%) | 2 (2.6%) |
| 5. School based formal help | 10 (8.3%) | 1 (2.%) | 9 (12%) |

**Table 4d Who would you want to talk to in Aisling's situation?**

| Type of Help | Total N (%) | Male (%) | Female (%) |
|---|---|---|---|
| 1. Friends | 22 (18.3%) | 9 (20%) | 13 (17.3%) |
| 2. Family and friends | 17 (14.2%) | 6 (13.3%) | 11 (14.6%) |
| 3. Parents | 16 (13.3%) | 3(6.6%) | 13 (17.3%) |
| 4. School based formal help | 12 (10.0%) | 3 (6.6%) | 9 (12%) |
| 5. Professional formal help | 11 (9.2%) | 6 (13.3%) | 5 (6.6%) |

Table 5a summarises the students response to the question: "In the past have you ever suggested to one of your friends that they needed to talk to someone about an emotional problem?"

**Table 5a**

| | Yes | No | Missing | Total |
|---|---|---|---|---|
| | N (%) | N (%) | N (%) | N (%) |
| Male | 20 (44.4%) | 18 (40%) | 7 (15.5%) | 45 (100%) |
| Female | 36 (48%) | 19 (25.3%) | 20 (26.6%) | 75 (100%) |
| Total | 56 (46.7%) | 37 (30.8%) | 27 (22.5%) | 120 (100%) |

Table 5b summarises the participants response to the question: "Has anyone ever suggested to you that you should talk to someone about an emotional problem ?"

**Table 5b**

| | Yes | No | Missing | Total |
|---|---|---|---|---|
| | N (%) | N (%) | N (%) | N (%) |
| Male | 15 (33.3%) | 28 (62.2%) | 2 (4.4%) | 45 (100%) |
| Female | 28 (37.3%) | 42 (56%) | 5 (6.6%) | 75 (100%) |
| Total | 43 (35.8%) | 70 (58.3%) | 7 (5.8%) | 120 (100%) |

Table 5c summarises the number of students who had already heard a talk in school about mental health problems.

**Table 5c**

| Gender | Yes | No | Missing | Total |
|---|---|---|---|---|
| Male | 21 ( 46.7%) | 22 (48.9%) | 2 (4.4%) | 45 |
| Female | 47 (62.6%) | 23 (30.8%) | 5 (6.6%) | 75 |
| Total | 68 (56.6%) | 45 (37.5%) | 7 (5.9%) | 120 |

## 4.4 Results of Nested Qualitative Study

In response to the question “Is it easier to give advice than to look for help yourself?” 86.3%of respondents said “yes”, 8.7% said “no” and there were 5% missing responses. Respondents were also asked to give reasons for their response. There were a considerable number of simple Yes/No responses and blanks but really no inappropriate responses to this question. There were 78 responses which were coded into nine exclusive themes and ranked. They are listed here in table 6a in descending order of frequency.

**Table 6a Ranked Themes**

| Reason it is easier to give advice | Percentage of Responses |
|---|---|
| Outside Perspective | 32% |
| Feelings of shame, embarrassment, shyness | 15.3% |

| | |
|---|---|
| Find it difficult to talk about a problem | 12.8% |
| Find it hard to admit to having a problem | 11.5% |
| Person not thinking rationally | 6.4% |
| Don't want to be seen as needing help | 3.8% |
| Hard to find someone to understand, listen | 3.8% |
| "Feel good" factor | 3.8% |
| Other | 8.9% |

## 4.5 Additional Qualitative Information

Further qualitative information was obtained in response to the help-seeking question "who would you want to talk to?" A considerable number of participants simply listed their choice of help sources but a large number also used the space to make further spontaneous comments about their likely help seeking behaviour. Responses were coded into nine exclusive themes and ranked and, in descending order of frequency include the benefits of help-seeking, the idea that a person who is depressed is not able to think rationally, the fact that it can be hard to find someone who understands or will listen, wanting to talk to either someone who had been through the same thing or no-one, the idea that formal help is pursued only when informal help doesn't work out. Less frequent comments were that they would like to talk to someone they could trust, someone they didn't know and they also made reference to having a difficulty admitting to having a problem.

The following chapter will consider these results in relation to the current literature on adolescent mental health literacy and help-seeking behaviour.

# CHAPTER 5
# ANALYSIS AND DISCUSSION

## 5.1 Introduction

This study was conducted to examine the mental health literacy and help-seeking behaviour of Irish adolescents in relation to depression. This is of interest because of the under-recognition of the disorder and the associated morbidity and mortality. The main objectives of this study were achieved and will be considered now in the light of the literature in this area and the Irish context they were found in.

## 5.2 Limitations

Although the results of the study are interesting because this is an area which has not been looked at in Irish adolescents to date it would have been better to have included a greater number of schools especially in light of the low response rate. Unfortunately the time frame and the resources available to the researcher were such that it was not

possible to include more schools. As mentioned a limitation of this study is the low response rate, especially in the all boys school, which is substantially below the targeted sample. As consent forms were only given to students who were present on the day they were given out this could have had quite an impact on the participation rate. The response rate may be partly attributed to the fact that participation required active parental consent. Only those students who returned parent and student consent forms were allowed to participate, therefore it is not known whether a more inclusive sample might have yielded different results. Also Transition Year students spend significant periods of time away from school and this affected participation rates and one way to counteract this would be to conduct such a study early in the school year before they become involved in other activities. This age of students was chosen as there is an increase in depression in this cohort, particularly in girls, and also children over 16 in Ireland have, to date, attended adult mental health services and such services are not generally coordinated or integrated with the school system and as this is currently under review it was felt that it was better to focus on a group where it would be possible to make recommendations in relation to service planning and provision.

There was a particularly low rate of response in the all boys school and it is possible that boys who had better mental health literacy chose to participate.
Apart from the more practical reasons for a low response rate it is also possible that the study content held little appeal for many of the students and their parents. Thus the low response rate could be linked to a low level of interest and, or, knowledge in the area which in effect was subsequently borne out by the results which highlighted poor levels of mental health literacy.

Another limitation was that although the study targeted a cross section of schools this was only in quite a small urban geographical area. Also only those adolescents who are attending a mainstream school were included in this study. Lynch et al (2004) conducted their study on the prevalence of psychiatric disorders in children in the same geographical area, albeit with a younger group of children and so they did not require student consent. They included a letter of support from the school principal with their information sheet however three schools out a possible eleven were excluded from the study as they did not achieve a target of 50% returned parental

consent forms. As the response rate in my study was better in the schools where students were given more than one or two days to return the forms it would have been better in retrospect to allow for more time and perhaps to have given reminders to the boys and gone back a second day to the boys school.

A further limitation is that the study sample, of 120, consisted of boys and girls and was large enough to look at prevalence rates but was not large enough to look at statistically significant differences between the genders. Further research in this area should have sufficiently large sample sizes to look at boys and girls as separate samples.
In spite of the limitations it is felt that this study was worth doing as it is the first study to look at recognition of depression from this perspective and it points the way forward for further work in the area.

### 5.1b Literacy

There is always a concern regarding literacy with questionnaires, particularly with school students, however the readability level did not seem to be a problem for all but one or two of the respondents.

## 5.3 Key Findings Mental Health Literacy

### 5.3a Recognition of depression

This study would suggest that Irish adolescents ability to recognise depression is quite low, with only one third able to recognise depression in boys and slightly more than half able to recognise it in girls. The results show that both boys and girls were almost twice as well able to recognise depression in girls than in boys and that girls were better able to recognise depression in both a boy and a girl. In comparison with Burns and Rapee's (2006) study Irish male adolescent's ability to identify depression in a boy and a girl was very similar to Australian male adolescents (22.2% compared with 22.3% for recognition in boys and 53% compared with 58.3% for recognition in girls). While Irish girls were better able to recognise depression they were not as

literate as their Australian counterparts, (37.5% compared with 51.3% for recognition in boys and 61.3% compared with 81.3% for girls.)

Of interest is the result that 48% of boys and 40% of girls felt that the depressed boys main problem was his parents separation which is an indication of the seriousness with which both sexes view such an event and perhaps a reminder for those working with this age group that they are still as much children as they are young adults.

In light of the high suicide rate in young men it is deeply concerning that the group of Irish adolescents studied had such a low rate of mental health literacy in relation to depression in boys. The indications are that it could be much less recognised than in girls for this age group and this could ultimately lead to tragic consequences in light of the high mortality associated with suicide in young Irish males (Lynch et al, 2006)

Fifty six percent of students indicated that their class had been given a talk on mental health problems yet many males were still unable to recognise problems and this would support previous findings that school based programs need to focus on skill development as much as provision of information.

**5.3b Symptoms**

With respect to the symptoms identified by the adolescents one very pattern that emerged was that both sexes were very consistent in the symptoms they highlighted as being concerning for both depressed scenarios. This would suggest that boys and girls have the same information. Both sexes expressed greatest concern about the suicidal ideation expressed in the female depression scenario. Initially it was felt that this was perhaps what had led to an increased recognition of depression in the girl. However a comparison with the anorexic girl, Jenny, indicated that both boys and girls were just as likely to correctly label her condition. In Jenny's case her symptoms are actually not as debilitating as those of Dave, the depressed boy. This would suggest that both sexes might be more inclined to perceive that girls are more likely to suffer from these disorders. As the incidence of depression is supposed to increase in girls of this age it could be that they are more likely to have met depressed girls but these results could also suggest that it might be recognition rather than incidence that

increases in this age range. Suicide and eating disorders are more in the public eye and this may also have been a factor in the higher correct identification of girls. Further research reversing the sexes of the adolescents would perhaps shed greater light on these dynamics.

One finding that is worth mentioning in the Irish context is the adolescent's appraisal of the 15 year old who got drunk. Most participants made comments such as "there's nothing wrong with him" and virtually all the respondents found it quite "normal" for a 15 year old not only to drink alcohol but to get very drunk, even though it is illegal for people under 18 to drink. Their acceptance and dismissal of this scenario is not only a reflection of Irish cultural mores but is also of concern as Cotton et al (2006) study has shown that male adolescents are "significantly more likely than females to endorse alcohol as a way of dealing with depression".

## 5.4 Key Findings Help-Seeking

The results of this study are similar to results in other countries as it indicates that Irish adolescent's , similar to Australian adolescents in Rickwood, Deane, Wilson and Ciarrochi, (2005) study, are more likely to want to seek help from informal sources and they prefer to talk to their friends or family. Similarly Raviv et al (2000) found that adolescents will turn to friends first, then family and formal help will be their last resort. Although both boys and girls indicated that they felt that the depressed boy and girl needed some formal help, either school based or professional almost fifty percent of them indicated that they would want to talk to family and friends in a similar situation.

With respect to gender differences this study does not support their findings that boys are much less likely than girls to seek help for mental health problems. It is encouraging that boys report that they are equally as likely as girls to want to talk to friends and family members when they are experiencing emotional difficulties.

This study did not specifically ask about the adolescents help seeking intentions as many other studies have but rather asked them who they would like to talk to. Deane

Wilson and Ciarrochi (2001) found that many Australian young people indicated a preference for seeking help from “no-one” for personal-emotional and suicidal problems but neither male or female Irish adolescents chose this for the depressed girl scenario and only 7.5% chose it for the depressed boy scenario.

**5.4a Gender Trends**

An interesting trend was observed in that boys and girls had different ideas about where the other sex should go for help. For example 18% of boys felt that the depressed boy should get help from his family and friends and only 2.6% of girls agreed. 24% of girls felt that he should seek help from the school counsellor while only 8% of boys made this recommendation. This could suggest that girls perception of boys could be that they are less likely to receive emotional support from friends and family and more likely to seek it outside. Similarly 20% of boys felt that the depressed girl needed to obtain help from a professional whereas only 2.6% of girls made the same recommendation however the sample size was too small to really capture the significance of such differences.

**5.4b Referral route**

Although about half of the adolescents indicated that the depressed adolescents should seek either school based or professional formal help, they indicated their own preference would be to talk to their friends or family. This could reflect an acknowledgement that they are aware that such symptoms warrant professional help but in terms of their preference as to who they would talk to this would be their friends or family. This implied gap between knowledge and behaviour can perhaps be explained by considering the stage adolescents are at and by reflecting on the process they are likely to engage in when they are help-seeking. This could have a lot to with their age and ability to engage in such relationships with unfamiliar adults. It would seem that conversations with friends or family members might be considered as the first point on the referral pathway for adolescents. These first steps can either be facilitative of onward referral when necessary or it could be a barrier depending on the mental health literacy and attitudes of who they approach. Therefore it is so

critical that those who adolescents are talking to are sufficiently well informed to be in a position to determine what the situation warrants..

There is a concern that, if adolescents turn to people who do not have good mental health literacy themselves the opportunity for timely recognition and identification of depression could be missed. One girl noted “I have always found that advice from a friend or family member is always what they know you want to hear and far from being truly honest”. Often there may be problems which are beyond the scope of parents and friends to resolve. They might provide well intentioned but ill informed guidance and the young person could be reassured and yet not receive appropriate guidance and timely interventions. As Jorm et al (2006) note “how they respond may make a difference to whether the person gets professional help and feels supported by their social network. Such responses may be most critical for young people when they are first developing a disorder.”

From the results it can be argued that adolescents who are proficient at forming relationships will have a good social network and will be in a position to give and get plenty of support, especially from parents and friends. This is supported by findings such as those of Sheffield et al (2004) which demonstrated that greater social support predicted willingness to seek help from informal sources When working with adolescents it would appear that identifying the students social network and recognising the risk associated with a poorly developed network should be a crucial part of the assessment and intervention process.

Swenson and Rose (2003) looked at friends as reporters of children and adolescents’ depressive symptoms as they felt that friends are in the best position to observe symptoms in social contexts. The results of their study indicated significant relations between friend- and self-reports of depressive symptoms that were moderated by gender and positive friendship quality which would lend support to the argument that problems are more likely to be identified in those adolescents with a good social network.

## 5.5 Key Findings Nested Qualitative Study

For this part of the study the vast majority of students (86.7%) agreed with the statement that “It is easier to give advice to someone else than to look for help yourself”.

### 5.5a Outside Perspective

The most frequent theme they identified was the idea that it is easier to give advice because you have an outside perspective on the situation. This theme highlights the difficulty of recognising when you have a problem. A related theme that was identified, albeit less frequently and ranked fifth, was the idea that the affected person is not thinking logically or rationally and so is not in a position to realise that they need help. This theme would suggest that limited help-seeking behaviour may sometimes be less about stigma and embarrassment and not being seen as being emotionally resilient and more about the fact, as Cauce (2002) noted, that you need to know there’s a problem before you engage in help-seeking.

Burns and Rapees felt that a limitation in their study is that what people believe will help another person is not necessarily what they will do for themselves (Raviv, Sills, Raviv and Wilansky, 2000). However what appears to be emerging from this study is the concept that adolescents believe that when someone is experiencing emotional distress it affects their ability to think rationally and that an outside perspective is often needed. Therefore it is perhaps unreasonable to have an expectation that what we would do for ourselves and what we would suggest to other people should be the same.

Also while adolescents felt that an outside perspective is important others felt that the reverse of this was true, i.e. if they had not experienced the problem themselves they would be unable to advise someone else. Studies such as Rowley, Ganter and Fitzpatrick (2001) quoted by Lynch et al (2004) have shown that for depressive symptoms and suicidal thoughts the most reliable source of information is the young

person him/herself. Therefore the high rate of adolescents highlighting the difficulty of talking about a problem is of concern.

**5.5b Stigma**

Many of the other themes identified in the qualitative analysis highlighted quite specific difficulties such as feelings of shame embarrassment and shyness, finding it difficult to talk about having a problem, finding it hard to admit to having a problem and not wanting to be seen by others are having a problem. Jorm et al (2006) expressed some dismay at their findings that many people felt that it was better to deal with depression alone than to look for help. However the qualitative responses given by the participants in this study would suggest that this is more likely to be related to the difficulty they had in admitting that they needed help rather than because they felt that they did not need help.

These findings are similar to Sawyers and colleagues (2000) in their national survey of Australian adolescents where adolescents reported that being worried about what others might think was a major barrier to their seeking help for an emotional or behavioural problem. While the difficulties highlighted can be addressed in different ways they are all linked to the stigma associated with having a mental illness and much of the current work in improving mental health literacy is targeted at reducing this stigma.

The theme of not wanting to admit to having a problem also lends support to Miraudo and Pettigrew's (2002) suggestion that the need to maintain an idealised version of self represents a barrier to achieving mental health. Comments such as "When it's yourself you keep problems in because you don't want to look "gay"". ….. reflect this. These findings suggest that if adolescents are to look for help from others they need to be able to do in such a way that they can still maintain a positive self image and therefore initial responses to them will be crucial.

Tishby et al (2001) found that adolescents feel that their friends views are valid because they share similar experiences and the qualitative comments for the Kerry scenario would suggest that this is the case in a situation such as this where a boy is

breaking up with a girl. However peers opinions may be less valid when the experience is not a shared one and this is a concern for adolescents who are in need of more help than their friends can offer.

### 5.5c Previous help-seeking

When asked about previous help seeking, i.e whether they had ever suggested to someone else that they talk to someone about an emotional problem, or whether anyone had ever suggested to them that they talk to someone, there was no significant difference between boys and girls.

### 5.5d Further Findings Help Seeking

The following themes were identified from the qualitative comments participants added to their responses when they were asked who they would like to talk to if they were in the same situation as the person in the scenario.

The benefits of help-seeking was the theme that was identified most frequently. The type of responses highlighted mainly indicated that they would be listened to and they would get support and reassurance and "help to get through it". They also implied that talking to others would "cheer me up", "give me confidence". It is worth noting that very few of these responses recognise that more than reassurance or support might be needed and that professional intervention might be necessary. In fact only one girl addressed why it is better to talk than not, "I would talk to who I could, because it could be dangerous and emotionally damaging" (the situation). Rickwood et al (2005) noted that "a major barrier to seeking professional help is a negative attitude towards professional help-seeking" yet there was no evidence of this in the responses given in this study.

Another frequent theme that has not been discussed above was that it can be hard to find someone who understands, who will listen. As noted earlier only slightly over 50% of Irish students reported that they find their peers to be kind and helpful and to accept them as they are. (HBSC, 2002) This would suggest that there are a great number of students who feel that their friends may not be receptive to what they have to say when they need help. However it could be that they are simply not aware of

available formal help sources and so the lack of a negative attitude noted above might just be due to a lack of awareness of professional help.

The next most frequent theme was that you pursue formal help only if informal help doesn't work out. The idea that seeking professional help should only be a last resort is not new e.g. (Wilson, Deane and Ciarrochi, 2005) and they note that a difficulty is that the "ability to recognise when you have a problem and the judgment to assess accurately whether you have the personal coping resources to manage it alone or with help are complex skills" therefore there is a danger that an adolescent may wait too long before looking for help.

## 5.6 Conclusion

In summary the key findings of this study suggest that male and female Irish adolescents have similar levels of mental health literacy in relation to depression in their peers, with very poor recognition of male depression in both sexes. They are likely to differ slightly more in their choice of help providers, however they are similar to adolescents in other countries in that they are most likely to turn to informal help sources such as friends and family, then school based formal help sources and they are least likely to use the services of professional help providers.

# CHAPTER 6
# CONCLUSIONS

## 6.1 Introduction

The results of this study suggest that there is a definite need in Ireland to improve adolescent mental health literacy in depression, most particularly in relation to its occurrence in boys. As mentioned in the literature review the BC Partners for Mental Health and Addictions in Canada suggest that this should include the ability to recognize specific disorders, knowing how to seek information on mental health, knowledge of risk factors and causes, of self-care techniques, and of professional help available as well as attitudes that promote recognition and appropriate help seeking. As Miraudo and Pettigrew (2002) have noted "educating adolescents about mental health has the potential to increase the general acceptance of mental health issues as well as encourage the adoption of effective coping strategies among those adolescents experiencing mental health problems."

While this may fall largely within the remit of the health and education systems the broader societal context in Ireland also needs to be considered. Results of an NDA Survey on Public Attitudes to Disability completed in 2001 suggested that attitudes in Ireland to people with mental health difficulties are more uncomfortable than those relating to physical, sensory or learning difficulties and many of the students comments reflect this discomfort. For example they made statements such as "you don't want to be seen as needing help", "some people are ashamed and embarrassed about how they feel," and "you keep problems in because you don't want to look gay". It will not be enough just to target our adolescents. If adolescents are to be convinced that mental health problems such as depression are quite a common aspect of life that can be talked about openly and treated effectively society in general needs to be more knowledgeable about prevalence rates and effective treatments. Also if typical gatekeepers such as teachers and parents hold negative attitudes themselves towards help seeking they will be less likely to ensure that adolescents are directed towards appropriate help providers.

## 6.2 Recommendations for School Programs

School based programs need to emphasize psychological competence but also de-stigmatize help-seeking behaviour and facilitate accessibility to services. On the one hand we need to develop emotional resilience in our young people yet on the other we

need to increase recognition and identification in those youngsters who are in need of more support, i.e. those who are experiencing psychological distress to the extent that they require services. Otherwise there is a danger that if people aren't helped through a crisis they can develop far more severe difficulties. This is important from an educational as well as a health perspective as the presence of psychological distress or disorder is a significant barrier to learning. There should be an emphasis in school based programs on the availability and effectiveness of various sources of help.

As Rickwood et al (2004) note there is also a need to build the evidence base on the effectiveness of such interventions designed to promote mental health and prevent mental illness among young people. The Department of Health in the Australian Capital Territory has made funding of all health promotion programmes contingent on evaluation reports. Their evaluation of the MIE Mental Illness Education Program showed that the programme had a strong impact on increasing knowledge and a moderate impact on reducing stigma, but a weak impact on changing help seeking intentions. The Health Service Executive and the Department of Education and Science would be well advised to adopt this policy and to look to other countries for material that has already been evaluated on an adolescent population. In Australia for example “Mind Matters” have developed a series of booklets which is a mental health promotion resource for secondary schools which is recommended to be used as part of a comprehensive whole school approach to mental health promotion.

## 6.3 Recommendations for Health Policies

There should be an active commitment to linking education and mental health services. Educational initiatives and programs informing adolescents about the efficacy of treatment will only be effective if there are also clear referral pathways and easily accessed treatment facilities for adolescents. Lynch et al (2004) have highlighted the lack of services available therefore service development is a high priority. The policy document “ A Vision for Change” provides a blueprint for such services at a secondary care level, therefore an in initial step would be to provide the

funding necessary to implement the recommendations for children and adolescents mental health teams.

Services can also be developed and delivered at a primary care level. The Health Promoting Schools approach seems to provide an ideal context for promoting the mental health of adolescents in schools. This approach provides opportunities for primary health care professionals to become involved in delivering programs which can either be tailored to meet the identified needs of the young people in their area.

In "Guidelines for Health Professionals" the health promotion department of the former North Eastern Health Board outlines extensive research on what approaches are effective and what approaches are ineffective in Health Promotion in schools. They suggest that approaches which are reacting to crises and which rely on external resources are ineffective as they have limited teacher involvement, don't have whole school involvement and aren't coordinated. Effective interventions are holistic, comprehensive and age and stage appropriate. They have an issue based, problem solving approach which addresses skill development as well as provide information. The role of the mental health practitioners should be to support and complement that of the school staff. In Australia the Do It Together Kit is a booklet that promotes appropriate help-seeking in young people and is an outcome from a collaborative relationship between the Illiwara Institute for Mental Health, the Student Representative Council and the school welfare staff.

## 6.4 Recommendations for Peers

According to Wilson and Deane (2001) the delivery of school based preventative programs can address help seeking behaviours, highlight its benefits, provide knowledge and resources on help providers and skill up students in positive help seeking behaviours. However given that this study indicates that many adolescents are likely to turn to friends when they need help it would also suggest that such programs need to help adolescents consider themselves in the role of both providers and receivers of help and to focus on the skill development needed for an adolescent help provider. Wilson and Deane (2001) also suggested that "consideration should be

given to training peers to present and coordinate help-seeking education programs." There is evidence that such peer support schemes are significantly more effective when they are part of a whole school approach to mental health.

Ideally therefore school based programs should address mental help problems from both the perspective of improving adolescents emotional resilience and coping skills and also promoting effective help-seeking behaviour on their own behalf and on behalf of their friends and siblings who need this help. Wilson et al (2004) argue that "programs should convey messages suggesting that part of being independent and self directed is knowing the times and circumstances to seek appropriate help and support."

## 6.5 Recommendations for parents

Many of the respondents in this study indicated that they recognise that the person in the scenario should talk to more than one person however for themselves they are likely to talk to either friends or family. As recognition of adolescent depression can be improved by ensuring information from more than one source is considered parents, teachers and peers need to be aware that if an adolescent is presenting with difficulties the information should be cross checked with others, so if a teacher is noticing a fall off in marks and concentration they could be asking parents for example about changes in interests or in sleeping and eating habits. Such a process might usually only be formally considered at an assessment stage when a child is referred for formal help but there is a concern that many adolescents experiencing depression are missed at the point where less intrusive interventions might be sufficient to address their difficulties. In order for parents to be as effective as possible in relation to this it is critical that they are included in school programs. At home also parents need to be available to their children when they approach them and to be sufficiently well informed themselves to know when additional help is needed and where they can access such help.

At a broader level there needs to be a collaboration across all agencies, with schools fostering a better relationship with parents and other professionals in turn building on

existing links between parents and schools. In tandem with school programs there should be an increase in the emphasis on primary care which is readily accessible for teenagers and their parents and which can provide immediate intervention.

## 6.6 Recommendations for Further Research

Although this study did not focus on barriers to help-seeking several were highlighted in the qualitative piece of this study. Benefits of help seeking were also identified however this tended to be social support and reassurance and there was no mention of any benefits associated with professional help or treatment. It is possible that Irish adolescent's tendency not to choose to talk to formal professional help sources could be linked to a lack of knowledge of the usefulness and availability of help from such sources. This could be an area that warrants further investigation as well as Irish adolescents and their parents attitudes to psychological treatments and interventions.

One area that would be particularly useful for further research is looking at the mental health literacy of parents of Irish teenagers. Generally speaking because of the developmental stage they are at young people can't access help by themselves. They may not have the necessary practical or emotional resources and so they continue to be dependent on their parents. However unless parents are well informed they could act as a barrier towards their adolescent children obtaining professional support when it is needed.

There also needs to be further research into gender differences and greater efforts to establish the views of Irish adolescent boys to ensure that service provision and interventions can be better tailored to meet the needs of this group. This study looked at where adolescents were most likely to look for help however they were not asked anything about their knowledge of existing services or types of treatment and this would a be useful area for further research.

## 6.7 Conclusion

There needs to be far more attention paid to the problems of adolescent depression in Ireland at all levels and it must become a priority for targeted improvements in recognition and treatment. The mortality associated with suicide in young males is higher than that of the numbers killed in road traffic accident yet only a fraction of public funding is aimed at addressing the problem. Given the high rate of reoccurrence of depression in adults for those who have experienced depression in adolescence, especially before the age of fifteen, this should have long term health benefits for the nation as habits formed in adolescence tend to carry on into adult life. Adolescence is a prime time to effect attitudinal change and encourage good problem solving and coping strategies and to lower the risk of our young people developing depression which could persist into adulthood with the associated social, vocational and personal costs associated with it. It is felt that this study highlights the usefulness of improving adolescents mental health literacy and help-seeking behaviours in achieving these aims.

# CHAPTER 7
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# Appendices

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**A Study of Irish Adolescents Mental Health Literacy and Help-Seeking**

## Appendix 1

## Letter to Principal

Dear Mr/Ms----------

Subsequent to our phone conversation I am writing to request your permission for your students to participate in a study which is aimed at looking at Irish teenager's mental health literacy and help-seeking.. Mental health literacy refers to a person's knowledge and beliefs about mental illnesses which assists in their recognition, treatment or prevention.

This is of interest to me as up to one in five people will experience a mental illness at some stage in their lives and there are signs that depression and suicide are on the increase in teenagers. However often people are not able to talk about their difficulties or to look for help for themselves or others. It is hoped that by finding out more about our teenagers knowledge and beliefs and to identify where they are most likely to look for help that we can make recommendations for improving early detection and support for those students who are experiencing difficulties.

This is important not just to alleviate their mental suffering but also because there is evidence to suggest that there is an increased likelihood of below average academic performance in students with an identified mental health problem.

As part of the study I will be asking the students to complete a confidential questionnaire during class time with the others members of their class. I would suggest that other written work will be assigned to those students who chose not to participate in the study.

I am a registered educational and clinical psychologist, working as a principal psychologist with the HSE and I am currently undertaking an MSc in Child Health. This study is in partial fulfilment of the requirements for completing the Masters program. I plan to share my results with the schools involved and anyone else who expresses an interest in my findings.

If you have any questions or concerns about this study before you give your permission I can be reached at 087-6120085.

Thank you,

_____

Valerie Moffatt, B.A. (Hons) M.A. Reg Psychol AFPsSI

Registered Educational and Clinical Psychologist

**Principal Psychologist, Health Service Executive**

**UCD School of Public Health and Population Science**

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**A Study of Irish Adolescents Mental Health Literacy and Help-Seeking**

# Appendix 2

# Parent Consent Form

**Dear Parent/Guardian**

I am writing to request your permission for your son/daughter to participate in a study which is aimed at looking at adolescent's mental health literacy and help-seeking. Mental health literacy refers to a person's knowledge and beliefs about mental health problems which help their recognition, management or prevention.

This is of interest to me as a psychologist as up to one in five people will experience psychological problems at some stage in their lives. However often people are not able to talk about their difficulties or to look for help for themselves or others. It is

hoped that by finding out more about our teenagers knowledge and beliefs and to identify where they are most likely to look for help that we can make recommendations for improving early detection and support for those students who are experiencing difficulties.

## *What does this involve?*

I will be asking your son/daughter to complete a questionnaire during class time along with other members of the class. If you wish your son or daughter to take part, you are asked to read this document, sign the consent form at the bottom.

## *Does my son or daughter have to take part?*

No. Participation is completely voluntary, and anonymous. Other work will be assigned to those students who are not participating in the study.

**What will happen to his or her answers?**

Your child's answers will be typed into a computer by the researcher. The paper questionnaires will be held in secure storage in the School of Public Health and Population Science in UCD for 1 year and then destroyed. The data will be analysed by Valerie Moffatt, and will be held on a secure computer in UCD. No identifying information will be recorded. Nothing which could identify any individual will ever

be published. The questionnaires and the data from them will not be available to your child's teachers or school principal.

I plan to share my results with the schools involved and hopefully to publish a paper that will make recommendations for people working in schools and in the health system who are in regular contact with teenagers.

## *Who is doing this?*

My name is Valerie Moffatt and I am a registered educational and clinical psychologist working as a principal psychologist with the HSE in Dublin North Central and I am currently undertaking an MSc in Child Health This study is in partial fulfilment of the requirements for completing the Masters program.

## *Where can I find out more?*

If you would like more information about this study I can be reached at 846-7334

Yours sincerely,

_____

Valerie Moffatt, B.A. Hons, M.A. Reg Psychol AFPsSI
Principal Psychologist, Manager, Health Service Executive

---

I/We give consent for our son/daughter to take part in the above study.

Mother's Signature _____

Father's Signature _____

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**A Study of Irish Adolescents Mental Health Literacy and Help-Seeking**

# Appendix 3
# Consent Form Student

**Dear Student**

I am writing to request your permission for you to participate in a study which is aimed at looking at adolescent's mental health literacy and help-seeking.

Mental health literacy refers to a person's knowledge and beliefs about psychological problems which help their recognition, management or prevention.

## *What does this involve?*

I will be asking you to complete a questionnaire during class time along with other members of the class. If you wish to take part, you are asked to read this document and sign the consent form at the bottom.

## *Do I have to take part?*

No. Participation is completely voluntary, and anonymous. Other work will be assigned to any students who are not participating in the study.

**What will happen to my answers?**

Your answers will be typed into a computer by the researcher. The paper questionnaires will be held in secure storage in the School of Public Health and Population Science in UCD for 1 year and then destroyed. The data will be analysed by Valerie Moffatt, and will be held on a secure computer in UCD. No identifying information will be recorded. Nothing which could identify any individual will ever be published. The questionnaires and the data from them will not be available to your teachers or school principal. I plan to share my results with the schools involved and hopefully publish a paper that will make recommendations for people working in schools and in the health system who are in regular contact with teenagers.

## *Who is doing this?*

My name is Valerie Moffatt and I am a registered educational and clinical psychologist working as a principal psychologist with the HSE in Dublin North Central and I am currently undertaking an MSc in Child Health. This study is in partial fulfilment of the requirements for completing the Masters program. If you would like more information about this study I can be reached at 846-7334

Yours sincerely,

_____

Valerie Moffatt, B.A. Hons, M.A. Reg Psychol AFPsSI
Principal Psychologist, Manager, Health Service Executive

I have read the information about the study, I understand the purpose of the study, and I give consent to take part in the study.

Student's Signature _____

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Appendix 4

# Questionnaire

This questionnaire is part of a study which is aimed at finding out what teenagers know about mental health problems and where they would look for help if they, or a friend, needed it. Your answers are completely anonymous. (Please put a tick in the boxes beside your answers.)

Are you male? [ ] female ? [ ]

What age are you now?_____

Do you live with one parent? [ ] both parents? [ ]

What level of school did your parents complete? Please put a tick beside one option

| | Mother | Father |
|---|---|---|
| Primary School | [ ] | [ ] |
| Junior Cert | [ ] | [ ] |
| Leaving Cert | [ ] | [ ] |
| College/Trade | [ ] | [ ] |
| University | [ ] | [ ] |

This questionnaire contains a brief description of five young people. Your job is to read each description and then decide whether this person has a serious problem, and if so, what they should do about it. There are no right or wrong answers- we just want to get some different points of view about what different people would think or do.

## Scenario 1Kerry

Kerry is in 5th year. She is a good student, a member of the school hockey team, and hopes to work as a travel agent when she leaves secondary school. She has had a couple of boyfriends over the past two years. Four days ago, Conor, her boyfriend of 8 months, dumped her. He told Kerry that he had met another girl who he wanted to be with now. She has been a total wreck for the past three days, she is crying all the time and can't concentrate at school. She keeps asking her friends “What is wrong with me that Conor doesn't love me any more?” She says that she doesn't think that she can ever go out with another boy again. She is especially upset because she and Conor had been planning to go to her Debs and now she won't have anyone to go with.

## Questions Scenario 1 (Kerry)

If Kerry was your friend, how worried would you be about her overall emotional well-being? (Again please put a tick in the boxes beside your answers.)

Not be at all worried [ ] A little bit worried [ ]

Quite worried [ ] Extremely worried [ ]

Which parts of Kerry's story are the **strongest hints** to you that she might be experiencing emotional difficulties? (Please quote the words from the scenario that are the strongest hints.)_____

_____

How would you describe what, if anything, is the matter with Kerry?_____

_____

How long do you think it will take Kerry to feel better again?

1-2 days [ ] 1-2 weeks [ ]

1-2 months [ ] Longer than a few months. [ ]

Do you think Kerry needs help from another person to cope with her problems?

No [ ] Don't know [ ] Yes [ ]

If yes, who do you think she needs help from?

Mother [ ] Father [ ] Sister [ ] Brother [ ]

Friend [ ] Teacher [ ] Doctor [ ] Counselor [ ]

Psychologist [ ] Help-line [ ]

Now imagine that instead of Kerry, the situation applied to you. Who would you want to talk to? _____

_____

## Scenario 2: Dave

Dave is in third year. His parents recently separated after an extended period of fighting. Dave's year head called a meeting with his mother to discuss his school progress. Over the past nine months Dave's marks have been getting worse and he was often late coming into school. Dave explained that he had been feeling constantly tired lately, and was finding it difficult to get to sleep at night-that was why he was not able to get out of bed in the mornings. His mother said that she thought he just wasn't eating enough-in fact, she thought that he had lost quite a bit of weight over the last few months. In relation to his marks, Dave said that although he wanted to do well, he just could not concentrate or think as well as before and he didn't seem to be able to do anything right. The year head said that he thought it would be good for Dave to start playing on the school soccer team again, as he had always enjoyed it so much. Dave said that he had no energy and anyway he just wasn't interested in soccer or anything too much lately.

### Questions Scenario 2 (Dave)

If Dave was your friend, how worried would you be about his overall emotional well-being? (Again please put a tick in the boxes beside your answers.)

Not be at all worried [ ] A little bit worried [ ]

Quite worried [ ] Extremely worried [ ]

Which parts of Dave's story are the **strongest hints** to you that he might be experiencing emotional difficulties? (Please quote the words from the scenario that are the strongest hints.)_____

_____

How would you describe what, if anything, is the matter with Dave?_____

_____

How long do you think it will take Dave to feel better again?

1-2 days [ ] 1-2 weeks [ ]

1-2 months [ ] Longer than a few months. [ ]

Do you think Dave needs help from another person to cope with his problems?

No [ ] Don't know [ ] Yes [ ]

If yes, who do you think he needs help from?

Mother [ ] Father [ ] Sister [ ] Brother [ ]

Friend [ ] Teacher [ ] Doctor [ ] Counselor [ ]

Psychologist [ ] Help-line [ ]

Now imagine that instead of Dave, the situation applied to you. Who would you want to talk to? _____

_____

## Scenario 3 Steve

Steve is in third year. He lives with his mother and younger sister. Sometimes he fights with his sister about family matters such as what show they will watch on TV or whose turn it is to do the dishes. On Saturday night Steve went to a 15th birthday party for his friend Chris. Chris's parents had gone away for the weekend and he used it as an opportunity to have a party. Steve is not used to drinking much alcohol. However he joined in a "drinking game" with Chris and his other mates. Steve ended up very drunk and puking over the carpet at Chris's house. When he arrived home later that night, his mother smelled alcohol on his breath, and questioned him about

whether he had been drinking at the party. At first he said that someone had spilt a drink on him, but later confessed that he had been drinking.

## Questions Scenario 3 (Steve)

**If Steve were your friend, how worried would you be about his overall emotional well-being? (Again please put a tick in the boxes beside your answers.)**

Not be at all worried [ ] A little bit worried [ ]

Quite worried [ ] Extremely worried [ ]

Which parts of Steve's story are the **strongest hints** to you that he might be experiencing emotional difficulties? (Please quote the words from the scenario that are the strongest hints.)_____

_____

How would you describe what, if anything, is the matter with Steve?_____

_____

How long do you think it will take Steve to feel better again?

1-2 days [ ] 1-2 weeks [ ]

1-2 months [ ] Longer than a few months. [ ]

Do you think Steve needs help from another person to cope with his problems?

No [ ] Don't know [ ] Yes [ ]

If yes, who do you think he needs help from?

Mother [ ] Father [ ] Sister [ ] Brother [ ]

Friend [ ] Teacher [ ] Doctor [ ] Counselor [ ]

Psychologist [ ] Help-line [ ]

Now imagine that instead of Steve, the situation applied to you. Who would you want to talk to?_____

_____

# Scenario 4 Aisling

Aisling is in 6th year. She and her friend, Nicky, have been planning to go away together for a week after the Leaving Cert to Crete with a group of other boys and girls from their local area. Aisling and Nicky have been planning this trip since Aisling's older sister did her Leaving two years ago and went to Ionappa. Lately, Nicky has noticed that Aisling hadn't been so excited about the trip-in fact, she had noticed that over the past month, or maybe longer, Aisling hadn't been interested in anything very much, had lost her usual spark and energy, and often seemed to be sad and tearful. To make things worse, Aisling had forgotten to call the travel agent when she was supposed to, to confirm their tickets, and had cost them both an extra 50 Euro. Aisling was very apologetic to Nicky, but nothing Nicky said seemed to cheer her up. Aisling just kept saying that she was "a loser" and "good for nothing" and that "she might just as well be dead because no-one would care if she wasn't here".

## Questions Scenario 4 (Aisling)

**If Aisling was your friend, how worried would you be about her overall emotional well-being? (Again please put a tick in the boxes beside your answers.)**

Not be at all worried [ ] A little bit worried [ ]

Quite worried [ ] Extremely worried [ ]

Which parts of Aisling's story are the **strongest hints** to you that she might be experiencing emotional difficulties? (Please quote the words from the scenario that are the strongest hints.)_____

_____How would you describe what, if anything, is the matter with Aisling?_____

_____

How long do you think it will take Aisling to feel better again?

1-2 days [ ] 1-2 weeks [ ]

1-2 months [ ] Longer than a few months. [ ]

Do you think Aisling's needs help from another person to cope with her problems?

No [ ] Don't know [ ] Yes [ ]

If yes, who do you think she needs help from?

Mother [ ] Father [ ] Sister [ ] Brother [ ]

Friend [ ] Teacher [ ] Doctor [ ] Counselor [ ]

Psychologist [ ] Help-line [ ]

Now imagine that instead of Aisling, the situation applied to you. Who would you want to talk to? _____

_____

## Scenario 5 Jenny

Jenny and Gemma have been friends for over 3 years and they usually meet for lunch at school. This term Jenny has been doing a lot of exercise and says that she is on a diet although she has never been overweight. She keeps saying that she is fat and needs to lose weight. Gemma doesn't know what to say about this as Jenny always wears baggy clothes and it is hard for her to comment. Recently she has noticed that Jenny is not bothering to eat her lunch except maybe some popcorn or a piece of fruit. When Gemma asks her about this she usually says that she had a big breakfast or that she is saving herself for her favourite dinner. Jenny talks about food quite a bit and often offers to cook for her friends when they call over but she just pushes her own food around the plate.

### Questions: Scenario 5 (Jenny)

**If Jenny was your friend, how worried would you be about her overall emotional well-being? (Again please put a tick in the boxes beside your answers.)**

Not be at all worried [ ] A little bit worried [ ]

Quite worried [ ] Extremely worried [ ]

Which parts of Jenny's story are the **strongest hints** to you that she might be experiencing emotional difficulties? (Please quote the words from the scenario that are the strongest hints.)_____

_____

How would you describe what, if anything, is the matter with Jenny?_____

_____

How long do you think it will take Jenny to feel better again?

1-2 days [ ] 1-2 weeks [ ]

1-2 months [ ] Longer than a few months. [ ]

Do you think Jenny needs help from another person to cope with her problems?

No [ ] Don't know [ ] Yes [ ]

If yes, who do you think she needs help from?

Mother [ ] Father [ ] Sister [ ] Brother [ ]

Friend [ ] Teacher [ ] Doctor [ ] Counselor [ ]
Psychologist [ ] Help-line [ ]

Now imagine that instead of Jenny, the situation applied to you. Who would you want to talk to? _____
_____

## General Questions

In the past have you ever suggested to one of your friends that they needed to talk to someone about an emotional problem?
If yes, who did you recommend?_____
_____

Do you think it is easier to give advice to someone else than to look for help yourself?
Yes [ ] No [ ]
Can you give a reason for your answer?_____
_____
_____

Has anyone ever suggested to you that you should talk to someone about an emotional problem? Yes [ ] No [ ]
If yes, who did they recommend? _____
_____

Have you ever had anyone come in to your class to talk to you about mental health issues? Yes [ ] No [ ]
If yes, was this: A professional [ ] A community group [ ] A member of a religious community [ ] Other [ ]
Please mention briefly the one that applies to your class._____
_____

---

**Thank you for your time in completing this survey.**