An Exploration of Adolescent Boys' Perceptions of Mental Health and Awareness of School-Based Support Systems

A thesis submitted in partial fulfilment of the requirements of the University of East London for the degree of Professional Doctorate in Educational and Child Psychology

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Abstract

Historically, there has been a disparity in the ways in which mental health are viewed by males and females, and also in how society has directed and determined the appropriateness and acceptability for these groups to express difficulties with mental health, and to seek support. Males have typically been encouraged to hide their feelings and emotions and to adopt a stoic stance, whilst females have been encouraged to express their feelings and difficulties, and to seek support when needed. This research explored adolescent, cisgender boys', aged between 11 to 16 years, perceptions and understanding of, and attitudes to mental health, as well as their awareness of support systems available to them, and was conducted from a social constructionist perspective. The views of five cisgender, adolescent males were elicited using semi-structured interviews, conducted virtually. Themes were identified using Thematic Analysis with a deductive perspective. Participants constructed a range of meanings of the term *"mental health"*, together with varying levels of awareness of support available to them. Differences in how girls and boys perceive and share ideas linked to mental health were identified, with participants uniformly reporting that they felt it is easier for girls to express feelings and mental health difficulties, and to seek help. Participants identified three main sources of support: school, the internet and friends and families. Relationships were deemed important in relation to the seeking of mental health support and also to maintaining positive mental health, and participants felt, generally, that schools were providing adequate mental health support. The internet was thought to be both a positive and negative force in relation to mental health and related support. Participants also found helpful the perceived distance that speaking to others via a screen affords. Although participants felt many traditionally held, gender-based stereotypes linked to mental health still exist, they neither agreed with nor subscribed to them.

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Student Declaration

University of East London

School of Psychology

Doctorate in Educational and Child Psychology

Declaration:

I declare that whilst registered as a degree student at UEL, I have not been a registered or enrolled student for another award of this university or of any other academic or professional institution.

I declare that no material contained within the thesis has been used in any other submission for an academic award.

I declare that my research required ethical approval from the University Ethics Committee (SREC) and that confirmation of approval is embedded within the thesis.

Luca Turi

Signature: 

Date: 19th September 2022

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Table of Abbreviations

Term	Abbreviation
American Psychological Association	APA
Children and Young People	CYP
Department for Children and Family Services	DCFS
Department for Education and Skills	DFES
Department of Health	DH
Educational Psychology/Psychologist	EP
Emotional Wellbeing	EWB
Further Education	FE
Personal, Social and Health Education	PSHE
Preferred Reporting Items for Systematic Reviews and Meta-Analyses	PRISMA
Special Educational Needs Co-ordinator	SENCo
Special Educational Needs and Disabilities	SEND
United Kingdom	UK
University of East London	UEL
World Health Organisation	WHO

1. Introduction

1.1. Chapter Overview

The chapter begins with explanations, and definitions of terms and concepts, which are central to the current research. Links between these concepts and the research are outlined. The researcher then discusses the national and local contexts in which the research was undertaken, with a focus being on how the understanding of mental health and associated support has developed over time. Theoretical and conceptual underpinnings of the research are discussed, in relation to participants' perceptions of mental health and awareness of available sources of support for mental health. Finally, the researcher outlines their position, and gives a rationale for and aims of the current research.

1.2. Defining Terms and Concepts

1.2.1. Mental Health

For the purpose of this research, the term, *"mental health"* will have the following definition:

"a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community," (World Health Organisation (WHO), 2022, p21).

This mental state exists within all individuals and also exists on a continuum. It is subject to change throughout our lives, with individuals experiencing both positive mental health and mental health difficulties at different points in their lives.

The researcher is aware of how historically, language and terminology linked to mental health has often served to increase stigma linked to it and to express discrimination and prejudice linked to mental health. The researcher has used the terms, *"positive mental health"* and *"mental health difficulties"* within this research, to refer to varying states of mental health, other than when directly quoting or referring to research which has used other terms.

1.2.2. Adolescence

Adolescence, historically, has proved a nebulous concept to define in absolute terms. In the broadest sense, adolescence refers to the period marking the transition from childhood to adulthood. This typically spans the period between 12 to 18 years of age, which roughly corresponds to the time from pubertal onset (i.e., specific hormonal changes) to guardian independence, i.e., the legal definition of *"adulthood"* in many countries. Adolescence frequently co-occurs with puberty, a biological phenomenon defined, in part, changes driven by physiological events such as increases in adrenal and gonadal hormones, including the development of secondary sex characteristics and modulations in muscle and fat.

Adolescence is often associated with a period of increased risk-taking behaviours as well as increased emotional reactivity. This is typically coincident with changes in the social and school environment, such as spending less time with parents and more with peers, as well as an increase in autonomy. These behavioural changes occur in the context of developmental changes that are influenced by both external environmental and internal factors that elicit and reinforce behaviours. Adolescence is temporally confined but not fixed and so should be conceptualized as a developmental period rather than a temporal snapshot, as it is highly variable culturally, behaviourally, and developmentally.

Recent work by researchers such as Jaworska, N. & MacQueen, G.,(2015), has expanded the definition and timeframe of adolescence to include young adulthood, often up to about 25 years of age. While this encompasses some of the neurological changes that occur beyond 18 years of age, it creates challenges in the clinical approaches to adolescents and the policies that guide them. It also exacerbates the challenges of both studying and treating young people throughout this time, as the brains, behavioural profiles and social demands and roles of a typically developing 12-year-old and those of a 24-year-old are strikingly different. The expanded definition of adolescence is, however, consistent with both a biological and sociological phenomenon known as the prolongation of

adolescence. This definition encompasses earlier pubertal onset, particularly in girls. Similarly, in terms of the social and personal responsibility associated with adult roles, adolescence has extended into the early 20s, with more individuals delaying traditional adult responsibilities (e.g., starting a family, full-time employment or buying property) in contemporary societies.

Steinberg, (2014), defines adolescence as;

"Adolescence" is a dynamically evolving theoretical construct informed through physiologic, psychosocial, temporal, and cultural lenses. This critical developmental period is conventionally understood as the years between the onset of puberty and the establishment of social independence" (Steinberg, 2014).

The most commonly used chronologic definition of adolescence spans the ages between 10-18 but may incorporate a span of nine to 26 years, depending on the source (American Psychological Association (APA), 2002). Inconsistencies in the inclusion criteria and definition of "adolescence" can create confusion in the construction of adolescent focused research. Although regard for developmental variability is important when discussing adolescence, there is an equal necessity for conceptual clarity. For the purpose of clarity within the current research, the term *"adolescence"* refers to chronological ages between 11 and 16 years of age.

1.2.3. Gender

In many ways similar to adolescence, defining gender is both nebulous and complex. Hegarty, (2001), suggests that the quantitative researcher should address this definition from a performative perspective in order to de-construct the gender concept. In this way, gender is a non-essential category which instead is used in a way which is based on societal norms. As the division of gender *is 'culturally and historically specific, internally contradictory, and amenable to change'* (Hegarty, Ansara & Barker, 2018, p. 59), quantitative research could support constructive arguments, (Hegarty & Pratto, 2004).

The construction of gender as binary is performed in, for example, social sciences when it is treated as a binary category (Morgenroth & Ryan, 2018). Such construction is enacted each time a researcher formulates an item in a survey or questionnaire where gender is assessed as a dichotomous variable with only two (mutually exclusive) response options, because the notion of gender as binary is thereby maintained. Instead, researchers such as Lindqvist, A., Sendén, M. G.& Renström, E. A., (2020), have suggested regarding gender as consisting of several aspects, which can be divided into the four main facets of: (a) physiological/bodily aspects (sex); (b) gender identity or self-defined gender; (c) legal gender; and (d) social gender in terms of norm-related behaviours and gender expressions (the American Psychological Association refers to this aspect as 'sex role'; APA, 2015). These aspects may change over a lifetime, due to external impact, such as from society. Other researchers have focused on how these aspects affect each other (Moerman & Van Mens-verhulst, 2004).

In addition to these facets, the umbrella term *"transgender"* , Thanem (2011), refers to individuals whose assigned gender at birth does not correspond to their self-defined gender identity. Transgender individuals can identify within, outside or beyond the traditional dichotomy of woman/man. In comparison, cisgender refers to individuals whose assigned gender at birth corresponds to their self-defined gender identity (Caverly & Johns, 2014).

Cisgenderism refers to the idea that it is possible to visually see the gender identity or infer bodily characteristics of an individual based on their appearance (Ansara & Hegarty, 2013, 2014). Such assumptions imply a discriminatory ideology which devalues individuals' own self-designated gender, because of the assumption that appearance and bodily characteristics are linked to gender identity (Ansara & Hegarty, 2014). Cisgenderism is also related to the performance of a binary gender system with two discrete genders that are biologically determined. The term *"cisnormativity"* promotes the idea that sex and gender are aligned and includes the underlying assumption that all women have bodily attributes associated with a female sex, such as a vagina, while all men are presumed to have bodily

attributes associated with a male sex, such as a penis (Geist, Reynolds& Gaytán, 2017). In the case of the current research, and in line with its social constructionist elements, the researcher focused on how the participants themselves chose to define their gender identity,

As is apparent from the aforementioned research. gender is conceptualised in many ways and is subject to changes according to time and place. Gender and sex are separate, distinct concepts. The term, *"sex"* refers primarily to biological aspects of male and femaleness, whilst *"gender"* encompasses psychological, social, and behavioural aspects of male and femaleness (APA, 2013). For the purposes of this research, the researcher recruited cisgender males, i.e., individuals who identified with the gender they were assigned at birth and the terms "male" and "boy" refer to cisgender males. Similarly, the terms "girl" and "female" refer to cisgender females.

1.3. Understanding Mental Health and Support Linked to Schools and Learning

Perceptions of, and attitudes towards mental health have changed considerably throughout history. Learoyd-Smith (2010), provides an account, beginning in Medieval times, when behavioural abnormalities were considered to be part of a divine plan, and stigma attached to mental health was unknown. However, with the Reformation came a splitting of Christianity, and a subsequent need for scapegoats (Fink & Tasman, 1992). From then, individuals displaying behaviours outside what was considered the norm were thought to be possessed by demonic spirits, and so began the relationship between stigma and mental illness (Mora, 2006), which will be explored further within this research.

In more recent times, estimates of mental health difficulties amongst children and young people (CYP) aged 11-16 years in the United Kingdom (UK) are, according to Green 2004, 13% for boys, and 10% for girls, although difficulties with recognition and diagnosis have led to higher estimates of 20%, according to Macdonald (2000).

A report conducted by Green, McGinnity, Meltzer, Ford& Goodman (2005) showed that 10% of 5-16-year-olds in the UK had diagnosable mental health conditions, and that 12% of 11-16-year-olds had been diagnosed with a mental illness, the most frequent being conduct and emotional disorders. This was broken down in a review of the mental health of CYP in the UK by Green et al (2005), which suggested that 10% of 5-16-year-olds have a diagnosable mental health condition, of which 4% are considered to be emotional disorders such as anxiety or depression. Of these, 54% were girls.

A report from the Department of Health (DH), (2011), titled *No Health without Mental Health,* estimated that 40% of CYP with mental health difficulties are not receiving support, and further suggests that similar numbers of CYP experience less severe forms of mental health difficulties, for which they would benefit from support. Furthermore, the report states that lifelong mental health illnesses are present by the age of 14, with this rising to 75% by the age of 18, and so the importance of early identification and intervention is highlighted.

A report by the WHO suggested that mental health needs in adolescents, as compared to adults, are less likely to be recognised, and may therefore go untreated (Stengard & Appelqvist-Schmidlechner, 2010). The Mental Health Foundation (MHF) claims that up to one in five CYP in the UK experience some form of psychological difficulty (MHF, 1999).

"Young Minds," a UK based charity supporting children and young people's mental health and wellbeing, provides the following statistics:

- One in six children aged five to 16 were identified as having a probable mental health problem in July 2021, a huge increase from one in nine in 2017, equating to five children in every classroom.
- The number of Accident and Emergency attendances by young people aged 18 or under with a recorded diagnosis of a psychiatric condition more than tripled between 2010 and 2018-19.

- 83% of young people with mental health needs agreed that the coronavirus pandemic had made their mental health worse.
- In 2018-19, 24% of 17-year-olds reported having self-harmed in the previous year, and seven per cent reported having self-harmed with suicidal intent at some point in their lives. 16% reported high levels of psychological distress.
- Suicide was the leading cause of death for males and females aged between five to 34 in 2019.
- Nearly half of 17-19-year-olds with a diagnosable mental health disorder has self-harmed or attempted suicide at some point, rising to 52.7% for young women.

(Young Minds Mental Health Charity For Children And Young People, 2022)

Mental health difficulties in childhood can be detrimental to later life chances, and quality of life in adulthood and can increase difficulties with employment and relationships. As well as directly affecting later mental health, it can also lead to increased incidents of criminal behaviour and social isolation (Richards, Abbot, Collis, Hackett, Hotopf, Kuh, Jones, Maughan & Parsonage, 2009). In the UK, the Department of Health ((DH) (2011b), estimates the wider economic cost of unmet mental health needs across all government departments to be £105.2 billion, annually.

Recent UK legislation such as the green paper, *Transforming Children and Young People's Mental Health Provision: A Green Paper* (2017), has helped to bring mental health to the forefront of the public face of the government's agenda. The paper states that the government wants every school to have a "designated lead in mental health." Responsibilities included within this role would include:

- Overseeing the support that the school gives to students with mental health difficulties
- Helping staff to identify pupils who show signs of mental health difficulties

- Offering advice to staff about mental health
- Referring pupils to specialist services if needed

As well as this, designated leads will be offered training to develop their skills in leading mental health work, and funds will be given over to developing training and building on the skills of designated leads. Views will be sought on how children should learn about mental health in schools.

This builds on previous legislation such as the Special Educational Needs and Disabilities (SEND) Code of Practice, 2014, which, amongst other objectives, aimed to put CYP and their families at the centre of support, and to shift the emphasis from processes being done to them, to a more collaborative process in which they were invested, thereby promoting, and increasing autonomy. In a recent briefing paper, published on the 21st of July 2020, by the government, it is stated that:

"By promoting good mental health and intervening early, particularly in the crucial childhood and teenage years, we can help to prevent mental illness from developing and mitigate its effects when it does" (Parkin & Long, 2020).

According to the World Health Organisation (WHO), Emotional Wellbeing (EWB) is a precursor of mental wellbeing or positive mental health (WHO Europe, 2005). EWB can incorporate problem-solving skills, self-awareness, emotional self-management, and resilience to distressing life events (Stallard, Simpson, Anderson & Goddard, 2008). EWB can therefore be regarded as a protective factor against long-term mental health difficulties. According to Burns & Hickie (2002), EWB can also be viewed as a valid focus for interventions, and also as a building block for good long-term mental health. Mykletun, Knudsen & Mathieson (2009) report that the mental health difficulties of 20-40% of adolescents with symptoms of anxiety and/or depression will continue into adulthood.

All of this makes clear the importance of early recognition of mental health difficulties in children and young people (CYP) and the importance of ensuring that they are aware of and able to access the support they need at any given time.

1.4. Local Context

In the local authority in which this research was conducted, CYP's mental health was supported by the Behaviour and Attendance Service (ESBAS), along with the Educational Psychology Service (EPS). The researcher noted the omission of terms relating specifically to mental health within the former service's title, with a focus centred more on behaviour and attendance. A possible implication of this is that CYP and families who are seeking mental health support but are not familiar with the service setup of the authority might not recognise this as being the service they need to access. Since leaving the authority, the researcher has also noted that said authority now has a Mental Health Support Team, dedicated as its name suggests to supporting mental health and wellbeing in CYP.

1.5. Theoretical and Conceptual Considerations

Social Learning Theory was developed by Bandura (1971) and posits the idea that children's real-life experiences either directly or indirectly shape their behaviours. Learning through observation is a central tenet of this theory, to which Bandura added four mediational processes, one of which is paying attention. The learner needs to pay attention if behaviours are to be learned. If he or she is distracted, it will probably affect the quality of learning. Being focused on the task at hand becomes the first step in retaining the information and acquiring the knowledge to learn the behaviour. For this to occur, the behaviour that we are trying to imitate has to attract and maintain our attention, so that no external factors become distractions. This implies that the behaviour has to be of some interest to the learner, in order for them to notice and focus on it. This research explored which behaviours amongst peers, in real life and online, caught the participant's attention and influenced their behaviours, in particular with reference to their perceptions of and how

they talked about mental health. Retention concerns how much of an observed behaviour a learner has remembered, in order to reproduce that behaviour. Reproduction enables learners who have observed, paid attention to and remembered the behaviour/task to be able to perform the task themselves. Finally, learners need to be motivated to learn and reproduce behaviours, and to see that to do so will be favourable to them. Another concept that comes from the social learning theory and which also becomes key in the learning of the students is self-efficacy. The concept, which basically means the belief in one's abilities, is highly regarded by Bandura, who says:

"In order to succeed, people need a sense of self-efficacy, to struggle together with resilience to meet the inevitable obstacles and inequities of life" (Bandura, 1971).

There is research to show strong links between positive psychological, self-efficacy and perceptions of sources of support and which states: *"Perceived availability of social support is a better predictor of well-being than is actual support given,"* (Wethington & Kessler, 1986).

Social constructionism, developed by Berger & Luckmann (1966), sees the world and what we know about it as having been produced via language, representation, and other processes. Our understanding of the world is seen as being linked to socio-political, cultural, and historical contexts, with assigned meanings being viewed as social artefacts, resulting from social interactions. This was of relevance to this research due to the importance assigned to language in generating meanings, and also with reference to social interactions. The researcher was particularly interested in how young males relate to others in person and online, and whether or not the context and quality of these interactions affects their perception of the quality of the interaction.

Eco-systemic theory, developed by Bronfenbrenner (1974), focused on the systems around the child, and how these affect the child's development. This research explored how interactions between participants and the systems within and around them affected and

shaped their perceptions of mental health, their ideas of maleness and their awareness of available support. Systems focused on ranged from the micro, for example systems within the participants, to the macro, such as the internet which is on a global scale. Chronosystems i.e., changes over time were also touched upon.

One of the researcher's aims with this research was to identify factors which would help to increase awareness of support with mental health, thereby helping to contribute to young people's psychological and emotional wellbeing.

1.6. Reflexive Statement

When undertaking research, it is important for the researcher to recognise how their own background, experiences, values, and beliefs shape their generation and interpretation of findings and also for them to position themselves to acknowledge this and facilitate reflexivity, thereby minimising researcher bias (Creswell & Creswell, 2017). The researcher acknowledges that his personal experiences and preconceptions will have influenced the current research and so offers an account of said experiences, which he believes to be relevant to the research, in this section, which will be written in first person.

Prior to commencing the doctoral training, I worked in primary schools, for 17 years, in a variety of roles, two of which were Personal, Social and Health Education (PSHE) co-ordinator and school counselling co-ordinator. As PSHE co-ordinator, I oversaw the introduction of Social and Emotional Aspects of Learning (SEAL) into a school's PSHE curriculum, whilst as the counselling co-ordinator, I was responsible for, amongst other things, managing referrals to the counsellor. Other than SEAL being taught as part of the PSHE curriculum, I observed a paucity of support and advice within the school, for mental health. Conversations with colleagues working in secondary schools implied that this was even more true as children progressed through the education system. I also observed that the majority of children seen by the counsellor were female and that referrals for boys were rare. I therefore sought to investigate whether the profile of mental health support had been

raised in schools, and also if boys were aware of and accessing mental health support sources.

As a class teacher and manager, I was aware that behaviour policies were often founded on simplified behaviourist principles, with punishment and reward systems at their centre. Little attention seemed to be paid to possible underlying causes of what was often deemed to be, "*challenging behaviours"*, even when the behaviour policies and systems in place proved to be ineffectual. During the doctoral training, my interest in social, emotional, and mental health aspects linked to learning deepened, and I therefore wished also to investigate schools' current stance on links between mental health and learning.

On a personal level, whilst attending school in the 1970s and 80s, I had first-hand experience of support with mental health within education, some helpful, some not, and this was also a driver for my professional curiosity about this element of learning. In addition, experiences of people close to me, with regard to mental health issues not being recognised and supported early, and the later, sometimes tragic consequences of this, further fuelled my interest in this field.

1.7. Research Rationale and Aims

There is evidence which suggests that boys and young men have negative connotations linked to mental health, and view talking about their mental health or telling others they are experiencing mental health difficulties as somehow diminishing their masculinity. Linked to this is the idea that boys and young men are far less likely to seek help regarding their mental health than their female counterparts (Seamark & Gabriel, 2016). In addition, research also indicates that young men are less inclined to seek help for mental health difficulties than young women (Rickwood, Deane & Wilson, 2007), and that this unmet treatment need is believed to be linked to young men having higher rates of antisocial behaviour, substance misuse difficulties and completed suicides than women of the same age (Slade, Johnstone, Oakley, Browne, Andrews & Whiteford, 2009). All of this has the

potential to lead to scenarios in which adult men experience mental health difficulties and associated social and economic disadvantages. In line with the overarching exploratory title of the research regarding adolescent boys' perceptions of mental health, awareness of available support and the implicit question of whether or not they are willing to seek help with mental health, the aim of this research is therefore to explore if these perceptions of and attitudes towards mental health still exist among adolescent boys, and also to explore factors which might encourage this demographic to find and seek support with regard to mental health.

1.8. Chapter Summary

This chapter has provided an explanation of key terms and concepts linked to the current research, in particular the terms *"adolescence"* and *"gender"*, both important concepts in relation to this research. The development of understanding how mental health and associated support has also been explored, as have the local and national contexts within which this has occurred. Key conceptual and theoretical underpinnings of the research have been outlined. Finally, the researcher has given his position and rationale for conducting the research.

2. Literature Review

2.1. Chapter Overview

The focus of this research was adolescent boys' perceptions of mental health and their knowledge and awareness of school-based and other support systems for mental health. The chapter begins with an explanation of the method of the search, including exclusion and inclusion criteria, databases used, and search terms. Themes identified during the literature search are discussed, as are gaps within the literature.

2.2. Rationale for the Literature Search

The literature search focused on research related to CYP in secondary schools, and also further education (FE) colleges, with the focus being on exploring adolescent boys' perceptions of mental health, their concepts of male identity and possible links between these and help-seeking behaviours as represented in the existing literature. For the purpose of this research, help-seeking behaviour can be defined as the process of being able to translate one's own personal, internal psychological distress to the interpersonal realm of seeking support, i.e., communicating distress to others, with the aim of receiving support (Rickwood, Deane & Wilson, 2005).

A narrative-based, mapping review, based on research questions was conducted, following an initial scoping review of the research carried out with this population, with a focus on both the population's understanding of mental health, and consequent behaviours, in terms of help seeking. In addition, papers mentioned within selected pieces of research were found, used, and cited, in a "snowballing" manner.

Studies including both girls and boys were included for comparative purposes, in that how boys cast their identity in relation to girls was a common and pronounced theme of the research in this area. Studies focusing exclusively on girls were excluded.

2.3. Selection of Literature

It was important to maintain relevance and consistency, and to ensure that articles pertained to boys, their perceptions of and attitudes towards mental health, and also their knowledge of support available linked to this.

Despite methodological differences, the commonality which connects the studies included was that children's views were sought, recorded, and were central to the findings, in line with the social-constructionist perspective of the research.

2.3.1. Inclusion and Exclusion Criteria

For literature to be included in this review, it had to be:

- Carried out within the past 20 years, to reflect current legislation and practice
- Appear within peer reviewed journals
- Have full text available
- Encompass the age range of 11-16 years
- Be pertinent to adolescent boys, mental health, school-based support systems and/or help seeking behaviours

Literature excluded from the review was:

- Conducted outside of the past 20 years
- Of no relevance to adolescence, boys, mental health, school-based support systems or help seeking behaviours
- Inclusive of girls exclusively
- Not inclusive of children's views

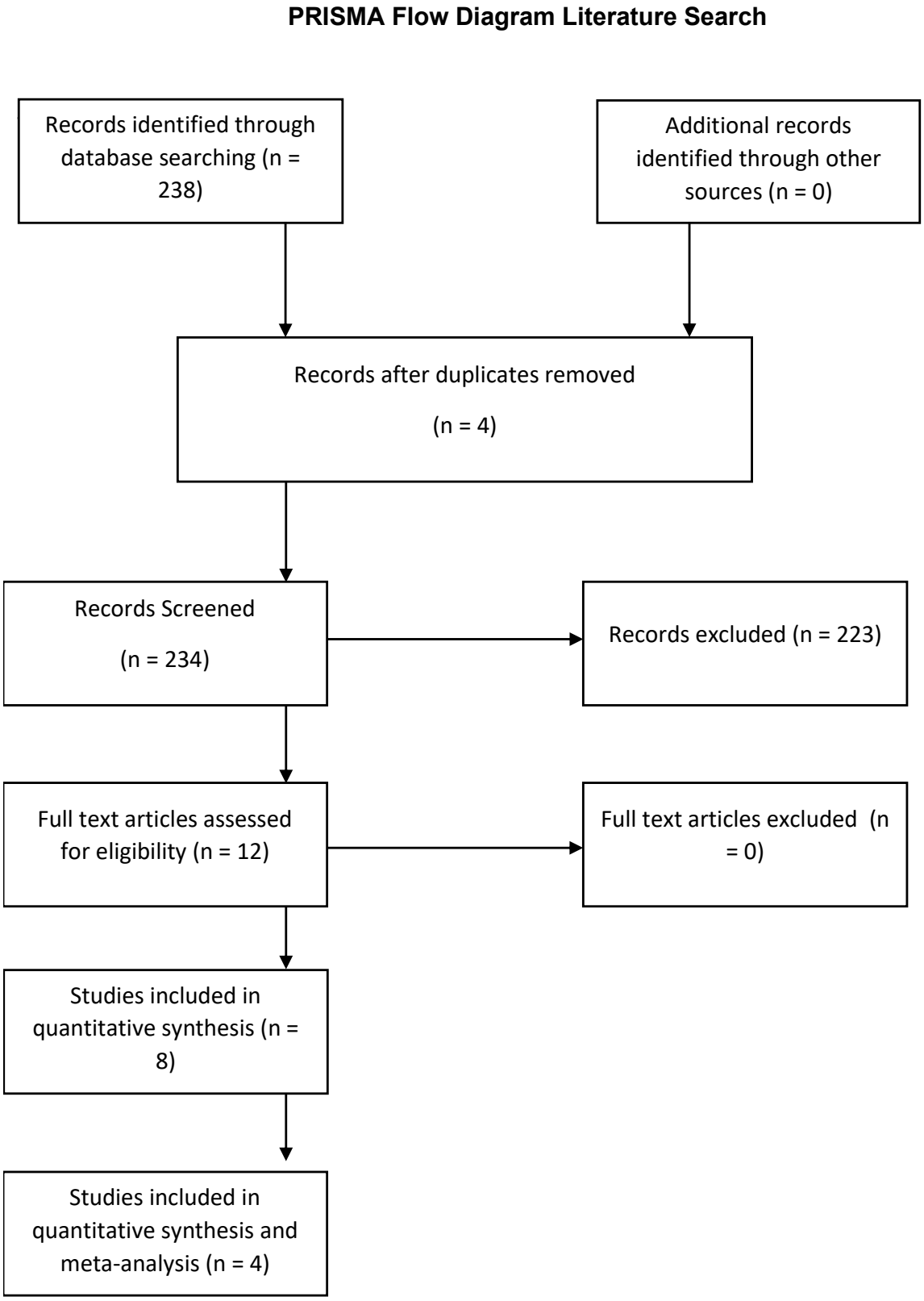
2.3.2. Database Search Details

The initial search was conducted on the 25th of September 2020, using the EBSCO Database, and included articles from: Academic Search Complete, British Education Index, Child Development and Adolescent Studies, Education Research Complete, ERIC, APA

PsycArticles, and APA PsycInfo. The following search terms were included within the search: *boy, male, masculinity, adolescence, mental health, support systems, help-seeking, well-being, and school.* Using Boolean Operators, simple words such as and, or, not or and not, as conjunctions between aforementioned terms, together with brackets, designed to combine or exclude keywords in a search, and resulting in more focused results, the following Boolean phrase was generated:

(boy or male* or masculinity AND mental health OR support systems OR help-seeking OR 'help-seeking' OR well-being or 'well-being' AND school) NOT (female or women or woman or females) AND (united kingdom or uk or Britain)*

Figure 2.1.


PRISMA Flow Diagram Literature Search
Records identified through database searching (n = 238)
Additional records identified through other sources (n = 0)
Records after duplicates removed (n = 4)
Records Screened (n = 234)
Records excluded (n = 223)
Full text articles assessed for eligibility (n = 12)
Full text articles excluded (n = 0)
Studies included in quantitative synthesis (n = 8)
Studies included in quantitative synthesis and meta-analysis (n = 4)

The search yielded 238 articles, which were screened for relevance. The researcher was seeking to ensure that the articles pertained to adolescent boys, their perceptions of mental health, and their knowledge of available support systems. After screening, and when duplicates had been removed, eleven studies were selected according to the above criteria. In addition, one thesis was referred to.

During the reading of the literature, initial themes were assigned by the researcher, which are detailed below. The connectedness between the themes meant that several of them fell within each category.

2.4. Reviewed Literature

Of the twelve studies selected, eight were qualitative. Prior (2012), conducted semi-structured interviews with eight CYP, six female and two male and the results were analysed using thematic analysis. Prior was looking specifically at CYP's involvement with school counselling and so the study may be seen to be relevant to the current research. The key recommendation of the study was a proposed multi-staged socially mediated process of disclosure and engagement, which ranged from initial acknowledgement of a problem to full disclosure of the problem. Prior's analysis of CYP's process of engagement highlighted a number of factors, including negotiation and evaluation by the CYP, management of stigmatisation, and the positioning of the counsellor.

In a study by Hanley, Sefi & Lennie (2011), nine 13-15-year-olds completed self-report questionnaires at four intervals. Their results showed a small improvement in well-being of the small sample, whilst awaiting and attending therapy.

Kendal, Keeley & Callery (2014) interviewed 23 students and 27 staff, in three UK high schools, and found that although students viewed help-seeking behaviour as a sign of weakness, they also valued learning skills in managing their feelings and friendships.

Tharaldsen, K., Stallard, P., Cuijpers, P., Bru, E.& Bjaastad, J. (2016) interviewed eight adolescents in a school in Norway. The sample consisted of six girls and two boys.

Qualitative content analysis indicated that all of the participants had limited knowledge of available resources, and that stigma related factors prevented them from seeking help linked to mental health.

Clark, Hudson, Dunstan & Clark (2018) used semi-structured interviews to elicit the views of 29 adolescent males in Australia and analysed the results using content analysis. Through this, they identified the themes of risk, effort, and the need for human connection, in relation to adolescent boys' perceptions of discussing mental health difficulties with others. Their work focused closely on the use of computerised systems of support and suggested that this format was a practical way to remove many of the barriers described by their sample.

Jobe & Gorin (2013) interviewed 24 CYP aged between 11 and 17 years and found that the quality of therapeutic relationships was central to the CYP, when seeking and receiving support for mental health.

Seamark & Gabriel (2016) sought the views of six college students through the use of semi-structured interviews, the transcripts of which were analysed using discourse analysis. Their results suggested that gender roles, awareness and perceptions of help, social and cultural expectations and norms and the risk of stigma and rejection represented significant barriers to help-seeking behaviours for adolescent boys and young men.

Chaturvedi (2016) conducted interviews with six young homeless men, regarding their experiences of mental health support. Their findings indicated that barriers to CYP seeking counselling were identified as stigma, participant's denial about needing help, past negative experiences of support and lack of familiarity with available help.

Oliffe, J. L., Rice, S., Kelly, M. T., Ogrodniczuk, J. S., Broom, A., Robertson, S. & Black, N. (2019) conducted a mixed-methods study, comprised of a qualitative lead to derive health-related masculine values regarding health, and a follow up quantitative survey to test the items. Initially, they sampled and interviewed 30 male participants, and combined their

responses with those of 600 survey respondents. From the results, they identified five key masculine values: selflessness, openness, well-being, strength, and autonomy. Their findings were discussed in terms of how these values might advance masculinities-focused health research.

Odimegwu, C., Pallikadavath, S. & Adedini, S. (2013) collected data from adolescent and adult men, aged between 15 and 75 years. They used both quantitative methods (surveys, *n*1372) and focus-group discussion (*n*20). Their results indicated that there were social and health costs associated to adherence to masculine ideologies, and a strong negative association between masculine ideologies and health-seeking and what were deemed by participants to be risk behaviours.

Fox & Butler (2007) surveyed 415 CYP from five secondary schools and found that although most of these were aware of available counselling services, 21% were not. For many who were aware, their knowledge of the services was limited. For boys in particular, the fact that the counsellor was a stranger was an inhibiting factor. Issues of lack of confidence regarding the confidentiality of the services was also cited as an inhibitory factor to help-seeking behaviours.

Learoyd-Smith (2010) studied literature pertaining to the mental well-being of children in schools in the UK and found that the organisational structure at the whole school level impacts on micro-interactions at the classroom level and that these interactions result in variations in expectations of behaviour and also the emphasis placed on the well-being of CYP by schools at a systemic, organisational level.

2.5. Identifying Themes

During the literature review, a number of themes relating to the overarching research question, and related sub-questions were identified by the researcher. This was achieved as a result of the scoping literature review and also through a process of *"snowballing."* This resulted in the following discursive approach being used as opposed to a systemic review.

2.6. Theme One: Contributors to Perceptions of Mental Health

2.6.1. Stigma Linked to Formation of Perceptions of Mental Health

Stigma may be defined as a mark or sign of disgrace, bringing negative attitudes to its bearer (Thornicroft, Rose, Kassam & Sartorius, 2007). Encompassed within the umbrella term *"stigma"* are knowledge, attitudes, and behaviour (Thornicroft et al,2007).

Stigma is a major contributor the formation of negative perceptions of mental health, and can, in theory be divided into three domains: cognitive (e.g., knowledge and beliefs), affective (e.g., negative affects), and behavioural (e.g., avoidance) (Byrne, 2000). Stigma in relation to mental healthcare describes a social-cognitive process which encourages people to avoid the label "mental illness" and is a major reason why many people who need this kind of healthcare do not seek it (Corrigan, 2004).

One behavioural element of stigma, discrimination, may be defined as *"rejection of, and negative behaviour towards people with mental health difficulties"* (Lasalvia, Zoppei, Van Bortel, Bonetto, Cristofalo, Wahlbeck & Bacle, 2013). Consequences of such discrimination may include social marginalisation (Lasalvia et al, 2013).

Anticipated stigma can have similar effects to behavioural stigma, for example, research shows that depressed individuals who are concerned about stigma may adapt their behaviour to avoid discrimination, and so develop a negative circle between anticipated stigma and the effect of the stigma at a behavioural level (Lasalvia et al, 2013). This is likely to prevent early identification of mental health difficulties and early help.

Public stigma, sometimes termed, *"perceived stigma"* (Moses, 2010) such as prejudice, can deprive those labelled as *"mentally ill"* of finding employment, obtaining insurance, and finding suitable housing, thus being labelled *"mentally ill"* by the public brings harm to those so labelled (Corrigan, 2004). Further to this, public stigma influences self-stigma, as those diagnosed with a psychiatric disorder tend to internalise stigmatising ideas, and this in turn is likely to have detrimental effects on their quality of life (Corrigan, 2004).

Further studies have shown that diagnosed youth who experience stigma within one domain, will additionally experience it within other domains, for example from friends, family members and school staff (Moses, 2010). Concealing difficulties due to experienced stigma can generate further difficulties, e.g., loss of social support networks and anticipatory anxiety (Crocker & Garcia, 2006).

Stigma associated with mental illness is a significant barrier to effective care (Barney, Griffiths, Jorm & Christensen, 2006). This applies in particular to younger adolescents with mental health difficulties (Chandra & Minkovitz, 2007). Studies indicate that adolescents who in some way endorse or adhere to the stigma attached to mental illness are less likely to obtain the care and support they need (Heflinger & Hinshaw, 2010). However, perceptions linked to the success of a particular treatment mediate the link between stigma and treatment, as perceptions of stigma are less important when adolescents believe the treatment is going to work (Penn, Judge, Jamieson, Garczynski, Hennessy & Romer, 2012).

Universal programmes to support mental health have been found to reduce stigma, but at the expense of smaller, more personalised systems, and in favour of support with greater impersonality (Offord, Chmura-Kraemer, Kazdin, Jensen & Harrington,1998). Less fear of stigma is crucial to help-seeking (Skre, Friborg, Breivik, Johnsen, Arnesen & Wang, 2013).

Vogel, Wade & Hackler, (2007), found that the more stigmatised a person felt, the less likely they were to seek support for mental health, and that perceptions of public stigma directly influence personal stigma. Using surveys, they measured the likelihood of seeking counselling, amongst 676 American college students, in relation to perceived self and public stigma and found that self-stigma had a strong negative relationship to the likelihood of seeking help, i.e., the more a person disapproved of themselves, the less likely they were to seek help. Their research also suggested that perceptions of public stigma influenced self-stigma and so, in turn, also influenced help-seeking behaviour. This was supported by

Harper, Lemos & Hosek (2014) who found that perceived risk of stigma negatively influenced the willingness to disclose, within a sample of college students, their HIV status.

Their findings were developed by Seamark & Gabriel (2016), who presented stigma in terms of the different groups or individuals who could judge help seekers, such as friends, and was construed as an omnipresent risk throughout all stages of help-seeking, suggesting that people's self-identity is at risk of attack and rejection, with help-seeking behaviour being viewed as weak and/or incompetent.

2.6.2. Gender Identity and its Role in the Formation of Perceptions of Mental Health

Central to the current research is the concept of gender, as defined in Chapter One, and its role in the development of perceptions of mental health.

Research on older adolescents suggests that perceived stigma is closely associated with being male (Anderrson, Bjorngaard, Kaspersen, Wang, Skre & Dahl, 2010). Yousaf, Popat & Hunter (2014) found that the more males subscribed to traditional male gender roles, the less favourable were their attitudes towards help-seeking behaviour. However, the study also found that as the ages of the participants increased, their attitudes towards help-seeking *"improved"*.

Young men have also been found to have lower levels of mental health literacy than their female counterparts (Ciarrochi, Wilson, Deane & Rickwood, 2003).

Leong & Zacchar (1999), found that out of a sample of 290 American college students, males, compared to females, had a more negative view of psychological difficulties and were less likely to seek support, due in part to the fear of being judged to be struggling with mental illness. By comparison, females were more accepting of mental illness, and so perceived less risk in seeking help (Leong et al, 1999).

2.7. Theme Two: Knowledge of Existing Support Systems

In order for help-seeking behaviour to occur, knowledge and awareness of support available is necessary. According to Best (1998), since the introduction of the National Curriculum in 1998, consideration of mental health issues has always been secondary to academic progress and attainment. Many believe that this set of priorities and subsequent failure, on the parts of successive governments, to consider CYP's emotional development, has led directly to a fall in CYP's emotional wellbeing (Layard & Dunn, 2009).

The introduction of initiatives such as Social and Emotional Aspects of Learning (SEAL) (Depart for Education and Skills (DfES) 2005, 2007), aimed to address this apparent pastoral/academic dichotomy. However, it has been reported that the use of therapeutic language within schools has caused individuals to be viewed, and also to view themselves as "mentally flawed" (Ecclestone & Hayes, 2008).

Despite this, the promotion of CYP's mental health within schools has, ostensibly, been a priority of the UK government for the past 20 years. An example of this may be found within the most recent Special Educational and Needs (SEND) Code of Practice (Department for Education [DFE], 2014b), which replaced *"behaviour"* with *"mental health"* as an educational need. This builds upon the work of the previous Labour government's *Every Child Matters* agenda, which aimed to outline the outcomes necessary for positive wellbeing outcomes for CYP (Department for Education and Skills [DfES], 2003). This work was concurrent with two reports from the United Nations' Children's Fund (UNICEF), in 2007 and 2013, which placed the UK at the bottom of a list of 21 developed countries, in terms of child wellbeing. However, it should be noted that the more recent 2013 report showed an improvement in that the UK was placed 16th out of 29 developed countries. Both reports highlighted a paucity of provision linked to these needs, and also some of the potential social and clinical implications mentioned above.

Increased awareness of difficulties faced by many adolescents led to government initiatives, for example, a previous minister for children, Margaret Hodge, set up "think tanks", and also for charities such as the National Society for the Prevention of Cruelty to

Children (NSPCC) to call for all children to have access to counselling. Partly as a result of this, therapeutic services for CYP have been developed within community settings, such as schools (Hanley & Morrison, 2003).

Linked initiatives came from the Department of Health (DH) and included the *No Health without Mental Health* initiative (Department for Health (DH), 2011a), and the associated 2012 *Implementation Framework*. This was followed by the *Closing the Gap* initiative (DH, 2014), which sought to identify priorities essential to change in mental health. These initiatives have, to a degree, developed policy designed to promote access to services, and timely interventions. This is in line with a general focus of the DfE in recent years, which has been to proactively and preventatively address CYP's mental health needs through early identification and intervention.

Within school initiatives designed to support the mental health and wellbeing of CYP have also included Social and Emotional Aspects of Learning (SEAL), which was introduced by the Department for Schools and Families (DCSF) in 2005, and sought to:

"provide a comprehensive whole school approach to promoting the social and emotional skills that underpin effective learning and positive behaviour" (p.1).

This was followed by the *Targeted Mental Health in Schools* (TaMHS) programme (DCSF, 2008), which sought to significantly change the delivery of mental health support to 5-13- year-olds, through within school interventions.

More recent advice came in the form of *Behaviour in Schools*, (DfE, 2014a), which aimed to

"*help schools promote mental health in their pupils and identify and address those with less severe difficulties at an earlier stage and build their resilience"* (p. T4).

It is interesting to note that the government here reverted to including mental health difficulties under the umbrella term of *"behaviour"*.

In European countries such as Norway, local mental healthcare services, such as nurses and counsellors, are available to adolescents, who may also receive support from more specialist services, such as Educational and Psychological Counselling Services. However, despite this, few receive appropriate help and work by, for example, Heflinger & Hinshaw (2010) suggests that this is not the case throughout the world.

There has been a significant expansion in counselling provision within UK secondary schools (Cooper, 2009). Despite this, school counselling remains under-researched, as does CYP's experiences of engaging with said services (Freake, Barley & Kent, 2007). Indeed, there is a significant gap in research on adolescent mental health, and also the number who meet clinical criteria for receiving help, and the number who actually do receive support (Andrews, Issakadis & Carter, 2001). In a comprehensive review, Cooper (2009) found that the majority of research on school counselling in the UK is linked to audit and evaluation, and this is complemented by government-commissioned research which focuses on policy and service development (Pattison, Rowland, Richards, Cromarty, Jenkins & Polat (2009). The fact that this research is commissioned by the government raises questions of bias.

2.8. Theme Three: Barriers to Help Seeking Behaviours

2.8.1. Gender

Research suggests that boys and men are less likely to seek support for mental health issues than women and girls, linked to their perceived concepts of mental health in relation to their concepts of maleness (Rickwood, Deane & Wilson, 2007, Rickwood, Deane & Wilson, 2007). This unmet treatment need is believed to be linked to young men having higher rates of antisocial behaviour, substance misuse difficulties and completed suicides than women of the same age (Slade, Johnstone, Oakley, Browne, Andrews & Whiteford, 2009). Further research suggests that only limited progress has been made in reducing the reluctance of adolescent males to seek and use mental health support for common mental health difficulties such as anxiety disorders (Reavley, Cvetkovski, Jorm & Lubman, 2010).

Literature also suggests that male and female adolescents utilise mental health support systems in different ways. Martinez-Hernaez, DiGiacomo, Carcellar-Maicas, Corea-Urquiza & Martorell-Poveda (2014) found that, in their research, male respondents were more likely to seek help from their friends, in an attempt to forget about mental distress, a behaviour associated with normalising symptoms of depression. Female respondents on the other hand, tended to regard their social networks as a resource for talking things through or problematising the distress.

Mackenzie, Gekoski & Knox (2006) also found that gender was a significant factor in determining attitudes towards help-seeking, although with slightly different results. In a survey of 206 adults, they found that women were more likely to access support. However, unlike the study conducted by Yousaf et al, their male participants did not show the same change in attitudes towards getting help, and women were found to be more likely to access support as they got older.

Further research suggests that women tend to access informal support, e.g., from friends, at all stages of distress, but that neither men nor women will access more formal help until their distress is perceived by them to be at least “moderate”. This in turn suggests that men will cope by themselves for longer, without accessing any form of support (Ansara & Hindin, 2010).

Addis & Mahalik (2003) explored the social construction of masculinity, and its relevance to males and help-seeking behaviour. They identified several factors which may impact on males’ willingness to seek help: whether the problem is considered by them to be “normal”, how it reflects on their masculine identity, the perception that the risk of stigma and rejection outweighs the benefits of getting support, a perceived loss of power and the attitudes held of males whom they respect. They concluded that although attitudes towards masculinity vary between individuals, they are heavily influenced by social factors, and that a mismatch between support offered and traditional male roles exists. They further suggested

that for male help-seeking behaviours to change, this mismatch would need to be addressed.

Seamark & Gabriel (2016) also examined the impact of gender roles on help-seeking. Within their research emerged the theme of gender roles. The impact of these roles on help-seeking suggested that there is a level of acceptance and desensitisation towards women being able to express themselves and seek help, as compared to men. Participants within their study tended to use gender stereotypes to assign accommodating, supportive roles to women, whereas men were viewed as breaking their masculine roles by expressing emotion or seeking help. Their research developed findings from previous studies, such as Ansara & Hindin's (2010), which also found that participant's perceived gender roles acted as a barrier to help-seeking, especially for males. In this instance, men were perceived as *"strong"* and able to cope alone, without resorting to any external support which was viewed as compromising their masculine roles, suggesting that help-seeking in males undermines their masculine identity.

To date, few studies have investigated attitudes towards a computerised mental health program designed specifically for young men. Ellis, McCabe, Davenport, Burns, Rahilly, Nicholas & Hickie (2015) recruited a sample of 15 young men who participated in a one-on-one user testing of the program and were then interviewed about the experience. The participants were found to be drawn towards websites which included video and music content and games, suggesting that computerised treatment programs aimed at young men should be more action oriented rather than information or talk based.

In a study by Clark et al (2018), many adolescents articulated views associated with social norms of masculinity. Help-seeking behaviour was categorised as *"weak"* or *"not macho,"* and perceived to leave young males open to stigma.

Within the realm of masculinity and men's health research, two foundational factors have been identified. Firstly, is western men's reduced life expectancy compared to

women's, which has, according to Goldenberg (2014) been an ever-present factor focusing the research on gender. Secondly, men's adherence to masculine norms and ideals have been linked to risking and/or promoting men's health (MacDonald, 2016).

Social constructionist frameworks have incorporated a range of qualitative methodologies to identify and chronicle patterns between masculinities and men's health behaviours (Gough, 2007). Within this context, the focus has often been on the hierarchical nature of masculinities, at the centre of which is the concept of hegemonic masculinity, i.e., men's alignment with masculine ideals have been understood to regulate a range of responses, from risk taking to promoting self-health (Brom & Tovey, 2009). More broad work linked to socialisation and masculinity has taken a quantitative approach (Thompson & Bennett, 2015).

Despite an apparent reticence in terms of help-seeking behaviour for mental health support, men do regularly seek health information from online sources (Lohan, Aventin, Oliffe, Han & Bottorff, 2015). The anonymity of computerised support is believed to reduce barriers to help-seeking, such as concerns over confidentiality (Gulliver, Griffiths & Christensen, 2010). Preliminary reports indicate that computerised mental health support has the potential to support many young men (Griffiths & Christensen, 2006).

2.8.2. Adolescence

Marcell & Halpen-Felscher (2007) reported that a willingness to seek help and also the type of help sought would depend on the problem, and also the perceived severity. Adolescents were found to be more likely to seek formal support for physical matters, and informal support for psychological issues. Further to this, Barker (2007) reported that the greater the level of distress, for example, suicidal ideation, the less likely adolescents are to seek help, suggesting that the people who are in the most need of support are also the ones least likely to seek it.

2.8.3. Social and Cultural Factors

Myrie & Gannon (2013) found, when surveying nine black, American males that males perceived asking for help as an affront to their masculinity, and also that support systems were discriminatory towards them.

Seamark & Gabriel (2016) identified the theme of *social and cultural factors,* which included family, friends, nationality, the media, and social-networking, all of which held the potential to both positively and negatively influence individuals' help-seeking behaviours. They suggested that informal help carries less risk and appears safer and more acceptable, which supports the findings of Oliver, Pearson, Coe & Gunnel, (2005). The results also suggest that although in decline, there exists within modern Britain the enduring idea that we should cope as individuals and maintain our *"stiff upper lip."* They concluded that given British people's cultural stereotype of stoical resilience, some may perceive a risk of negative societal judgement linked to help-seeking, which in turn may fuel feelings of self-stigma. This is in sharp contrast to the work of Hislop (2012).

Hislop (2012) described a weakening of the British "stiff upper lip" and used this to describe the results of the British Future Poll (Salkfield, 2013), which found that 51% of British people viewed this British stereotype as outdated, although 38% viewed it as continuing to be applicable. This does represent a shift in attitude, which was partially accredited to technology, which has exposed everyone to American values and perceptions of therapy, which are markedly different to British values.

Nam, Chu, Lee, Lee, Lee & Kim (2010) found that culture played a significant role in help-seeking behaviours, particularly between western and non-western cultures, but acknowledged that research in this area is in its infancy. This was supported by work by Hunt & Heisenberg (2010), who reiterated that research into cultural effects on the help-seeking behaviour of adolescents is particularly sparse.

2.9. Theme Four: Facilitators to Help Seeking Behaviours

2.9.1. Relationships

Research has shown that CYP are more likely to talk to someone with whom they have an existing relationship, for example family and friends, regarding mental health issues (Featherstone & Evans, 2004). In a review by Featherstone & Evans (2004), it was reported that while younger children are more likely to seek support from their parents, as they get older, they increasingly see their friends and peers as a support network. Cossar, Brandon, & Jordan (2011) argued that it is important for healthcare professionals to understand and acknowledge children's existing support networks, and also to establish who children feel able to confide in. In other research, many young people interviewed also said that they first spoke to their peers about difficulties they were experiencing, before approaching a family member or professional (Butler & Williamson, 1994). When children do eventually seek professional support, it is most commonly teachers (Featherstone & Evans, 2004). The teacher is usually known to them and is someone with whom they have formed an established and valued relationship.

According to Hill (1999), children often judged the support they received from Children's Social Services by their contact with social workers, with this relationship being central to disclosure and protection. Young people in this study valued having a consistent relationship with a professional whom they felt they could trust. This was echoed in work by Jobe & Gorin (2012), who found that CYP were unhappy when they saw social workers intermittently. The CYP expressed frustration at having to tell their story to new social workers and were often upset when they could not contact their identified professional. This often led to the CYP feeling as if they had not been listened to.

Martinez-Hernaez et al (2014), found that facilitators to help-seeking behaviour were comparatively under-researched, with, at the time, only three studies. Key facilitator themes which emerged from these studies included positive past experiences with help-seeking, positive relationships with the care giver(s) and, to a lesser extent, education on mental health.

Chaturvedi (2016), found that amongst her participant group of young, homeless people in London, facilitating factors regarding help-seeking behaviours were patience and consistency of offer, and also the demystifying and normalisation of counselling.

2.9.2. Ease of Access to Support Systems

Clark et al (2018), found that laziness was identified as a theme by many of their participants, therefore, ease of access contributed positively towards help-seeking. The theme of accessibility was extended, in that their participants also felt that information on, for example, anxiety linked support needed to be accessible at all times (Clark et al, 2018). Discussions within this study also revealed a desire for more relatable mental health information. Further to this, participants wanted a more personalised system of support.

2.10. Identified Gaps within the Literature

It is apparent that not only is there a significant gap in research linked to boys aged between 11 and 16 years and their attitudes to mental health and related help-seeking behaviours, but also that the findings are heavily weighted towards barriers, with a lack of focus on how to remove these. Facilitators are comparatively few, as are suggestions for promoting help-seeking behaviour in young males in the future.

Studies which have focused on young males and help-seeking behaviour have typically recruited young men aged 17 years and up (Tyler & Williams, 2014). Therefore, there can be seen to exist a considerable gap in the literature linked to younger adolescent males and mental health help-seeking behaviours.

The researcher has also identified a paucity of research regarding the role of technology, specifically online sources of both support and education, regarding mental health, aimed at young people.

2.11. Chapter Summary

This chapter has included inclusion and exclusion criteria, search terms and database details used by the researcher to identify prior research of relevance to the current research. Themes linked to gender, ideas of masculinity, confidentiality, stigma, and relationships have been identified. Gaps within the existing literature, linked to research on younger adolescent males, and to facilitators of help-seeking behaviours in relation to mental health difficulties have also been highlighted.

3. Method

3.1. Chapter Overview

Within this chapter, ontological and epistemological underpinnings of the research are discussed. This chapter also sets out the research questions and the rationale behind them. A qualitative research methodology is discussed, and the research process is set out, including data collection, participant selection, data analysis and ethical considerations. Lastly, thematic analysis is discussed in terms of how it was conducted, in relation to this research.

3.2. Ontology and Epistemology

Ontology and epistemology have their roots in the philosophy of science. They pertain to how we know something to be true, and how this can be explored. Ontology is the study of reality, and refers to the nature of reality, being and existence, and also asks, what is reality and does something actually exist?

The respective ontological position taken then informs the epistemological position adopted, providing a framework for exploring the nature of this existence. Epistemology asks, how do we actually know something, how is this knowledge created and how can this be measured and validly obtained (Robson, 2011)? Epistemology therefore relates to the validity and reliability of the resultant method used.

The two main ontological paradigms within social science research are realism and relativism and these are used to investigate social reality concepts, each having a differing view to the other. A realist stance argues for the existence of an external reality and has its roots and epistemology within the positivist, quantitative paradigm (Arghode, 2012). Therefore, its epistemological stance asserts that the external reality can be discovered via objective observation (Robson, 2011).

On the other hand, a relativistic ontological position, such as that of social constructionism, argues that there are multiple realities, which are all equally valid and socially constructed within their own cultural, geographical, and historical contexts, and it is necessary to explore these, by studying individual life experiences and the meanings which are socially constructed within.

Research paradigms encompass researchers' epistemological and ontological assumptions. It is therefore important to discuss ontology and epistemology in relation to this research.

Ontology specifies relationships between the world, human interpretations, and practices, and also determines whether or not we think reality exists separately from human practices and understandings. There are many ontological variations which exist on a continuum, ranging from a view where 'reality' is independent of human ways of knowing about it, known as realism, to a view where reality is dependent on human interpretation and knowledge, known as relativism (Tebes, 2005).

Realism assumes there is a knowable world which can be understood through the Scientific Method. Within a realistic paradigm, there exists a truth which can be accessed through the use of appropriate research techniques. This has been referred to as, in its most extreme form as a:

"correspondence theory of truth, in which what we observe mirrors truthfully what is there." (Madill, Jordan & Shirley, 2000:03)

The ontology of this research is social constructionist, in that it rejects the idea of one single truth. Social constructionism views the world and what we know of it as having been produced through language and other social processes, rather than having been discovered. There are many factors which contribute to our understanding of the world, such as, for example, historical contexts and cultural factors. Meanings arise from social interactions

rather than from an inherent truth about the nature of reality (Braun & Clarke, 2006). In the context of this research, social constructionism can be taken to mean

"a broad theoretical framework, popular in qualitative research, which rejects a single, ultimate truth. Instead, it sees the world, and what we know of it, as produced (constructed) through language, representation, and other social processes, rather than discovered" (Braun & Clarke, 2013).

Epistemology is concerned with the nature of knowledge and seeks to address the question of what it is possible to know. Epistemology can be realistic by, for example, assuming it can be possible to obtain the truth through a valid source of knowledge production. At the other end of the continuum on which it exists, epistemology can be relativist, meaning that knowledge is always perspectival and so no one absolute truth can exist (Henwood & Pigeon, 1994). The epistemology of this research, in line with its social constructionist ontology, is relativist in nature.

3.3. Research Purpose

This research was explorative in nature. Depending on the data gathered, the researcher's primary aim was to explore adolescent boys' perceptions of mental health. The researcher was also looking to explore possible links between gender identity and help-seeking behaviour. In addition to this, the researcher was seeking to raise awareness of mental health amongst young people, including possible and preferred sources of support. A qualitative methodology was selected to focus on perception and meaning, during individual, semi-structured interviews. The research was also exploratory in that the researcher sought to explore adolescent boys' perceptions of mental health and whether there is stigma attached to them and, if so, if this inhibits them from talking about them. The researcher also tried to find out if this group knew what sources of help are available and how to access them.

The researcher hoped that any findings might add to current understanding and, in a small way, encourage boys to seek help in maintaining their mental health. A further hope was that outcomes might challenge negative perceptions of mental health and increase awareness and knowledge of sources of support.

The researcher worked within a framework of critical realism; there is a reality of resources within schools and a reality of children's understanding of mental health. The research explored what can learned from this and how these two realities can be more closely linked.

This research was , in part, inductive in that it was conducted from a "bottom up" perspective and in an exploratory manner, in terms of examining the data from a social constructionist perspective, based on close examination of language used by participants. However, there was also a deductive element in that the researcher posited that there would be negative connotations associated with mental health and with seeking support in this area. The researcher came to the data with questions regarding the persistence of male understanding of mental health and help-seeking and sought to determine the continuing truth of the existence of that perception, and this underpinned the analysis of the data.

3.4. Research Questions

This research aimed to address an apparent gap in literature pertaining to a specific group and their understanding of mental health, as well as their awareness of potential support. With the aim of achieving this, the research questions were:

1. What are participant's perceptions of mental health?
2. Are participants able to distinguish between mental health issues in terms of severity and type? If so, how?
3. Do participants make links between perceptions of mental health and help seeking behaviours and their gender identity? If so, what are the links?

4. How do participants feel about discussing mental health by video rather than face to face?
5. Are participants aware of school based and other sources of support?

Question one related to participants' understanding of the term *"mental health"* and also sought, through analysis, to ascertain their feelings towards it, in terms of, for instance, perceived stigma. Question two aimed to discover if participants were able to distinguish between different forms of mental health issues in terms of severity and was supported during the interview process by the last section, which asked them to describe how different forms of mental health issues might manifest (see Appendix E). This was also linked to perceived stigma surrounding mental health. Question three was designed to discover what, if any links participants made between the concept of mental health and their gender identity.

Due to Covid-19 and the constraints it brought, the researcher collected data virtually, specifically using Microsoft Teams, and question four was linked closely to this process. Question five was linked to recent legislation, such as the UK Mental Health Act, 2020, designed to promote awareness of mental health in schools and also to provide designated support, with the ultimate aim being to gauge participants' awareness of available support for mental health.

A draft schedule was discussed by the researcher and his research supervisor before a finished version was agreed. This version was piloted by the researcher amongst peers and colleagues (see Appendices D and E).

3.5. Participants

3.5.1. Participant Characteristics

Participants were boys, aged between 11 to 16 years, who identified as male, the gender they were assigned at birth. All participants were on roll, at a secondary school, within the local authority in which the researcher completing his doctoral training. There were

no other criteria involved in the selection of participants. Participants were anonymised through the assignment of numbers, which was discussed and agreed with participants.

3.5.2. Participant Recruitment

SENCos of secondary schools in which the researcher was training were approached by the researcher and/or EP colleagues, working within either of the authorities, in several ways; by telephone, e-mail or in-person, when either the researcher or one of his EP colleagues was working at the school. The researcher collated an information pack, consisting of: participant debrief letter, parental information letter, participant consent form, parental consent form, research information letter and school information letter/consent form (see Appendix E). This was shared with SENCos within the authority in which the researcher was training, who forwarded the information to the parents of potential participants. Five participants were recruited from within one mainstream secondary school in the authority in which the researcher was training.

Table 3.1: Participant Information

Pseudonym:	Age:	Year Group:	School:	Data Collection Method:
Participant One	15	11	A	Interview
Participant Two	11	7	A	Interview
Participant Three	15	11	A	Interview
Participant Four	14	10	A	Interview
Participant Five	15	11	A	Interview

Parents of interested participants contacted the researcher via his University of East London (UEL) email address. All potential participants and families were invited to ask the researcher any questions they might have had. Signed consent forms from both participants and parents were returned to the researcher and stored securely on the university One-

Drive, which could only be accessed via a password protected laptop, belonging to the researcher, and also stored securely in a locked drawer.

3.6. Research Method

The researcher began designing the interview schedule by thought-showering questions he thought were relevant to his research's area of interest. This was discussed with his academic tutor and refined (see Appendix E). With the intention of gathering rich data through giving participants opportunities to give longer, fuller answers, the final part of the interview involved participants describing different forms of mental health issues. As stated, due to restrictions occasioned by the Covid-19 Pandemic, interviews were conducted virtually, using Microsoft Teams.

Before interviewing participants, the researcher trialled the interview schedule with an EP colleague. This was, in part, to counter the researcher's lack of experience with interviewing, and also to ensure that he was able to effectively multi-task, by for example, listening to what participants were saying, being attentive to participant's tone of voice and body language, being aware of whether or not participants had already answered questions found later within the schedule and recognising relevant information within responses, so as to be able to ask unplanned, follow up questions.

The participants' comfort and safety were also considered. All interviews took place virtually, between the participants' and the researcher's homes and participants were given the option of having a parent present if they wished. The researcher used a plain, neutral backdrop from Microsoft Teams, to minimise distractions. Interviews took place when the researcher was alone at home.

Each interview began with a period of ice-breaking questions and conversation, designed to put participants at ease and also to establish a rapport between the researcher and participants. The interview schedule acted as a prompt, and participants were encouraged to expand on their responses.

Although consent to record interviews had already been given, through signed consent forms, at the start of each interview the researcher asked participants for permission to record, reiterating that recordings would be stored securely.

Recorded interviews were transcribed by the researcher (see Appendix I).

3.7. Ethical Considerations

The British Psychological Society makes it clear that when working with young children, during research, ethical practice is essential (BPS, 2010). Participants must be clear on what they are agreeing to and who will have access to the information. To this end, participants and their families were given the interview schedule, prior to the interviews. As well as facilitating informed consent, this was intended to allay any anxieties participants may have felt regarding questions they would be asked, and also to reinforce the idea that the participants were the experts regarding their perceptions and knowledge within this area. Consent is an on-going process, and it was made clear to the participants that they could end their involvement at any time, up to three weeks after the interviews. This was done in both the debrief letter for participants and parents and at the start of each interview, by the researcher (see Appendix F).

The researcher was aware of the sensitive, and potentially upsetting nature of the research topic. With this in mind, conversations were had with SENCos and school safe-guarding leads who agreed to be points of contact and support, should the need arise. Participants and their families were made aware of this prior to the interviews.

All participants and families were informed that their participation would be anonymous and confidential. With safeguarding and this in mind, the researcher, having reiterated the confidential and anonymous nature of the research, did inform participants that if they disclosed something which made the researcher feel they would be at significant risk of danger, he would need to share that information with their parents. Through questioning, the researcher checked to ensure participants had understood this.

3.8. Thematic Analysis

Thematic analysis was first developed by Gerald Holton, a physicist and historian of science, in the 1970s (Merton, 1975). However, it was not until almost 30 years later that it was recognised as a distinctive method, with clear guidelines for use in social sciences (Braun & Clarke, 2006). Prior to this, researchers were essentially using thematic analysis, but calling it by other names, such as 'discourse analysis.' Braun & Clarke, (2006), *"named and claimed"* thematic analysis for use within psychology and it has become increasingly more widely used since then.

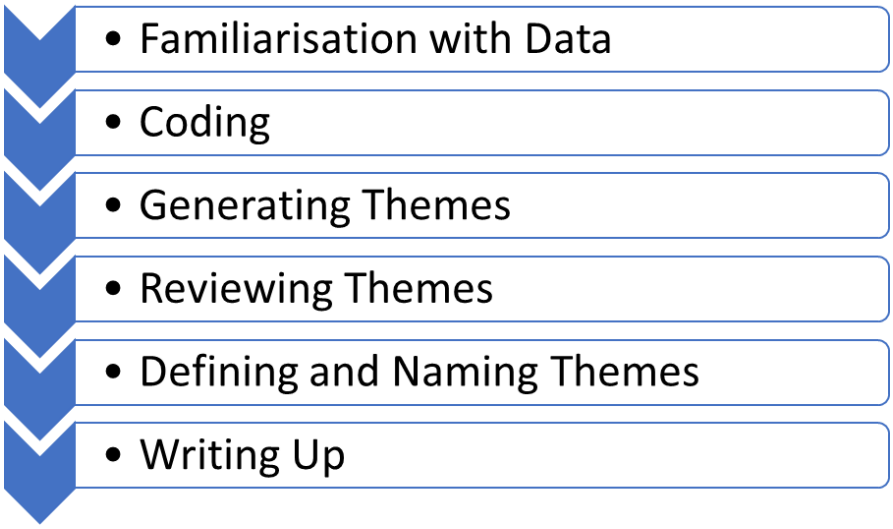
Thematic analysis provides a method for data analysis, rather than, for example, prescribing methods of data collection. It is flexible and can be used to answer a wide range of questions. Themes can be identified in a data driven 'bottom up' manner, dependent on what is contained within the data. The researcher chose this method of data analysis as, amongst other things, it can be used to develop a detailed, descriptive account of a phenomenon, for example, why boys do or do not seek help regarding their mental health. Furthermore, thematic analysis can also be used to develop a critical, constructionist analysis, which in turn can identify concepts and ideas underpinning the data. This was in line with the researcher's social constructionist ontological position.

Another reason thematic analysis was selected was that it helps to make sense of qualitative data, focused on human 'meaning making' through social interaction, and to discover possible themes and commonalities between participants' perceptions.

Thematic analysis is particularly helpful for those new to qualitative research, as was the case with the researcher. Although not prescriptive by nature, it does provide a clear set of stages:

Figure 3.1.

Stages of Thematic Analysis



3.8.1. Transcription

All recorded interviews were transcribed by the researcher. The style of transcription used by the researcher was orthographic, also sometimes referred to as *"verbatim."* This style of transcription focuses on recording what was said, as opposed to, for instance phonetic transcription, which, as well as recording what was said, aims to record how it was said. The researcher endeavoured to produce accurate and detailed transcripts. However, there is debate amongst social scientists regarding transcription accuracy and whether or not such a thing can be achieved (Potter,1996). All transcripts were anonymised, and participants were assigned numbers in the order in which they were interviewed. Transcripts were stored securely, on the researcher's password protected laptop.

3.8.2. Familiarisation with the Data

Rather than using software to transcribe the interviews, the researcher chose to transcribe them himself, in order to immerse himself in the data. The researcher sought to notice things of interest through reading and re-reading the transcripts. When reading the transcripts, the researcher was mindful of questions such as:

How does a participant make sense of their experience?

Why are they making sense of their experience in this particular way?

What kinds of experiences are revealed through their accounts?

As such, familiarisation in this context was not a passive process, but one involving reading in an active, critical, and analytical manner (Braun & Clarke, 2006).

3.8.3. Coding

Coding is the process of identifying elements of data which are relevant to one's research. There are two approaches to coding: selective coding, which involves identifying instances of areas relevant to research, and complete coding, which involves identifying everything of relevance to one's research. The researcher used complete coding during this research. This was in order to identify anything and everything of interest, rather than searching for particular instances of certain responses (see Appendix K for example).

3.8.4. Searching for Themes

According to Braun & Clarke, (2006), a theme may be thought of as:

"a patterned meaning across a dataset that captures something important about the data in relation to the research question, organised around a central organising concept."

This process was completed during the readings of the data by the researcher.

3.8.5. Reviewing Themes to Produce a Thematic Map

A thematic map was produced in order to explore relationships between codes, themes, subthemes, and overarching themes. (see *Figure 4.1.*)

3.8.6. Defining and Naming Themes

Themes were defined in that unique and specific qualities of themes were identified and named. This also applied to sub and overarching themes. The themes had clear focus, scope and purpose and were discrete.

When naming themes, importance was given to the names as the researcher was aware they could act as signals regarding his analytical stance on the data.

3.8.7. Finalising Analysis

This stage involved the researcher collating all themes and codes to tell the story of the data, in relation to the research questions. The researcher used a deductive, bottom-up method of analysis. Analysis was impacted by both the research questions and the themes identified in within the literature review.

3.9. Chapter Summary

This chapter began with an explanation of the epistemology and ontology, both generally and of those underpinning the research and made links between these and the exploratory objectives of the researcher. The exploratory purpose of the research was also discussed before Research questions were named and considered. The characteristics and recruitment of participants was described, as was the method used to gather data. Within this section, ethical considerations were also discussed. Thematic Analysis was described, as was its application to the current research and its role in the analysis of the data.

4. Research Findings

4.1. Chapter Overview

The preceding chapter provided an overview of methods used, an outline of the ontological and epistemological position of the researcher, considered the design and purpose of the research and gave details of participant recruitment, data collection and data analysis. This chapter presents the findings from the interviews with the five participants, as obtained through the thematic analysis process. The participants were a group from one school, in a specific area and the data is representative of this. A thematic map illustrates the themes and subthemes within the data, as identified by the researcher and is followed by a more detailed description of the themes and subthemes, which is supported by data extracts from the data. Participants are referred to by number, corresponding to the order in which they were interviewed. Within this description the five research questions are further explored.

4.2. The Themes

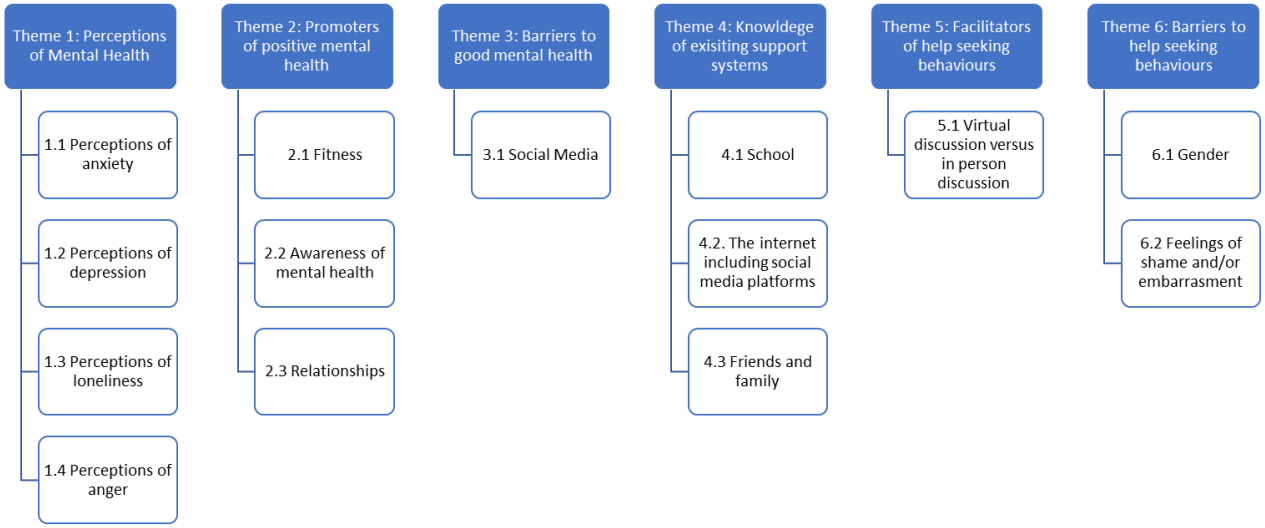
In addition to the four themes identified during the literature search, due to data gathered during interviews, a further two were added meaning that six themes from within the data were identified by the researcher during the thematic analysis process:

1. Perceptions of Mental Health
2. Promoters of Positive Mental Health
3. Barriers to positive Mental Health
4. Knowledge of Existing Support Systems
5. Barriers to Help Seeking Behaviours
6. Facilitators to Help Seeking Behaviours

These themes spanned the entire data set and were not necessarily specific to the research questions. Figure X represents the themes and the corresponding subthemes found within them.

Figure 4.1.

Thematic Map Outlining Themes and Sub-Themes



4.3. Theme One: Perceptions of Mental Health

Theme One reflects the responses participants gave with respect to their general concept of mental health. This question was central to this research and the question was asked at the beginning of the interviews. Within this theme is also contained participant's views on specific aspects of mental health and conditions, for example, anxiety and depression.

When asked what the words "mental health" brought to mind, Participant One replied;

"*Well, first, when other people think about it, it's usually in a bad sense, isn't that when they think about mental health?"* (Participant One, lines 21-22).

Participant One's response to this question with a question of his own, in this instance implied a level of uncertainty on his part, as to how to respond. This was despite assurances having been given at the start and throughout the interview that there were no correct or incorrect responses, and that the researcher was interested only in participants' thoughts and opinions. Notably, this response was also attributed to how other people think about mental health, thus distancing Participant One from the opinion. Although the researcher believed all participants gave honest, valid responses throughout the interviews, the researcher is also aware of possible *"experimenter effects"* in that participants may have been saying, to a degree, what they felt the researcher wanted to hear. Although Participant One attributed this negative connotation of mental health to others, he soon made it clear that, at least in part, he subscribes to the same view, saying: *"When I think of it I think is in a bad sense as well, if I'm honest, because that's, that's why I'm surrounded by"* (Participant One, lines 23-24), implying a feeling of being saturated by negativity concerning mental health. Participant One later counterbalanced this by saying; *"Everyone's got mental health and you either have bad or good mental health and if it's on either end, then you can. Yeah, so yeah, yeah"* (Participant One, lines 40-41), thus displaying what could be viewed as a more nuanced view of mental health.

Participant Two, when asked what the words *"mental Health"* brought to mind for him echoed Participant One's description of *"good and bad mental health"* saying;

"When I hear the words mental health, I thought things like, how, how people are thinking in a way, like if they're in a good state of mind, if they're in a bad state of mind, etc." (Participant Two, lines 12-13).

When asked the same question, Participant Three's response was;

"Er, wellbeing, um, how people feel inside, and how they think about other people. Yeah, just like, it's hard to explain, but like wellbeing and how they feel" (Participant Three, lines 27-28). The hesitancy and content of this response acknowledge that mental health is a

difficult concept to explain, although it was clear that Participant Three thought carefully about his response, as he expanded upon this adding;

"Well, yeah, well, some people have mental health, difficulties with how they perceive things and how they feel about themselves. Right, yeah, so" (Participant Three, lines 31-32).

When asked what he thought of when he thought about mental health, Participant Four responded;

"I think it's like, mental health is how, mainly it's like emotionally it's not physically and it's like how, I suppose you think of like, all the different mental health conditions like anxiety or depression or something like that. That's what I think of just a, well, I suppose I think of negative mental health, rather than positive. But yeah, I dunno" (Participant Four, lines 30-33). Again, in line with previous participants' responses, this comment from Participant Four focuses on the negative aspects of mental health. When combined with Participant One's earlier response, this gives the impression that young people are being exposed to more negative than positive depictions of mental health difficulties.

Participant Five, when asked what the words "mental health" brought to mind for him, made links between mental and physical health stating that;

"Um, like, issues that people will have internally, and they sometimes feel scared to share it with other people, and they kind of deal with it themselves and keep it to themselves, and it like, it affects their mental and physical health" (Participant Five, lines 12-14).

Participant Five expanded upon this, stating;

"Well, if you've got like an eating disorder, it might, your brain might trick you into not liking certain foods or that kind of thing. So, it kind of can affect you physically, if your brain is telling you to do something different" (Participant Five, lines 17-19).

This was the only reference made to eating disorders by participants.

4.3.1. Subtheme 1.1: Perceptions of Anxiety

Participants were asked for their thoughts and perceptions of anxiety. Participant One stated that he thought of anxiety in the following way;

"I'll have a think about that. Anxious, I think is pretty skittish, and on high alert. I don't know because they're not relaxed at all. They so if you're anxious, you're obviously pretty wary of everything, even if it's not to do what you're anxious about. And maybe in some cases, you're just anxious about everything. You're just an anxious person in general. But, yeah, I think you're just on high alert" (Participant One, lines 143-146).

Participant One's opening comment makes it clear that he had thought about his response. Despite this, he still says, *"I don't know"*, displaying a level of uncertainty. Participant One makes links between anxiety and being wary on *"high alert,"* thus making the often-present connection between anxiety and hypervigilance.

Participant Two felt unsure as to how to describe anxiety, stating;

"I think, there's quite a lot of ways that someone could show they're anxious or worried. Right? It depends on the person, it's hard to explain really" (Participant Two, lines 87-88). Although the researcher probed to elicit further views on this, Participant Two, at that time, felt unable to elaborate and in the interest of not triggering anxiety, the researcher did not persist.

Participant Three described anxiety in the following way;

"Maybe like a cowardly disposition, demeanour, or disposition? They seem very withdrawn. Yeah, withdrawn" (Participant Three, lines 93-94). By using the words *"cowardly disposition,"* Participant Three strongly implied that even though he may not necessarily subscribe to the view, at some level, he has a connotation between anxiety and weakness, in line with espoused theory on masculinity linked to the expression of mental health difficulties.

Participant Four described anxiety as;

"Erm, I suppose they can't still, moving their fingers a lot. I'd say quieter. I don't know, just not being very with it being like very well, what's around them? I suppose a bit paranoid. Yes. Something like that" (Participant Four, lines 164-167).

Other than someone feeling anxious also possibly feeling *"paranoid,"* Participant Four's description of anxiety also focused on physical, outwardly visible signs.

Participant Five gave a longer description of his perception of anxiety, describing it in the following way;

"Um, maybe if like, you're going to a place or going to speak to other people. Sorry, if they might be like, Oh, can we just stay here for a few more minutes, or I don't want to go and talk to them, or they kind of hang back behind on them. And like, on their phone the whole time, when you're trying something new, that kind of thing, like, just noticing a difference in their normal behaviour you might listen to, or they might not stop crying or something like that. But if they just act slightly different to how they used to, it could just be that was kind of makes you think this. Or they need a bit of help" (Participant Five, lines 196-202). Participant Five's descriptions included emotional and psychological factors such as feeling paranoid or nervous in social situations, along with physical manifestations of anxiety, such as moving one's hands.

4.3.2. Subtheme 1.2: Perceptions of Depression

Participants were also asked about their thoughts and perceptions on depression, and how it might manifest.

Participant One gave a detailed account of signs he would look for in someone he thought may be depressed, as well as reporting on action he might take:

"That's probably the hardest out of all of them. Because that's, that's like a major thing, isn't it? That is, it's quite hard to tell when someone's when someone's depressed. And I think when, when you're trying to look out for someone that's depressed, or they have said

they're depressed. I think they just try to bring out all the all the negatives, because they tend to bring out the negatives and not look at the positives. So that's when you I think you need to, you need to talk to them. And yeah" (Participant One, lines 152-156).

Participant Four focused on the sometimes-inconsistent presence of depression and how the effects of depression may fluctuate, saying:

"I think it shows itself as obviously feeling very low, but then also it could be like, you can be high and then low, it's not necessarily being depressed all the time. It can present as I think this so low mood and not being like yourself not feeling like energetic or anything like that it's probably either overdoing things like overeating or under eating or sleeping more or not sleeping at all. I think it goes to the extremes of like, how, what normal actions you would do. And like being not being able to concentrate on anything else" (Participant Four, lines 175-180).

Again, this description focuses on physical manifestations of mental health difficulties, but also makes links to cognitive functions, i.e., concentration. This response displayed an in-depth knowledge of how depression can affect many aspects of physical and mental health.

Participant Five focused on outward signs of possible depression, both physical and spoken, saying:

"Um, I mean, like, it's quite extreme, people can like hurt themselves because of that. So, like, people can see like scarring, that kind of thing. And I know, it's quite extreme, but I guess that's kind of what depression is, like people feel like they're so sad, they can't be able to try anything better. Like, if someone doesn't show up, or like, they're, you're finding, they're more like, secluded to themselves, they don't want to see other people, spending more time on their own. They're not really going out as much, they're not doing group activities and sports. Just if they kind of are. I don't know, being, being alone. And that's a real good indicator. It might be depression, I guess" (Participant Five, lines 205-211).

This response contained the only reference made by participants to self-harm in relation to mental health difficulties. In addition, the response made reference to social isolation and withdrawal as possible indicators of depression.

4.3.3. Subtheme 1.3: Perceptions of Loneliness

Although not a mental health condition in its own right, loneliness was discussed as a factor contributing to mental health and emotional wellbeing. When asked how he might recognise loneliness in a friend, Participant Three replied: *" They're not talking and just very dissociated"* (Participant Three, line 150). The use of the term "*dissociated,"* as well as displaying knowledge of psychological terms, ties in with themes of social isolation and withdrawal, discussed in relation to depression.

4.3.4. Subtheme 1.4: Perceptions of Anger

Anger, as a contributory factor to mental wellbeing, was also discussed.

Participant Three made links between depression and anger, stating:

"I think anger has got something to do with it as well, probably. But bursts of anger. 'Cos they think their life's so bad. And they might take it out on other people, just randomly" (Participant Three, lines 154-155).

Participant Four spoke about triggers and how anger might manifest, saying:

"Well, they've got a short temper, so anything could annoy them anything can set them off. I suppose. When doing like physical activity? I don't know. Maybe they take part quite viciously, violently" (Participant Four, lines 186-188). Although not stated directly, this response implies that Participant Four feels that anger may often be displaced.

Participant Four then also made connections between anger and other mental health difficulties/states, in addition to expanding upon how anger might manifest, saying:

"Yeah, I suppose it's all quite similar to like all the others. So maybe they'd be quieter than usual or, yeah, just not being able to sit still because they're so angry" (Participant Four, lines 191-192).

Participant Five began by speaking about how he thought people might manage their feelings of anger before moving onto describing how anger might manifest, saying:

"*Um, like, I think a lot of people are trying to hide their anger. So, if there's like a situation they just kind of remove themselves from the situation like you can kind of tell that they're angry because they're upset but I think people deal with that anger or internally now the next thing obviously if they get physical or like you said, shout it's quite obvious. I guess more subtle examples are like if they're kind of twitching like kind of a bit like on edge, they're sweating, they've gone red, that kind of thing. By, like, cartoony things, like when they go red. Yeah"* (Participant Five, lines 226-231). As well as describing outward signs of anger, Participant Five spoke about possible ways in which to ameliorate it, i.e., removing oneself from the situation.

4.4. Theme Two: Promoters of Positive Mental Health

Linked to their perceptions of mental health and how they could maintain positive mental health, participants identified a number of factors.

4.4.1. Subtheme 2.1**:** Fitness

Good physical health, encompassing elements such as exercise and diet, were mentioned by participants, in relation to maintaining good mental health.

Participant One stated that:

"fitness can have a good effect, and sort of your dieting. But and then we've talked about stress quite a few times, because that's a major, a major factor of bad mental health, you would say" (Participant One, lines 80-82).

This was echoed by Participant Four, who stated that:

"And then mentally, I think just trying to be healthy, not like staying in bed all day, exercise. Yeah" (Participant Four, lines 48-49).

Participant Five expanded upon this, saying:

"Having good physical health can help you mentally, like playing lots of sports and stuff because it gives you something to do" (Participant Five, lines 42-44).

Participant Four *was the only respondent to mention drugs and alcohol, saying: "Obviously, I feel like drugs and alcohol can probably have a big effect"* (Participant Four, line 135).

Tied in with the idea of fitness being a facilitator to positive mental health was the idea of doing things one enjoys.

4.4.2. Subtheme 2.2**:** Awareness of Mental Health

Being aware of mental health concepts and issues was deemed to be a promoter of good mental health by some of the participants. When asked his thoughts on what might promote good mental health, Participant Two stated: *"Yeah, I think people should be more aware of mental health, definitely"* (Participant Two, line 25).

Participant Two believed this to be especially true of boys and later stated: *"They should definitely be more aware of it"* (Participant Two, line 114).

Although participants reported that much of their knowledge around facilitators to mental health had been gained at school, usually as part of the PSHE curriculum, this last response was made in relation to school's coverage of the topic.

4.4.3. Subtheme 2.3**:** Relationships

Relationships, within families, peer groups and with school staff members were cited as being promoters of good mental health by some of the participants. Participant One stated that:

“ Um, yeah, I think I think that that can help. I mean, some people don't really need that, that sort of friendship, to get stuff off their chest, they really just want to do it to feel better. But I think having a relationship with a pastoral person is quite a good thing to have, as well. It does. It's not even really a pastoral person, because I have quite a good relationship with my form tutor. And she's helped me out several times with stuff that has been going on. And she's been she's been very nice. So yeah” (Participant One, lines 69-74).

Later, Participant One *also said:*

“And I think friendships got a lot to do with that as well. You've got to have that loyalty and responsibility to give that information out, because it really has an effect on other people as well” (Participant One, lines 90-92).

Expanding upon how he and his friends support each other’s mental health, Participant One added:

“Well, I think sometimes we do talk about it because maybe we get worried about one another, but usually it doesn't really lead on to anything so I we just say, okay, everything's fine. But I think we do have to have that check-up once in a while that that we are doing okay. I like to ask my friends how they're doing” (Participant One, lines 106-109).

Outside of friendships, Participant One felt:

“because most of them are just teachers, you to get to know them and you're sort of friends with them anyway. So, you sort of have that relationship and you feel safe enough to share that while I did say it was confidential” (Participant One, lines 57-59).

Participant Three described how he has supported friends with their mental health in the past, saying he had done this by:

“talking to them at a quiet time, not when there's a lot of people around. So, they don't feel overwhelmed or just like, sit come talk to me today. How are you? Okay. I'm here to help, and stuff like that” (Participant Three, lines 97-99).

Participant Three added:

“Yeah, sometimes I have. Yeah. And they like, yeah, like when they're struggling, I talk to them talked to them and when I'm struggling, I also talked to them as well” (Participant Three, lines 101-103).

And:

“Yeah, I have quite a few friends that can help me when I feel stressed or anything like that” (Participant Three, line 104).

Whilst discussing who young people might prefer to talk to about their mental health, Participant Five said: *“I think people would rather talk to their friends like they maybe trust them more.”* (Participant Five, line 138)

Trust and a need for privacy and confidentiality in relation to relationships and who participants felt either they or friends would talk to regarding mental health difficulties were recurring themes.

4.5. Theme Three: Barriers to Positive Mental Health

Participants also discussed what they felt to be barriers to achieving and sustain positive mental health.

4.5.1. Subtheme 3.1: Social Media

The use of social media platforms such as Facebook and Instagram were identified by some of the participants as being a significant barrier to good mental health and wellbeing.

When asked how he might try to support positive mental health, Participant Three suggested:

"Trying to limit social media? Probably. Yeah, not constantly thinking about what other people are doing" (Participant Three, lines 59-60).

This response from Participant Three strongly suggests that as well as being a barrier to positive mental health, he feels that using social media can be habit forming, as can comparing oneself to others.

Participant Five also felt strongly that social media can have an adverse impact on mental health and conveyed this saying:

"social media is really dangerous. Because if someone is feeling quite like mentally unwell, then they might feel a bit lonely, and they have no one to turn to online and they might get lower" (Participant Five, lines 133-135).

Participant Five here made explicit links to the use of social media and loneliness and how, through using social media and comparing oneself to others, existing feelings of loneliness might be exacerbated.

Participant Five later added:

"I think people see numbers. And they link that to their, like, happiness or success that they've done. They've got, say, 1000 likes, and they think everyone cares about me. And then the next five posts, they get 20, 30, 25 likes, they might think that they've done something wrong. They've maybe become, like, uglier, or put on a bit of weight or something. Whereas it's, like, completely unrelated. They could link those numbers to something to do with them as a person. Yeah. Whereas it's just luck of the draw really, if you get 1000 likes, but they could link it to something with them that could really affect them, because they wouldn't know what to do at that point" (Participant Five, lines 139-145).

This response from Participant Five again makes reference to how young people may compare themselves to others via social media platforms but goes further this time by describing how validation of oneself may be sought from others, again through social media. Participant Five posits the idea that failure to gain the validation sought may lead to feelings of low self-esteem and self-doubt, even though he feels that the number of *"likes"* given is, to an extent, random.

Participant Five also stated:

"because social media is quite bad. That kind of thing, like, I guess they're shamed through it. Not shamed, they'll kind of use it against them in a way So." (Participant Five, lines 70-72).

Comparing oneself unfavourably to others, based on responses to posts on social media was clearly implied as being a major contributor to mental health difficulties. In addition, potential cyber-bullying is alluded to within this response.

4.6. Theme Four: Knowledge of Existing Support Systems

Linked to a central tenet of the research contained both within the title and research question five, participants were asked about their knowledge and awareness of possible sources of support, regarding both their and their friend's mental health.

4.6.1. Subtheme 4.1: School

One of the main sources of mental health support discussed by participants, was school, which was reported to provide support and information in several different forms, as well as providing information on how this support might be accessed.

Participant One reported:

"Well, I think we're sort of starting the last few years they've, they've started to do lessons and incorporate into the, the PSHE and stuff. And they've got, obviously, posters around the school about that" (Participant One, lines 38-40).

Participant One added:

"Um, oh, so we actually have so we have planners and timetables, as you probably know. And in those, we have, obviously stuff for our parents to sign and stuff, but they also have pages of like, support lines. I think, right there. There's, there's many on there. But, also with, without a mentor, we also have people at that school that are trained to help with people that maybe aren't having the best time. I don't know what they're called pastoral or something like that. So, they obviously have their own. They're obviously experienced in that field so they can, they can help whether it's feeling and they obviously they make it known that it's completely confidential. If they do go into that, into that sort of, yeah, I think that's good" (Participant One, lines 46-53).

This response describes several forms of support. To supplement aforementioned posters advertising support, there is information on *"support lines"* in *"planners."* There are also people trained in offering support with mental health difficulties in school, although Participant One seemed a little unsure as to their departmental name. Despite this, Participant One displayed a high level of confidence in both their ability to offer support in this area and also to the level of confidentiality offered.

With further regard to adults providing mental health support at school, Participant One stated:

"I think it is, yeah, because it's, it's publicised a lot around school, it's on the it's on the notice board, we get notified when they're on duty, because most of them are just teachers, you to get to know them and you're sort of friends with them anyway. So, you sort of have that relationship and you feel safe enough to share that while I did say it was confidential" (Participant One, lines 56-59).

Here it is apparent that the quality of relationships with adults at school who can help with mental health are important to this participant.

Participant One also felt that his school was promoting mental health well, saying: *“So yeah, but I think they do they do publicise it very well”* (Participant One, line 61).

Shortly after saying this, Participant One told the researcher:

“Oh no, I think in quite a lot of schools that I don't I don't think they do it very well. But in ours, I'd say that they do” (Participant One, lines 64-65).

However, despite attending the same school as Participant One, Participant Two did not share the same views, saying: *“Yeah, we've done a little bit.”* (Participant Two, line 20)

In relation to the amount of information on mental health given at school, Participant Two also reported:*“ Not that much”* (Participant Two, line 22).

However, Participant Two did have some awareness of support available at school and told the researcher: *“They're not doing a lot, although my school does have mental health awareness officers”* (Participant Two, line 29).

Participant Two further reported on his awareness of available support:

“Yeah, we do have posters up in the school about who the mental health officers are, but you can learn what they're there for, and how they can help you” (Participant Two, lines 36-37).

Describing mental health within his school’s curriculum, Participant Three said:

“A little bit, yeah, but not, it wasn't a massive focus. It was just like, oh, yeah, this is a thing. And I was like, right. Next, it wasn't heavily focused on” (Participant Three, lines 39-40).

Participant Three added, *“It wasn't really covered in lessons”* (Participant Three, line 54).

These responses indicate strongly that in Participant Three’s view, mental health was not being given enough importance or coverage within the curriculum.

Describing the adult support available at school, Participant Three stated:

"I think there's like a whole team and there's one person in lead, but there are also other teachers as well, like so it's not just his main role, not just mental health, he's like a science teacher or something as well" (Participant Three, lines 61-63).

This response makes it apparent that not only are there different people to whom students can turn for support with mental health, but also that they are known to students.

In terms of more general support available at school, Participant Three said:

"Yeah. So, there's a lot of posters around the school saying these are the people you can go to. On the front of the doors, it's like, Mental Health First Aid" (Participant Three, lines 74-75). He added: *"Well, they advertise some counselling services"* (Participant Three, line 85).

Participant Four was also aware of adult support available at school, saying:

"I think there is quite a bit of support. Obviously, there's like teachers, you can just go to random teachers and then there's, I think there's the pastoral team, which mainly cope with behaviour, but I think they cope with other, like they deal with other things. And then also there's a school nurse but I don't think, I don't know if she still comes in, I dunno" (Participant Four, lines 55-58).

Interestingly, Participant Four made direct links between behaviour and mental health support.

Participant Four expanded upon this, saying:

"Yeah, I think so. I think there's like a whole team and there's one person in lead, but there are also other teachers as well, like so it's not just his main role, not just mental health, he's like a science teacher or something as well" (Participant Four, lines 61-63).

This response implies that adults with mental health support responsibilities are not necessarily viewed as specialists by students.

In terms mental health within the curriculum, Participant Four stated:

*"I think we've had a few assemblies on it, then in PSHE we've had, cos we only have PSHE once every two weeks, we've had a few lessons, then. And then there's also leaflets around the school. That's how I know about it." (*Participant Four, lines 63-66) Participant Four, when asked if he thought mental health is given enough coverage, responded: *"I think it's enough"* (Participant Four, line 70).

Participant Five began talking about school based mental health support by focussing on the curriculum, saying:

"Kind of PSHE lessons and they like, run you through the main issues, the, the facts of how you can get help, but there's not that many, each year is only six in a year. So maybe not as much as I'd like, when I didn't really understand much about specific issues" (Participant Five, lines 25-27).

When asked what might be added to the curriculum, Participant Five then said:

"Probably like looking into the specifics, because they do like ones on depression and anxiety like the main ones, but I think like you're probably looking into different specific ones, there's a lot of stuff to cover" (Participant Five, lines 29-31).

When reporting on the adults who provide mental health support at school, Participant Five said:

"So, I mean, the teachers are quite helpful, like I have, I can't say from first-hand experience that I've like, openly spoken to teachers, that kind of thing, like me or someone else. They always like offered to help in like classes. There's, I think there's safeguarding officers, mental health officers, there now specifically for that, so they've been trained, I think it's quite good, or people are still very scared to do it because they're scared about

confidentiality. But I do still think that if people did to that it would be quite good" (Participant Five, lines 49-54).

Again, the importance of confidentiality is raised here by a participant.

Participant Five felt school to be an important source of information on mental health, but acknowledged possible obstacles to this happening, saying:

"I'm not like annoyed at schools, I know, like funding's a real big issue, and they might not be able to like, the teachers aren't like qualified, but I think it could make quite a big difference to some people. And even if it's just a few people that it helps that's better than it used to be. So" (Participant Five, lines 243-245).

For the first and only time, funding as an obstacle to increased mental health support is raised here by a participant, who goes on to stress how important he feels that support for mental health is.

4.6.2. Subtheme 4.2: The Internet, Including Social Media Platforms

On a par with school as a primary source of information and support regarding mental health, was the internet, including, and often focusing on social media platforms, in particular Facebook, TikTok and Instagram. Consistent within Participant's responses was ambivalence as to the supportiveness of the internet, in particular, social media.

When discussing social media as a source of information on meant health, Participant One said:

"Yeah, social media. I think there's the top one definitely. There's a lot of bad things. But I think social media is a really good place for people to find, like new friends and stuff. But it's also a bad place because of news and some, some publicity is, is really is really bad on there, some, like the fake news, you can get on there. And that can really upset some people with some of the subject matters they're talking about. So yeah, I think social media

and, and that that area is sort of the biggest contributor for mental health in society" (Participant One, lines 117-122).

This response shows clearly how powerful an influencer, both positively and negatively of mental health Participant One feels social media to be.

Participant Three when asked about sources of support and advice said: *"Social media probably is a big one, and just media in general"* (Participant Three, line 114).

When asked if he thought this was helpful and supportive, Participant Three responded: *"A bit of both, but largely negative, I think"* (Participant Three, line 117).

In contrast, Participant Four felt largely positive about the support for mental and physical health offered online, saying:

"I suppose it's like, TikTok. There's like videos, short videos, and they like some of them are educational, and like, just displaying different mental health disease? Because, yeah, and apparently a lot of people like self-diagnose what they have, whereas it could be something else, or it could be not as bad as what they think is, but it could be worse. So yeah, it is little educational videos" (Participant Four, lines 35-38).

This response from Participant Four highlights potential dangers of self-diagnosis via the internet.

When asked specifically if he found these videos to be helpful, he responded: "*Yes"* Participant Four, line 42).

Echoing the ambivalence of other participants and focusing solely on social media, Participant Four said:

"Well, I think there's a lot of negative effects that can, it can have, obviously, with body image, everyone thinking this perfect person and also, I don't know, the hate messages and hate comments and things like that. But then positive, I think it's brought people easier, to be able to talk about it. It's made it easier, and obviously, social media, you don't have to

see the person face to face, you can just message to them. You can talk about it, then. But when people are posting stuff, like saying it's alright, to have this though. It's just making it easier to talk about it" (Participant Four, lines 144-149).

When asked if he felt that social media was helping to normalise talking about mental health, Participant Four responded: *"Yeah"* (Participant Four, line 151).

Participant Five also felt largely positive about the influence of the internet and social media on the dissemination of available support for mental health, saying:

"there's a lot of good websites like and there's like, real good charities, like mind and that kind of thing that do a lot of work with that. That they like, I think that's probably the best way to go. Because as professionals, and they've been doing it for years and years, they've probably had so many people that they know how to help. And yeah, that's about it" (Participant Five, lines 75-78).

Participant Five also made reference to recent the recent pandemic related lockdown situations and the fact that he feels technology is playing an increasingly prominent role in disseminating information, particularly within his generation, saying:

"Like I've joined new apps and groups and that kind of thing. So, I'm finding myself on it, on my phone more, but like, less than lockdown, 'cos I can go outside, but I am yeah. And I've noticed it with my friends a lot too, like, whereas I'd message a couple hours, I'd get a reply, now it's kind of five, six minutes. So, I think it's kind of without sounding too broad. I think society's changed quite a lot in my age group" (Participant Five, lines 147-151).

This response alludes to the positive potential of technology's role in providing mental health support for young people.

4.6.3. Subtheme 4.3: Friends and Family

Participants also reported their friends and families as being important and available sources of information and support linked to mental health.

Participant One stated:

"Have to be confident enough to share that with someone that isn't within your family or friendships and stuff like that" (Participant One, lines 59-61).

This implies that Participant One feels more confident to talk about mental health to his friends and family and that trust is an important factor in deciding who to speak to about mental health. This inference was reinforced when Participant One said:

"And I think friendships got a lot to do with that as well. You've got to have that loyalty and responsibility to give that information out, because it really has an effect on other people as well" (Participant One, lines 90-92).

Speaking specifically about his friends, Participant One said:

"Well, I think sometimes we do talk about it because maybe we, we get worried about one another, but usually it doesn't really lead on to anything so I we just say, okay, everything's fine. But I think we do have to have that check-up once in a while that that we are doing okay. I like to ask my friends how they're doing" (Participant One, lines 106-109).

This idea of friends being part of a support network with regard to mental health was continued by other participants. Participant Three also cited friends as being a source of support, saying:

"Yeah, sometimes I have. Yeah. And they like, yeah, like when they're struggling, I talk to them talked to them and when I'm struggling I also talked to them as well" (Participant Three, lines 101-102).

Participant Three added:

"Yeah, I have quite a few friends that can help me when I feel stressed or anything like that" (Participant Three, line 104).

Earlier, in relation to school-based advice given as part of the PSHE curriculum, participants had described to the researcher an initiative referred to as, *"ask twice,"* involving asking friends if they are ok, listening to their response, often an automatic *"I'm ok,"* and then asking again, in an attempt to elicit a more in-depth response.

Participant Four felt that speaking to people is important with regard to mental health, saying:

"Well, you need to be socially well, so make sure you got a lot of interactions with people, a support network, things like that" (Participant Four, lines 47-48).

Speaking directly about which sources of information and support are important, Participant Four responded: *"I suppose your family, really"* (Participant Four, line 84).

When asked what he might do to support a friend he thought was experiencing mental health difficulties, Participant Four responded:

"There's not really much Well, there's a lot you can do. But you don't want to impose too much. I'll just, you ask if they're okay. But obviously, when someone asks you if you're okay, you probably just say yes. Maybe you could ask someone else for help. Not necessarily on their behalf, but asking what they would do for that friend? Yeah" (Participant Four, lines 93-96).

This implies uncertainty on the part of Participant Four as to how to talk to and support friends with their mental health. Participant Four acknowledged this when asked if he talks to his friends about mental health, saying: *"Not really, no, if I'm honest"* (Participant Four, line 103).

In relation to sources of online support as opposed to in person support, Participant Five said: "I think people would rather talk to their friends like they maybe trust them more" (Participant Five, line 138).

Participant Five felt it important that friends speak about mental health and said:

"Um, I think that a lot of help would be appreciated. But I still think specific, specific things can be touched on school like specific lessons. Because people might think I, they feel I don't feel happy mentally, but they don't know what it is. And I also think that by just checking on someone, you don't even have to, like, maybe go too far. Just asking someone if they're alright, it can make a big difference. But if they're struggling, I think you just even if you don't have any signs, you just check anyway, because we deal with themselves, and they deal with their issues. internally. It's something that needs to be dealt with" (Participant Five, lines 235-240).

Although this last response from Participant Five seems to imply that mental health issues are often dealt with autonomously, participants felt strongly that speaking to others, be they friends, family, or adults whose job it is to support mental health, is vitally important to the maintenance of positive mental health.

4.7. Theme Five: Facilitators of Help Seeking Behaviours

In line with research question three, help seeking in relation to mental health was discussed between the researcher and participants.

4.7.1. Subtheme 5.1: Virtual Discussion Versus In Person Discussion

One such facilitator, which is closely linked to research question four, was the idea of speaking about mental health virtually, as opposed to in person.

When asked if he found it easier to talk virtually or in person, Participant Four responded: *"I think maybe video is less nerve wracking"* (Participant Four, line 128). However, shortly after, he added:

"but probably face to face is just easier to have a conversation on there, especially if it freezes or something on video" (Participant Four, line 129).

On the same topic, Participant Five felt:

"Yeah. it's easier because there's not that, I guess physical interaction like, I'm not like socially inept or anything, but I do find it easier by video. There's kind of a barrier between you kinda like, I probably might not ever see you again. So, me saying these things might not affect us much, but I know it's not like, bad. So, if I were to say something over a screen, I know it's not a great mentality to have, it's like, it could get bad if you say something bad. But if I say something through a screen, it's kind of like, not physical. Like I can say more, be more honest and open about stuff" (Participant Five, lines 94-99).

This response implies that physical and emotional barriers make is easier for this participant to speak openly about mental health, without fear of judgement.

Participant Five added:

"Yeah, because it's still a person there. But you don't have, kind of like I guess anxiousness or kind of not wanting to say the wrong things when it's a physical person. Because there's more pressure in like a physical situation, to say the right thing. And it might be harder to tap into, or like, tap into your emotions when you're in person" (Participant Five, lines 102-105).

Participant Five's next response strengthened the implication that the screen acts as a barrier to judgements and makes it easier to speak honestly and openly about feelings and emotions.

4.8. Theme Six: Barriers to Help Seeking Behaviours

4.8.1. Subtheme 6.1: Gender

By far the most prominent barrier to help seeking behaviours identified by participants, was gender. Although gender identity exists on a continuum, it was discussed in binary terms, specifically male and female. The concept of gender fluidity was not mentioned during any of the interviews. Participants' concepts of male and femaleness were inherent within this. Without exception, all participants felt that it is easier for girls to talk about and seek help for their mental health than it is for boys.

Participant One stated:

"I know there's the stereotype with boys definitely. Or men? And they can't, they can't talk about it too much. Because it's demasculating. But I don't, I don't really I, I think that's a really bad way of looking at it because anyone can, anyone can, can talk about it. And then women and girls sort of, I feel they're encouraged to more sometimes, or that it's publicised that they they're encouraged more to speak. But recently, it has been publicised more often for men to speak up. And there's obviously Mental Health Day for men and stuff like that. So, they're sort of bunking down on that stereotype" (Participant One, lines 127-133).

Participant One's response indicates that although he believes that male stereotypes impeding men and boys from talking about mental health exist, that this is changing, in part due to publicity around this issue, and initiatives such as Mental Health Day for Men.

In relation to boys' awareness of mental health, Participant Two Stated: *"They should definitely be more aware of it"* (Participant Two, line 114).

Linked to Participant One's earlier response regarding the importance of publicity, Participant Two feels that more is needed and should be targeted at men and boys.

When asked if he thought there is a difference in the way that boys and girls talk about mental health, Participant Three responded: *"Definitely"* (Participant Three, line 127).

When further asked if he believed that boys are encouraged to hold onto their feelings and not talk about them, Participant Three responded: *"Yeah"* (Participant Three, line 135).

Participant Three then expanded on this, giving his views on how he believes boys and girls are treated differently by society, in relation to mental health:

"Um, I definitely think society treats men and women differently. But like, I don't know, men are supposed to grow up and be a man. Yeah, I think they'll be forced into hiding it. Whereas girls might be more open about it. And supported" (Participant Three, lines 129-131).

When asked what he thought of this situation, Participant Three responded:

"I don't believe in it, I don't, I don't think it should go like that, it should be everyone gets help, gets support with their mental health difficulties and mental health. And I kind of feel like it's two different things" (Participant Three, lines 137-139).

In line with the views expressed by other participants, Participant Four stated:

"I think girls, it may be a bit like it's not probably a bit easier. I would say I'm a maybe they've normalised it a bit more. But yeah, I think it's probably easier for girls to ask for help or get help because they've normalised it more" (Participant Four, lines 154-156).

Participant Four added:

"I'm not sure really, probably just through social media or just they find it easier to talk about it, maybe. And the stereotypes that from like before, that girls are allowed to be more emotional than men probably or they're really a bit further ahead about talking about it, and boys are just catching up to normalising it" (Participant Four, lines 158-161).

Participant Five took this idea further, saying:

"I think yes, as a kind of, as a gender I think girls and more like, into their emotions, like they'll be able to show their emotions more like I, I know, men can cry, but like, it's kind of seen as a, like, a weak, whatever, that kind of thing. But I think girls are able to tap into their emotions more, because kind of friends might be a bit more supportive or trusting. And I think it's not as much of an issue as it used to be. I think a lot more men come forward and there's definitely, is like this, persona that people have, like, they can't, they can't cry, like, they have to like be strong all the time. And I think that's unrealistic, and it shouldn't be an issue. But it definitely is, and I think that women definitely find it easier to kind of talk about mental health" (Participant Five, lines 169-176).

Participant Five went on to add:

"Um, I think that it's obviously still like a quite a big issue, like what I mean by it's changed is that there are a lot more men specifically that want to come forward and say it because they've seen the effects they can have, like, like, people, like the statistics for men and women dying from suicide, like men are like, six or seven times more likely. So, I think they've noticed that it's a real issue and there's some serious consequences if they don't get help. And I think that's kind of one of the main reasons. Like I said, with more people kind of getting on social media, I think a lot more like, boys and men are spending more time and they're finding ways that they can get help like websites and kind of speaking to more people. And they kind of find, I guess, release from life by going on social media and kind of just like doing things that they enjoy on them. And that's kind of helped them mentally as well, I guess" (Participant Five, lines 180-189).

These responses show that despite all of the input and initiatives around boys, men and mental health which have been delivered locally, nationally, and globally, the long-held stereotypes of men needing to remain silent about mental health issues in order to retain their masculinity are still present, although these boys and young men disagree with them and feel that this is changing, albeit slowly.

As discussed in chapter one, the term and concept of gender was used in a binary manner, and in many ways, traditional male and female stereotypes were implicit, both within the interview schedule and the research as a whole. The fact that participants were asked about possible gender differences in perceptions of and help seeking with mental health may have served to remind participants of the stereotypes and also, to an extent, perpetuate them.

4.8.2. Subtheme 6.2: Feelings of Shame and/or Embarrassment

Linked closely to the concept of stigma, discussed in chapter two, were feelings of shame and/or embarrassment, which some participants felt were barriers to help seeking behaviours.

Participant One felt that sharing concerns regarding mental health would be easier with some people than with others, stating:

"but you still have to be. Have to be confident enough to share that with someone that isn't within your family or friendships and stuff like that" (Participant One, lines 59-61).

This response is redolent of earlier answers linked to the importance of trusting relationships when deciding if or whom to speak to about mental health.

Participant Five stated: *"People are still very scared to do it because they're scared about confidentiality"* (Participant Five, line 54). Participant Five added: *"But it's like a taboo subject"* (Participant Five, line 61).

Participant Five expanded upon this, saying:

"People feel like they'll get kind of it won't be as secretive as they think like, you might like, laugh at them or something and make fun of them for that kind of thing. So, they kind of keep it to themselves., and don't risk that, I guess" (Participant Five, lines 64-66).

This view was later reinforced when Participant Five said:

"Maybe, I think the, I think it's lot better than it used to be, they won't like, hate someone because they have a mental illness, but I think that people are still scared to come forward and say they do, because social media is quite bad. That kind of thing, like, I guess they're shamed through it. Not shamed, they'll kind of use it against them in a way" (Participant Five, lines 69-72).

Social media perpetuating the idea of mental health being something to be ashamed of was clear within this response. Participant Five's use of the word *"shamed"* indicates that even though he did not believe that mental health difficulties are things to be ashamed of, at some level, he held a connection between feelings of shame and mental health.

4.9. Chapter Summary

This chapter has outlined the themes and subthemes which were identified by the Researcher during the thematic analysis process. The Chapter began with a thematic map illustrating the six themes identified, and corresponding subthemes within them. Themes and subthemes were discussed and accompanied by extracts from within the data. The chapter ended with a summary of findings in relation to the five research questions posed by the researcher.

5. Discussion

5.1. Chapter Overview

This chapter begins with a discussion of the findings of the research, in relation to the five research questions posed by the researcher, and also to the overarching research question regarding adolescent boys' perceptions of mental health and awareness of school-based support systems. Links to literature review in Chapter Two are made. Brief summaries are given, regarding participants' perceptions of mental health and awareness of support available to them. The researcher then discusses limitations of the research, followed by possible implications of the findings. The research is then reflected upon by the researcher before he gives final conclusions of the research.

5.2. Summary of Findings Linked to Research Questions

Within the data, participants expressed a range of perceptions of mental health and knowledge of sources of available information and support. The following sections summarise the findings in relation to the research questions of this research. Potential implications of the findings are posited, and limitations of the research are then discussed. The chapter and the research end with reflections on the research and researcher conclusions.

5.2.1. Research Question One: What are participant's perceptions of mental health?

In terms of their general perceptions of mental health, participants expressed what can be viewed as positive and negative perceptions, with a stronger weighting being given to the latter. Participants were aware that mental health exists on a continuum, and that everyone has mental health, be that good or otherwise. Participants also discussed mental health conditions as manifesting in both physical and emotional ways.

Participants showed a high level of awareness as to how to maintain positive mental health which they had gleaned from various sources: school, the internet and friends and family.

The idea of stigma and associated feelings of shame and/or embarrassment were evident within many participant's responses. Participants were aware of promoters of good mental health and were able to discuss these. Relationships were deemed by all participants to be important to the maintenance of positive mental health, as was fitness and doing things one enjoys. In terms of barriers to positive mental health, participants focused on social media, with every participant citing it as a possible cause of mental health difficulties. This corroborates the research conducted by Haraldsen, K., Stallard, P., Cuijpers, P., Bru, E., & Bjaastad, J. (2016), which found that stigma related factors prevented adolescent boys from seeking help linked to mental health. Research conducted by Kendal, Keeley & Callery (2014) UK high schools, also found that students viewed help-seeking behaviour as a sign of weakness, however also concluded that they valued learning skills in managing their feelings and friendships.

5.2.2. Research Question Two: Are participants able to distinguish between mental health difficulties in terms of severity and type? If so, how?

Participants were also able to distinguish between and discuss different forms of mental health issues and also to say how they might recognise them in others. When discussing anxiety, participants spoke about people feeling hypervigilant. Participants also associated anxiety with social withdrawal, fidgeting and excessive crying.

Depression was also characterised by participants as manifesting in social withdrawal. In addition, participants spoke about low mood. In physical terms, participants associated depression with either under or overeating and sleeping, and, in some cases, self-harm. Suicide as a possible result of depression was mentioned by one participant.

Participants seemingly found describing loneliness to be more difficult, with just one participant being able to give a description of the emotion as including feeling dissociated and as not talking very much.

Anger was described in greater detail, with participants describing the emotion as sometimes being expressed randomly and also as being displaced and expressed through physical activity. Physically, participants described anger as being recognisable by people sweating, turning red and twitching.

Within participant's description of anger was also a reference to the taboo nature of feeling angry, with one participant talking about anger as being often hidden.

5.2.3. Research Question Three: Do participants make links between perceptions of mental health and help seeking behaviours and their gender identity? If so, what are the links?

Strong links between gender and mental health were made by the participants, in particular with reference to help seeking behaviours and potential obstacles to them. As previously stated, during this research, gender was discussed in binary terms, namely male and female.

Participants felt that although society is changing, and times are different for people of their generation, that there is still stigma attached to mental health and speaking about it, with this being especially true for young people who identify as being male. One participant made a connection between this and the higher rate of suicide among males as compared to females.

Without exception, all participants felt that it is easier for girls to talk about and seek help for their mental health than it is for boys. Participants attributed this largely to long held stereotypes of maleness, which include not talking about or expressing emotion for fear of this being perceived as weakness by others. This supports the research findings of Seamark & Gabriel (2016) , which suggested that gender roles, awareness and perceptions of help, social and cultural expectations and norms and the risk of stigma and rejection represented significant barriers to help-seeking behaviours for adolescent boys and young men.

Although participants did not subscribe to them themselves, perceived gender roles in relation to discussing mental health were discussed by all participants. Participants did agree with research by Seamark & Gabriel (2016), which looked at the impact of these roles on help-seeking and suggested that there is a level of acceptance and desensitisation towards women being able to express themselves and seek help, as compared to men. This echoes findings in studies such as Ansara & Hindin's (2010), which also found that participant's perceived gender roles acted as a barrier to help-seeking, especially for males. In this instance, men were perceived as *"strong"* and able to cope alone, without resorting to any external support which was viewed as compromising their masculine roles, suggesting that help-seeking in males undermines their masculine identity.

5.2.4. Research Question Four: How do participants feel about discussing mental health by video rather than face to face?

Participants reported feeling positive about discussing mental health virtually as opposed to in person. Participants also reported feeling less pressure when discussing mental health virtually. This view supports research which found that men do regularly seek health information from online sources (Lohan, Aventin, Oliffe, Han & Bottorff, 2015). Linked to this, and to the idea of confidentiality, expressed by participants, is research which stated that the anonymity of computerised support is believed to reduce barriers to help-seeking, such as concerns over confidentiality (Gulliver, Griffiths & Christensen, 2010). Preliminary reports indicate that computerised mental health support has the potential to support many young men (Griffiths & Christensen, 2006).

The main negative mentioned in relation to virtual discussions on mental health were possible technical difficulties, such as screens *"freezing"* which it was felt would fragment conversations.

5.2.5. Research Question Five: Are participants aware of school based and other sources of support?

In terms of sources of support linked to mental health, participants' responses focused on three: school, the internet and friends and families. Participants were able to speak about the merits and potential pitfalls of these.

The general consensus amongst participants was that school is a good source of information on mental health. Participants reported that school is well equipped to support the mental health of young people, in terms of both human and environmental resources. The promotion of good mental health and sources of support were felt to be well publicised within school.

Ambivalence with regard to the internet, in particular social media, as a source of information and support for mental health was expressed by participants. Educational videos on platforms such as YouTube and TikTok were viewed as helpful resources, as was online support offered within school and by charities such as Mind.

Social media as a helpful source of information and support was also reported. However, participants also felt that social media can be detrimental to good mental health in that users may make unfavourable comparisons between themselves and other users in term of the number of *"likes"* they receive and therefore not receive the validation from others they may be seeking. Participants also spoke of social media as being a potential platform for bullying linked to mental health.

Family and friends were felt by all participants to be important sources of information and support with mental health, with one participant placing particular emphasis of speaking within these groups as opposed to with professionals. However, it was also expressed that mental health is not a regular topic of discussion within friendships groups.

The importance of trusting relationships and privacy were common threads within participant responses. This links directly to research conducted by Clark, Hudson, Dunstan & Clark (2018), which identified the themes of risk, effort, and the need for human connection, in relation to adolescent boys' perceptions of discussing mental health difficulties with others.

In line with responses given by participants linked to in-person as opposed to online support, their work also focused closely on the use of computerised systems of support and suggested that this format was a practical way to remove many of the barriers, such as feelings of embarrassment, described by their sample. The work of Jobe & Gorin (2013) also found that the quality of therapeutic relationships was central to the CYP, when seeking and receiving support for mental health.

Through the current research, the researcher was hoping to ascertain the perceptions of adolescent males, with regards to mental health, and also their awareness of and willingness to access school-based and other forms of support for mental health. Keeping in mind the qualitative methods used, and subsequent limitations in terms of generalisability, this was, to a large extent achieved, due largely to the honesty and openness of the participants.

5.3. Critique of the Current Research

5.3.1. Limitations of the Current Research

The researcher acknowledges that there are a number of limitations of the current research. The definition of adolescence used is one of them. The narrowness of the definition used, i.e., chronological ages between 11 and 16, does not allow for the development of attitudes and knowledge which often occur after the age of 16, as well as the neurological changes which accompany them.

Similarly, the narrowness of the term/concept *"gender"* operationalised within the current research is also a limitation. The participant's self-concepts of their gender identification were not fully explored, as was not the concept of what it means to be *"male"* or a *"boy."* Given the overarching research question, the researcher also acknowledges that further consideration should have been given to these concepts.

The fact that participants were gathered from one school also means the views of a very limited cross-section of this demographic were sought, in terms of lived school experience.

Despite these limitations, the researcher believes this research is of relevance to all professionals working within both education and mental health services for CYP, given its specific focus on boys' perceptions of mental health and their awareness of available support.

The findings indicate that, despite the work done by governmental agencies at all levels, disparities linked to long-held stereotypes of male and female still exist with regard to adolescent boys' perceptions of mental health, and by extension, their feelings about males accessing support with mental health, which are influenced by these same ideas, continue to exist. Although the notion of boys and men displaying signs of mental health difficulties was not regarded as a sign of weakness by participants, many felt that it is amongst the general population. Further work is needed to normalise expressing and seeking support with mental health difficulties amongst men.

Participants largely felt that school was doing a good job of both offering and advertising mental health support services, and also that the internet supplemented this well. However, given the substantial responses linking the internet, in particular social media with mental health difficulties, further targeted work in schools around this is needed, together with clear signposting to reliable sources of online mental health support. This is in line with participants' reporting feeling comfortable accessing these services online, including having virtual conversations about mental health.

5.4. Validity and Trustworthiness of the Current Research

Data gathered fulfilled, to an extent, the primary and secondary aims of the research in that boys' perceptions of mental health were explored, together with their awareness of support available linked to mental health. However, it is important to recognise and acknowledge the limitations of the research.

5.4.1. Validity

The concept of validity was formulated by Kelly (1927, p. 14) who stated that a test is valid if it measures what it claims to measure. For example, a test of intelligence should measure intelligence and not something else (such as memory). A distinction can be made between internal and external validity. These types of validity are relevant to evaluating the validity of a research study/procedure. Internal validity refers to whether the effects observed in a study are due to the manipulation of the independent variable and not some other factor. External validity refers to the extent to which the results of a study can be generalized to other settings (ecological validity), other people (population validity) and over time (historical validity). Face validity is whether the test appears (at face value) to measure what it claims to.

The small sample size of the current research means that it does not have the external validity often inherent within research based on quantitative methods. This is compounded by the fact that participants were drawn from one school. As mentioned in the researcher's Reflexive Statement in Chapter One, researchers, without exception, bring their own preconceptions to their research, and the researcher acknowledges the very real possibility that his own ideas and values may have produced an experimenter effect in that participants may have said what they felt he wanted to hear. This was further compounded by the researcher's lack of interviewing experience, for example, when the subject of drugs and alcohol was mentioned by a participant, the researcher failed to probe further to elicit more on this potentially important factor linked to CYP and mental health.

5.4.2. Reliability

Reliability refers to whether or not the same results might be generated by different researchers using the same methods, with a different group of participants (Yardley, 2008). Inherent within this concept is the idea that tools and their use will not be influenced by the researcher's views and values. In these terms, the researcher acknowledges that the findings from the current research are not generalisable to the general population of adolescent boys and young men.

5.4.3. Effects of the Covid-19 Pandemic on Both the Mental Health of CYP in the UK and the Current Research

Between March and June 2020, a period when schools were closed to most pupils, symptoms of depression and post-traumatic stress disorder (PTSD) were found to have significantly increased in children and young people aged between 7.5 and 12 years old compared to immediately before the pandemic (Bignardi, G., Dalmaijer, E. S., Anwyl-Irvine, A. L., Smith, T. A., Siugzdaite, R., Uh, S. & Astle, D (2020, July 10)).

On March 23rd, 2020, the UK Government announced the first Covid-19 linked lockdown, severely restricting movement and contact between UK citizens. This had varied and direct effects on the current research in terms of participant recruitment and subsequent data collection. All schools were closed for extended periods, meaning that the researcher had to rethink his method of recruitment and change from face-to-face interviews, which had been his original intention, to virtual interviews. This also meant that the researcher was not able to meet with school staff or families in person. It is possible that, without the restrictions imposed by the pandemic, the researcher would have found it easier to gather a larger sample, from more than one school

The validity of data obtained via online interviews as compared to in person is questionable. On the one hand, rapport, essential to the interview process, particularly when discussing potentially emotive or upsetting topics, is harder to establish. It is also possible that elements non-verbal communication may be missed by the researcher. However, recent research has suggested that;

"Qualitative interviews performed through video, telephone, and online are valid and trustworthy alternatives to traditional face-to-face interviews. Moreover, these interview methods might bring reform to the notion that face-to-face interviews are the gold standard, as interviews performed from a distance serve their purpose in a more cost-effective way while promoting inclusion and equality in research" (Saarijarvi M & Ewa-Lena B, 2021).

5.4.4. Trustworthiness

Lincoln & Guba, (1985), established four key criteria in determining the trustworthiness of research; credibility, transferability, dependability, and confirmability.

Credibility, in this instance, refers to the level confidence one might have in the *"truth"* of the findings of research. Participants in the current research were encouraged to be as honest as possible and were also given assurances that, subject to safeguarding issues, their responses would be confidential. However, the personal nature of the current research, combined with the inherent power imbalance of the situation between the researcher and participants means that it is possible that participants gave answers they felt the researcher wanted to hear, which would affect the level of credibility of the data. This could have been countered by adding another layer of confidentiality through the use of, for example, anonymised questionnaires.

Transferability refers to how applicable the findings are in other contexts. Given the specificity of both the demographic and overarching research question, the findings of the current research have limited applicability to other contexts.

Dependability refers to the extent to which the findings are consistent and might be reproduced if the research was repeated. The subjective nature of the research, ergo the findings, together with the social constructionist approach of the research and the researcher's interview technique mean that in these terms, the exact same findings would be unlikely to reproduced by another researcher, although it is possible that similar themes would emerge.

Confirmability is linked to the degree of neutrality or the extent to which the findings of a study are shaped by the respondents, and not researcher bias, motivation, or interest. As has been previously stated, the researcher had a longstanding interest in this topic, with the inextricable preconceptions which accompany it. Although the researcher was aware of this,

it would be erroneous and misleading for him to assert no bias, and so in these terms, levels of confirmability are also low.

5.5. Implications for Educational Psychology Practice

As outlined within Chapter One, mental health amongst young people is a serious and growing concern, both in this country and across the world. The possible lifelong effects of not recognising and seeking early help for mental health difficulties has also been touched upon. Factors such as the recent global pandemic and the ever-expanding use of technology and social media are having profound effects on the mental health and wellbeing of young people, some positive, some not. The current research and its findings have highlighted a reluctance amongst boys and young men, to discuss and seek help regarding their mental health.

Educational psychologists are well placed to help to address this, both at individual and systemic levels. On a case-by-case basis, EPs can support the normalisation of boys talking about their feelings and mental health worries, and, through training, can support schools with this normalisation process and also to promote preferred methods of support within this demographic. Whole school behaviour and mental health support policies can be jointly revisited and revised, as can school-based support systems. Local Authority Mental Health Support Teams, which include EPs can also be part of this.

Early identification has been identified by research in being vital in addressing mental health issues, and again, EPs are well positioned to support this within schools, beginning within the Early Years/Foundation Stages of education.

5.6. Conclusions

As with the Reflexive Statement contained within Chapter One, this section will be written in first person as it pertains directly to the researcher’s own, personal reflections.

Throughout the research process, I used Gibbs's Model of Reflection to guide and structure my reflections, following the stages contained within said model: action plan, description of what happened, how I was feeling, evaluation of the research process and research, analysis and concluding thoughts.

The action plan for the current research was formed with the support of my academic and professional tutor, towards the end of 2019, shortly before the pandemic occurred. I had a longstanding interest in all of the key elements of the current research, namely boys' experiences at school, their mental health and support within education for mental health. This meant that I need to be continually conscious of my potential bias and values linked to this so as to minimise the risk of influencing participant's responses. Although the research initially felt primarily clinical in nature, I felt that linking it to support in schools made it of relevance to the doctoral training in educational psychology that I was undertaking. Due to the subject matter's emotive nature and a belief that I had (and still hold) that rapport can be better established in person rather than online or via a questionnaire, I decided early on that data would be gathered via in person interviews.

Due to the pandemic, interviews were conducted online, and the processes of both recruitment and the gathering of data took much longer than I had anticipated. This led to feelings of frustration and anxiety on my part, which was ameliorated by my academic tutor and the local authorities in which the current research took place and the authority in which I later worked.

Given the limitations imposed by the pandemic, I believe the research was successful in gathering data linked to the perceptions of mental health by adolescent boys, and their awareness of school-based and other sources of support. This was largely due to their flexibility and familiarity with communicating virtually. Given more time and the relative freedom the UK is now experiencing in terms of movement, I would conduct the interviews in person.

In terms of messages which can be gleaned and taken away from this research, there are several.

The importance of trusting and authentic relationships in helping young men and boys to talk about and seek help with mental health is apparent both within this research and research linked to it. The importance of being able to trust others was prominent within the participant's responses.

Technology and its potential to be both helpful and harmful was also clear within the data gathered in this research. Although the majority of responses focused on the potential harm that technology and social media can do, in relation to mental health, online support and social media platforms were cited, respectively as preferred means of support and useful sources of information and support.

The normalisation of mental health difficulties was another clear thread within the research and, linked to this and all of the above findings was the importance of finding ways in which to empower boys and school staff/trusted adults to talk about mental health.

Even though the findings from this research make it apparent that traditionally held views of masculinity linked to mental health and talking about feelings still exist, perhaps the strongest message from this research is one of hope, in that although the participants were all aware of said stereotypes, they did not personally subscribe to them, but rather strongly disagreed and felt that boys should be encouraged to and supported in talking about mental health and their feelings.

5.7. Future Research

From both the findings and limitations of the current research, many possibilities for future related research arise, in terms of both subject matter and methods used to conduct the research.

As stated, a major limitation of the current research was the size of the sample. In addition, the sample was drawn from only one school. The sample was also homogenous in that all participants were from the same ethnic background and similar socio-economic background. Future research would benefit from a larger sample, made up of participants from a variety of ethnic, cultural, and socio-economic backgrounds.

Future studies may wish to focus on the means of delivering support to this demographic, specifically whether in-person or online support is felt by them to be more helpful and also whether or not they would feel more inclined to access this type of support.

The role of relationships, felt by all participants to be vitally important to the seeking of mental health support is also an area on which future research could focus.

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Appendices

Appendix A: Table of Qualitative Literature Reviewed

Qualitative Research
Chaturvedi, S. (2016). Accessing psychological therapies: Homeless young people's views on barriers and facilitators.
Hanley, T., and Morrison, R. (2003). Accessible services for 11- to 25-year-olds. Child and Adolescent Mental health in Primary Care
Hanley, T., Winter, L., and Burrell, K. (2019). Supporting emotional well-being in schools in the context of austerity: An ecologically informed humanistic perspective.
Jobe, A., and Gorin, S. (2012). 'If kids don't feel safe they don't do anything': young people's views on seeking and receiving help from Children's Social Care Services in England. *Child and Family Social Work*
Kendal, S., Callery, P., and Keeley, P. (2011). The feasibility and acceptability of an approach to emotional wellbeing support for high school students. *Child And Adolescent Mental Health*
Prior, S. (2012). Young people's process of engagement in school counselling. *Counselling And Psychotherapy Research*
Seamark, D., and Gabriel, L. (2016). Barriers to support: a qualitative exploration into the help-seeking and avoidance factors of young adults.
Tharaldsen, K., Stallard, P., Cuijpers, P., Bru, E., and Bjaastad, J. (2016). 'It's a bit taboo': a qualitative study of Norwegian adolescents' perceptions of mental healthcare services. Emotional And Behavioural Difficulties

Appendix B: Table of Quantitative Literature Reviewed

Quantitative Research
Fox, C. L., and Butler, I. (2007). 'If you don't want to tell anyone else you can tell her': young people's views on school counselling.
Newbold, A., Warren, F., Taylor, R., Hulme, C., Burnett, S., and Aas, B. et al. (2020). Promotion of mental health in young adults via mobile phone app: study protocol of the Eco Web (emotional competence for well-being in Young adults) cohort multiple randomised trials.

Appendix C: Table of Mixed Method Literature Reviewed

Mixed Method Research
Learoyd-Smith, S. (2010). An exploration of the impact of contextual school factors on students' ways of thinking, speaking, and acting. Emotional And Behavioural Difficulties,
Odimegwu, C., Pallikadavath, S., and Adedini, S. (2013). The cost of being a man: social and health consequences of Igbo masculinity.
Oliffe, J. L., Rice, S., Kelly, M. T., Ogrodniczuk, J. S., Broom, A., Robertson, S., and Black, N. (2019). A mixed-methods study of the health-related masculine values among young Canadian men.
Walsh, C., and Harland, K. (2019). Research Informed Youth Work Practice in Northern Ireland: Recommendations for Engaging Adolescent Boys and Young Men.

Appendix D: Draft of Semi-Structured Interview Schedule

Draft Semi-Structured Interview

What do you think of when you hear the words “mental health”?

What is your idea of a more serious mental health issue?

What is your idea of a less serious mental health issue?

Do you think there are differences in the way boys and girls discuss mental health?

Do you ever discuss mental health with your friends?

Do you ever discuss mental health with your family?

Tell me what you know about support available for young people’s mental health.

Do you think there are differences in the ways boys and girls seek help with their mental health?

Appendix E: Semi-Structured Interview Schedule

1. What do you understand by mental health?

2. How did you come to understand this?

3. What can you do to keep yourself mentally healthy?

4. What support is there at school if you are worried about mental health?

5. How else can you get help if you are worried about your mental health?

6. How could you support a friend who had mental health issues?

7. Do you talk about mental health with your friends? If so, when, and how?

8. How do you feel about talking about mental health on a video call? Do you feel it is easier or harder than talking face to face?

9. In society, what do you think has an effect on young people's mental health?

10. Do you think there is a difference in how boys and girls talk about mental health? If yes, what, and why?

11. How would you know if someone had mental health difficulties?

12. What might it look like if someone was feeling:

a. Anxious?

b. Lonely?

c. Depressed?

d. Sad?

e. Angry?

Appendix F: Parental Information and Consent Form

UNIVERSITY OF EAST LONDON

Parental consent to participate in a research study

An Exploration of Adolescent Boys' Perceptions of Mental Health and Awareness of School-Based Support System

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my child's involvement in this study, and particular data from this research, will remain strictly confidential. Only the Researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to my child participating in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw my child from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw my child; the Researcher reserves the right to use my anonymous data after analysis of the data has begun.

Parent's Name (BLOCK CAPITALS)

……

Parent's Signature

……..

Researcher's Name

LUCA TURI

……..

Researcher's Signature

……

Date: ……..…….

Parent/Guardian Information

Thank you for agreeing to allow your child to participate in my research study on exploring adolescent boys' perceptions of mental health and awareness of school-based support systems. This letter offers information that may be relevant in light of you having now taken part.

The research pertains to adolescent boy's perceptions of mental health and awareness of available support systems.

Interviews will be conducted via Microsoft Teams and will last for approximately 45 minutes.

The questions are:

What do you understand by mental health?

2. How did you come to understand this?

3. What can you do to keep yourself mentally healthy?

4. What support is there at school if you are worried about mental health?

5. How else can you get help if you are worried about your mental health?

6. How could you support a friend who had mental health issues?

7. Do you talk about mental health with your friends? If so, when, and how?

8. How do you feel about talking about mental health on a video call? Do you feel it is easier or harder than talking face to face?

9. In society, what do you think has an effect on young people's mental health?

10. Do you think there is a difference in how boys and girls talk about mental health? If yes, what, and why?

11. How would you know if someone had mental health difficulties?

12. What might it look like if someone was feeling:

a. Anxious

b. Lonely?

c. Depressed?

d. Sad?

e. Angry?

What will happen to the information that they have provided?

The following steps will be taken to ensure the confidentiality and integrity of the data they have provided:

- All data (including personal contact details) will be securely stored on the University of East London One Drive and will be password protected.
- The data will be pseudo anonymised, which means that each participant will be assigned a number, rather than using names.
- The fully anonymised data may be seen by my supervisor, examiners and may be published in academic journals.
- After the research has been completed, the data will be stored for as long as is deemed necessary by UEL but will be stored securely.
- They are free to withdraw from the research study at any time without explanation, disadvantage, or consequence. Separately, they may also request to withdraw their data even after they have provided data, provided that this request is made within three weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

What if they have been adversely affected by taking part?

It is not anticipated that they will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise potential harm. Nevertheless, it is still possible that their participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. Parents will be informed of this and invited to be present during interviews, should they deem it necessary or appropriate. If they need further support, this can be obtained by visiting www.kooth.com, which provides free and confidential help and support for young people, linked to mental health issues.

You are also very welcome to contact me or my supervisor if you have specific questions or concerns.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Luca Turi: u1825081@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr Miles Thomas, School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: m.thomas@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ.

Appendix G: Participant Information and Consent Form

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

An Exploration of Adolescent Boys' Perceptions of Mental Health and Awareness of School-Based Support System

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this

information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the Researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the Researcher reserves the right to use my anonymous data after analysis of the data has begun.

Participant's Name (BLOCK CAPITALS)

…….

Participant's Signature

……..

Researcher's Name

LUCA TURI

……..

Researcher's Signature

……

Date: ……..…….

Appendix H: Participant Debrief Letter

PARTICIPANT DEBRIEF LETTER

Thank you for participating in my research study on exploring adolescent boys' perceptions of mental health and awareness of school-based support systems. This letter offers information that may be relevant in light of you having now taken part.

There will be an interview on Microsoft Teams which will last for about 45 minutes. The questions will be:

What do you understand by mental health?

2. How did you come to understand this?

3. What can you do to keep yourself mentally healthy?

4. What support is there at school if you are worried about mental health?

5. How else can you get help if you are worried about your mental health?

6. How could you support a friend who had mental health issues?

7. Do you talk about mental health with your friends? If so, when, and how?

8. How do you feel about talking about mental health on a video call? Do you feel it is easier or harder than talking face to face?

9. In society, what do you think has an effect on young people's mental health?

10. Do you think there is a difference in how boys and girls talk about mental health? If yes, what, and why?

11. How would you know if someone had mental health difficulties?

12. What might it look like if someone was feeling:

a. Anxious?

b. Lonely?

c. Depressed?

d. Sad?

e. Angry?

What will happen to the information that you have provided?

The following steps will be taken to ensure the confidentiality and integrity of the data you have provided.

- All data (including personal contact details) will be securely stored on the University of East London One Drive and will be password protected.
- The data will be pseudo anonymised, which means that each participant will be assigned a number, rather than using names.
- The fully anonymised data may be seen by my supervisor, examiners and may be published in academic journals.
- After the research has been completed, the data will be stored for as long as is deemed necessary by UEL but will be stored securely.
- You are free to withdraw from the research study at any time without explanation, disadvantage, or consequence. Separately, you may also request to withdraw your data even after you have participated data, provided that this request is made within

three weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

What if you have been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise potential harm. Nevertheless, it is still possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. Parents will be informed of this and invited to be present during interviews, should they deem it necessary or appropriate. If you need further support, this can be obtained by visiting www.kooth.com, which provides free and confidential help and support for young people, linked to mental health issues.

You are also very welcome to contact me or my supervisor if you have specific questions or concerns.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Luca Turi: u1825081@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr Miles Thomas, School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: m.thomas@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.lomas@uel.ac.uk.

Appendix I: University Ethical Approval and Risk Assessment

UNIVERSITY OF EAST LONDON

School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

(Updated October 2019)

FOR BSc RESEARCH

FOR MSc/MA RESEARCH

FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING and EDUCATIONAL PSYCHOLOGY

1. Completing the application

1.1 Before completing this application please familiarise yourself with the British Psychological Society's Code of Ethics and Conduct (2018) and the UEL Code of Practice for Research Ethics (2015-16). Please tick to confirm that you have read and understood these codes:

1.2 Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will then look over your application.

1.3 When your application demonstrates sound ethical protocol, your supervisor will submit it for review. It is the responsibility of students to check this has been done.

1.4 Your supervisor will let you know the outcome of your application. Recruitment and data collection must NOT commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (see section 8).

1.5 Please tick to confirm that the following appendices have been completed. Note: templates for these are included at the end of the form.

- The participant invitation letter [x]
- The participant consent form [x]
- The participant debrief letter [x]

1.6 The following attachments should be included if appropriate:

- Risk assessment forms (see section 6)
- A Disclosure and Barring Service (DBS) certificate (see section 7)
- Ethical clearance or permission from an external organisation (see section 8)
- Original and/or pre-existing questionnaire(s) and test(s) you intend to use
- Interview protocol for qualitative studies
- Visual material(s) you intend showing participants.

2. Your details

2.1 Your name: Luca Turi

2.2 Your supervisor's name: Dr. Miles Thomas

2.3 Title of your programme: Professional Doctorate in Educational and Child Psychology

2.4 UEL assignment submission date (stating both the initial date and the resit date):
April 2021

3. Your research

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and details of your proposed research.

3.1 The title of your study: An exploration of adolescent boys' perceptions of mental health and awareness of school-based support systems

3.2 Your research questions: What are participant's perceptions of mental health?
Do participants able to distinguish between mental health issues in terms of severity? If so, how?
Do participants make links between perceptions of mental health and their gender identity? If so, what are the links?
How do participants feel about discussing mental health by video rather than face to face?
Are participants aware of external/internal sources of support?
Are participants willing to access support if they feel they need to?

3.3 Design of the research: This research will be qualitative, and data will be gathered via semi structured interviews, using Microsoft Teams. The data will be analysed using thematic analysis.

3.4 Participants: Participants will be recruited through purposive sampling within secondary schools in the Local Authority that the Researcher is on placement in. The Researcher will aim to recruit between 10 and 15 participants to take part in the research, boys aged between 11 and 16 years.

3.5 Recruitment: Participants will be recruited from secondary schools by the Researcher and subject to parental consent being obtained. The Researcher may also engage with snowball sampling if the participant group are proving difficult to recruit. If recruitment is challenging, there is a possibility of the Researcher recruiting participants from the patch of schools that they are currently working in by liaising with school staff and the authority, with children and young people, as a trainee educational psychologist.

3.5 Measures, materials, or equipment: Data will be collected by recording semi-structured interviews on Teams. It will be stored on the UEL OneDrive which is compliant with GDPR regulations and password protected.

3.6 Data collection: Data from the interviews will be recorded on a personal, password protected laptop. These will then be transcribed by the Researcher. Data will then be transferred to the UEL Onedrive. All data collection will be undertaken in line with school and government guidelines.

3.7 Data analysis: The data gathered from the interviews will be fully transcribed by the Researcher. It will be analysed using thematic analysis from a social constructionist perspective.

4. Confidentiality and security

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

4.1 Will participants data be gathered anonymously? No

4.2 If not (e.g., in qualitative interviews), what steps will you take to ensure their anonymity in the subsequent steps (e.g., data analysis and dissemination)?

- Submission of UEL data management plan
- Data will be anonymised. Participant interviews will be assigned a number (names not used)
- Number/ Participant information to be saved securely on UEL One Drive
- Transcripts saved securely on UEL one drive (password protected) This ensures compliance with GDPR regulations.
- Laptop cleared following transcription

4.3 How will you ensure participants details will be kept confidential?

Pseudo anonymisation of interviews.

4.4 How will the data be securely stored? Data will be stored on the UEL One Drive and will be password protected.

4.5 Who will have access to the data? The Researcher and the research supervisor.

4.6 How long will data be retained for? The data will be retained for the minimum amount of time required by the university. It will be stored securely until it can be deleted.

5. Informing participants

Please confirm that your information letter includes the following details:

5.1 Your research title: [x]

5.2 Your research question: [x]

5.3 The purpose of the research: [x]

5.4 The exact nature of their participation. This includes location, duration, and the tasks etc. involved: [x]

5.5 That participation is strictly voluntary: [x]

5.6 What are the potential risks to taking part? [x]

5.7 What are the potential advantages to taking part? [x]

5.8 Their right to withdraw participation (i.e., to withdraw involvement at any point, no questions asked): [x]

5.9 Their right to withdraw data (usually within a three-week window from the time of their participation): [x]

5.10 How long their data will be retained for: x

5.11 How their information will be kept confidential: x

5.12 How their data will be securely stored: x

5.13 What will happen to the results/analysis? x

5.14 Your UEL contact details: x

5.15 The UEL contact details of your supervisor: x

Please also confirm whether:

5.16 Are you engaging in deception? If so, what will participants be told about the nature of the research, and how will you inform them about its real nature. No

5.17 Will the data be gathered anonymously? If NO what steps will be taken to ensure confidentiality and protect the identity of participants? The interviews will be anonymised, and password protected.

5.18 Will participants be paid or reimbursed? If so, this must be in the form of redeemable vouchers, not cash. If yes, why is it necessary and how much will it be worth? No

6. Risk Assessment

Please note: If you have serious concerns about the safety of a participant, or others, during the course of your research please see your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g., a participant or the Researcher injures themselves), please report this to your supervisor as soon as possible.

6.1 Are there any potential physical or psychological risks to participants related to taking part? If so, what are these, and how can they be minimised? Yes, psychological. Questions and responses may raise difficult issues to think about. Participants will be fully informed of the nature of the research. These will also be discussed with parents. If participants request it, parents will be able to be present during the interviews. External sources of support will also be signposted by the Researcher. If the interviews take place in a school setting, there will be a named member of staff who will be able to offer support. For interviews which take place in a home setting, should support be required, participants and their families will be directed to www.kooth.com which offers free online support with mental health issues.

6.2 Are there any potential physical or psychological risks to you as a Researcher? If so, what are these, and how can they be minimised? No. Participants will be informed that although their responses are confidential and anonymous, if they disclose something which makes the Researcher feel they may be harmed, an appropriate safeguarding professional will be informed, as per the authority's safeguarding policy.

6.3 Have appropriate support services been identified in the debrief letter? If so, what are these, and why are they relevant? Yes, parental support

6.4 Does the research take place outside the UEL campus? If so, where? Interviews will be conducted in secondary schools within the authority.

If so, a 'general risk assessment form' must be completed. This is included below as appendix 4. Note: if the research is on campus, or is online only, this appendix can be deleted. If a general risk assessme [x] rm is required for this research, please tick to confirm that this has been completed:

6.5 Does the research take place outside the UK? If so, where? No

If so, in addition to the 'general risk assessment form', a 'country-specific risk assessment form' must be also completed (available in the Ethics folder in the Psychology Noticeboard), and included as a [ ] pendix. If that applies here, please tick to confirm that this has been included:

However, please also note:

- For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on 'sign in' and then 'register here' using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance.
- For *on campus* students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Head of School (who may escalate it up to the Vice Chancellor).
- For *distance learning* students conducting research abroad in the country where they currently reside, a risk assessment must be also carried out. To minimise risk, it is recommended that such students only conduct data collection on-line. If the project is deemed low risk, then it is not necessary for the risk assessments to be signed by

the Head of School. However, if not deemed low risk, it must be signed by the Head of School (or potentially the Vice Chancellor).

- Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.

7. Disclosure and Barring Service (DBS) certificates

7.1 Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?

Yes

7.2 If so, you will need a current DBS certificate (i.e., not older than six months), and to include this as an appendix. Please tick to confirm that you have included this: The Researcher has an enhanced DBS form which allows him to work with children and young people as a trainee educational psychologist. [ ]

Alternatively, if necessary for reasons of confidentiality, you may email a copy directly to the Chair of the School Research Ethics Committee. Please tick if you have done this instead: [ ]

Also alternatively, if you have an Enhanced DBS clearance (one you pay a monthly fee to maintain) then the number of your Enhanced DBS clearance will suffice. Please tick if you have included this instead: Enhanced Certificate Number 001634608408 [X]

7.3 If participants are under 16, you need 2 separate information letters, consent form, and debrief form (one for the participant, and one for their parent/guardian). Please tick to confirm that you have included these: [x]

7.4 If participants are under 16, their information letters consent form, and debrief form need to be written in age-appropriate language. Please tick to confirm that you have done this [x]

* You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, and people who have been involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children click here.

8. Other permissions

9. Is HRA approval (through IRAS) for research involving the NHS required? Note: HRA/IRAS approval is required for research that involves patients or Service Users of the NHS, their relatives, or carers as well as those in receipt of services provided under contract to the NHS.

9.1

NO

If yes, please note:

- You DO NOT need to apply to the School of Psychology for ethical clearance if ethical approval is sought via HRA/IRAS (please see further details here).
- However, the school *strongly discourages* BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
- If you work for an NHS Trust and plan to recruit colleagues from the Trust, permission from an appropriate manager at the Trust must be sought, and HRA approval will probably be needed (and hence is likewise strongly discouraged). If the manager happens to not require HRA approval, their written letter of approval must be included as an appendix.
- IRAS approval is not required for NHS staff even if they are recruited via the NHS (UEL ethical approval is acceptable). However, an application will still need to be submitted to the HRA in order to obtain RandD approval. This is in addition to a separate approval via the RandD department of the NHS Trust involved in the research.
- IRAS approval is not required for research involving NHS employees when data collection will take place off NHS premises, and when NHS employees are not recruited directly through NHS lines of communication. This means that NHS staff can participate in research without HRA approval when a student recruits via their own social or professional networks or through a professional body like the BPS, for example.

9.2 Will the research involve NHS employees who will not be directly recruited through the NHS, and where data from NHS employees will not be collected on NHS premises?

NO

9.3 If you work for an NHS Trust and plan to recruit colleagues from the Trust, will permission from an appropriate member of staff at the Trust be sought, and will HRA be sought, and a copy of this permission (e.g., an email from the Trust) attached to this application?

N/A

9.4 Does the research involve other organisations (e.g., a school, charity, workplace, local authority, care home etc.)? If so, please give their details here.

I am a second year Trainee Educational Psychologist on the Professional Doctorate in Educational and Child Psychology. I have a bursaried placement within a Local Authority and have a patch of schools that I work within. I have an enhanced DBS and am fully up to date with safeguarding training. The research will be conducted within schools in order to be accessible to participants, although these schools have not been approached yet, and will not be until the research has been approved.

Furthermore, written permission is needed from such organisations if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation. If that is the case, please tick h[X]o confirm that you have included this written permission as an appendix:

Please note that even if the organisation has their own ethics committee and review process, a School of Psychology SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s as may be necessary.

9. Declarations

Declaration by student: I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name (typed name acts as a signature): Luca Turi

Student's number: u1825081 Date: 15/06/2020

Supervisor's declaration of support is given upon their electronic submission of the application.

UEL Risk Assessment Form			
Name of Assessor:	Luca Turi	**Date of Assessment**	05/05/20
Event title:	Research into adolescent boys perceptions of mental health and awareness of school based support systems	**Date, time and location of activity:**	Secondary schools in East Sussex, October 2020
Signed off by Manager (Print Name)	[redacted] **Dr Miles Thomas**		
Please describe the activity in as much detail as possible (include nature of activity, estimated number of participants, etc) If the activity to be assessed is part of a fieldtrip or event please add an overview of this below:			
Semi-structured interviews to be conducted with between 10 and 15 boys aged between 11 and 16, in school settings			
Overview of FIELD TRIP or EVENT:			

Which Activities Carry Risk?								
Activity / Task Involved	**Describe the potential hazard?**	**Who is at risk?**	**Likelihood of risk**	**Severity of risk**	**Risk Rating (Likelihood x Severity)**	**What precautions have been taken to reduce the risk?**	**State what further action is needed to reduce risk (if any) and state final risk level**	**Review Date**
Personal safety of individuals	Disclosure of sensitive, personal information	All	1	2	2	Researcher has current DBS. All interviews to take place in schools	All data anonymised and stored securely	15/06/20
Discussion of potentially personal and sensitive issues	Possible distress	All	1	2	2	School member of staff to be identified as support/external support to be signposted	None	15/06/20

Appendix J: Sample Transcript

Interview 5

Researcher: Okay, so my name is Luca, I'm doing some research into adolescent boys and their understanding of mental health, but also, but also sort of their awareness of support

that's available to them as well. So, everything that you say is completely confidential, completely anonymous, you are participant number five, so your name will not appear anywhere, at all. I have to do the safeguarding thing and I know that your mum's in the vicinity. But if you say something that makes me worried about you, then I might have to share it with an appropriate adult. Is that okay? Okay. And there are absolutely no right or wrong answers. It's not a test. It's just me finding out what you know about mental health. So, it should last about half an hour. Is that all right? Okay, brilliant. All right. So, P5, when you hear the words mental health, what do you think of, what's your understanding of mental health?

P5: Um, like, issues that people will have internally, and they sometimes feel scared to share it with other people, and they kind of deal with it themselves and keep it to themselves, and it like, it affects their mental and physical health.

Researcher: Okay, all right. That's, that's really interesting. In what ways might it affect their physical health, do you think?

P5: Well, if you've got like an eating disorder, it might, your brain might trick you into not liking certain foods or that kind of thing. So, it kind of can affect you physically if your brain is telling you to do something different.

Researcher: Okay. All right. So, you're kind of making that neurological connection that your brains kind of in control of it. And

P5: Yeah, your brain health's bad then everything can be bad.

Researcher: Yeah, okay. All right. That's, that's an interesting answer, haven't heard that before. Yes. Thank you. How did you come to, how have you learned about mental health?

P5: Kind of PSHE lessons and they like, run you through the main issues, the, the facts of how you can get help, but there's not that many, each year is only six in a year. So maybe not as much as I'd like, when I didn't really understand much about specific issues.

Researcher: Do you think there should be more?

P5: Probably like looking into the specifics, because they do like ones on depression and anxiety like the main ones, but I think like you're probably looking into different specific ones, there's a lot of stuff to cover.

Researcher: That's interesting, is it something you're quite interested in then?

P5: Kind of, I'd like to know how the brain works. I think it's quite interesting. How it can send links like how consciousness works, that kind of thing. It's very, very interesting, because no one really knows much about the brain.

Researcher: Just out of interest, does your school do psychology GCSE?

P5: Yeah, and I was interested in it, but the course filled up literally instantly. It was a bit annoying. I might look at it in college or something.

Researcher: Okay, and I absolutely recommend it. It was a fantastic subject to study. So, what can you do to kind of stay well, mentally? What kind of things can you do to keep yourself mentally healthy as it were?

P5: Well, kind of the other way around. Having good physical health can help you mentally, like playing lots of sports and stuff because it gives you something to do and when your body is quite healthy, like you don't have issues with like, a body image or that kind of thing, or yes. And also, just doing things you enjoy, there's no point beating yourself with something that you don't enjoy, it would just be pointless to waste your time doing stuff that you hate.

Researcher: Yeah, no, there's no arguing that okay. So, at school, what, what kind of support is there if you're worried about either your own mental health or a friend's mental health?

P5: So, I mean, the teachers are quite helpful, like I have, I can't say from first-hand experience that I've like, openly spoken to teachers, that kind of thing, like me or someone else. They always like offered to help in like classes. There's, I think there's safeguarding

officers, mental health officers, there now specifically for that, so they've been trained, I think it's quite good, or people are still very scared to do it because they're scared about confidentiality. But I do still think that if people did to that it would be quite good.

Researcher: All right. So, the support that you've just described at school? Do you feel? Do you think that that's very well known about?

P5: I mean, they mention it quite a lot. But I think a lot of people either choose not to use it or pretend that they're okay, because they don't want to have to go through the whole system. And I think that they, they mention it a lot, like, there's posters of it in pretty much every classroom, that kind of thing. I don't think that gets used very much, not because it's not known about, but it's like a taboo subject.

Researcher: It's like a taboo subject? Okay what makes that, that's again, that's really interesting. What makes you feel that it’s a taboo subject?

P5: People feel like they'll get kind of, it won't be as secretive as they think like, you might like, laugh at them or something and make fun of them for that kind of thing. So, they kind of keep it to themselves., and don't risk that, I guess.

Researcher: So, are you are you saying that you feel that there's still an element of shame or stigma attached to mental health?

P5: Maybe, I think the, I think it's lot better than it used to be, they won’t like, hate someone because they have a mental illness, but I think that people are still scared to come forward and say they do, because social media is quite bad. That kind of thing, like, I guess they're shamed through it. Not shamed, they'll kind of use it against them in a way. So.

Researcher: All right. So, you've talked about safeguarding, and mental health professionals at school. How else might you get help and support if you're worried about your mental health?

P5: I mean, I know they talk about, there's a lot of good websites like and there's like, real good charities, like mind and that kind of thing that do a lot of work with that. That they like, I think that's probably the best way to go. Because as professionals, and they've been doing it for years and years, they've probably had so many people that they know how to help. And yeah, that's about it.

Researcher: Okay. So just supposing that one of your friends that you were worried about, one of your friends and their mental health, how might you support them?

P5: Well, if I didn't, I can't, if I kind of had hints that they were a bit like struggling, I'd try and talk to them. Like, are you okay? Do you need me to help you out in anyway? And if they say no, if they don't want me to know, I'm not going to really force it out of them, I'd wait till they were ready to tell me because it's something that they choose, I don't want them to feel quite upset if I force something out of them.

Researcher: Okay. Do you talk about mental health with your friends at all?

P5: Um, in like, somewhat, like, not, it's not like a main topic of conversation. But you know, now and again, maybe if someone's a bit upset, or, you know, they're not coming to school for a couple days. They might not even be for that reason. I might just say it. Not really, all the time, being serious, because it might not be that, but kind of, in a way, just making sure that everyone's fine. And everyone's like being honest.

Researcher: Okay, all right. What's it like? How is it talking about mental health on a video call, as opposed to talking about it face to face? Do you think it's easier?

P5: Yeah. it's easier because there's not that, I guess physical interaction like, I'm not like socially inept or anything, but I do find it easier by video. There's kind of a barrier between you kinda like, I probably might not ever see you again. So, me saying these things might not affect us much, but I know it's not like, bad. So, if I were to say something over a screen, I know it's not a great mentality to have, it's like, it could get bad if you say something bad.

But if I say something through a screen, it's kind of like, not physical. Like I can say more, be more honest and open about stuff.

Researcher: So, so you're saying you find, you think it's helpful to have that screen, to have that barrier?

P5: Yeah, because it's still a person there. But you don't have, kind of like I guess anxiousness or kind of not wanting to say the wrong things when it's a physical person. Because there's more pressure in like a physical situation, to say the right thing. And it might be harder to tap into, or like, tap into your emotions when you're in person.

Researcher: And again, you're giving me lots of interesting stuff. Thank you for it. Do you? Do you think? Because you've kind of hinted at maybe masking behaviour or camouflaging behaviour, do you think that happens a lot amongst young people that you know?

P5: I think yeah, especially among young people, because in a school environment, when there's more than 1200 kids in my school, there's bound to be, like, quite a lot of people that are struggling, and I never hear, or barely hear people actually being honest and open about it. I don't think some of the behaviours, like open, I wouldn't see someone be like they're definitely struggling because people have learnt to suppress it. I think that it does happen quite a lot. And I'm not sure if I've experienced a real open event that kind of shows me in my friend’s circle, but I know it happens, like, people just keep quiet and they suddenly explode one day, and they kind of all those feelings and emotions come out, and they can't deal with it alone.

Researcher: Is that, is that because they've kind of kept it to themselves?

P5: Yeah, they pretend like everything's normal. And it's kind of built up to like a boiling point. And I think, in the situation like that, there are people are very, like, friendly, very helpful. I initially they're pretty, quite shocked. Where's this come from? I think in a situation like that, people will understand that it's quite, quite serious. Now we'll know how to check that.

Researcher: Okay. All right. So, you mentioned you mentioned social media earlier on. My next question was is in society, what do you feel has an effect on children and young people's mental health? For example, social media?

P5: Yeah, that's definitely the main one. I think. While school is quite stressful at times. I don't know, there's quite a lot of expectations. I don't think that's really an issue as much as social media is. Yes, school can cause mental health issues, but also, can help if you have a lot of people to talk to, but social media, sometimes, if your friends aren't active on it, or like you don't really talk to your friends, if, if you do have issues that have stemmed from that, and there's not really anywhere to turn, but there's websites and things where I guess some people would rather talk to their friends about it than someone like professionals, they might think they understand more, and they trust them more maybe, but if they're not there to turn to, social media is really dangerous. Because if someone is feeling quite like mentally unwell, then they might feel a bit lonely, and they have no one to turn to online and they might get lower.

Researcher: So, you think that social media can have quite a negative effect on mental health?

P5: I think there's there are a lot of good things out there if people trust it enough. I think people would rather talk to their friends like they maybe trust them more. But um, yeah, I think there's a lot of, I think people see numbers. And they link that to their, like, happiness or success that they've done. They've got, say, 1000 likes, and they think everyone cares about me. And then the next five posts, they get 20, 30, 25 likes, they might think that they've done something wrong. They've maybe become, like, uglier, or put on a bit of weight or something. Whereas it's, like, completely unrelated. They could link those numbers to something to do with them as a person. Yeah. Whereas it's just luck of the draw really, if you

get 1000 likes, but they could link it to something with them that could really affect them, because they wouldn't know what to do at that point.

Researcher: Okay. And I guess you're just alone with your social media and your thoughts. And it's gonna stew, isn't it?

P5: And yeah, I mean, yeah. I mean, the link to lockdown, whatever. I think the people used social media a lot more obviously because they couldn't go out. And I think that that kind of mentality has grown a lot more over the last couple of years. So maybe there's not enough support specifically for that, because it's such a new event.

Researcher: Okay. Do you think? Yeah, that's a really interesting point. And it makes perfect sense that people would be using more social media if they got, do you think that people that might amongst your group of friends, or are they still using social media a lot more than they used to before lockdown? Do you think?

P5: Yeah, I think personally, I've had that too, because I kind of started things that I hadn't really thought about before. Like I've joined new apps and groups and that kind of thing. So, I'm finding myself on it, on my phone more, but like, less than lockdown, 'cos I can go outside, but I am yeah. And I've noticed it with my friends a lot too, like, whereas I'd message a couple hours, I'd get a reply, now it's kind of five, six minutes. So, I think it's kind of without sounding too broad. I think society's changed quite a lot in my age group. Because whereas in like the 80s, I know they didn't have phones, but in like the 80s people used to go out with their friends and ride bikes. Now Yeah. Like, I know, that happened a lot. But I think that's kind of the social media of today is no kids getting phones at young age, you know, kind of all the time now. And I think I've definitely noticed that amongst friends.

Researcher: Okay, all right. Finally, do you think there's a difference in the way that girls and boys talk about mental health?

P5: I think yes, as a kind of, as a gender I think girls and more like, into their emotions, like they'll be able to show their emotions more like I, I know, men can cry, but like, it's kind of seen as a, like, a weak, whatever, that kind of thing. But I think girls are able to tap into their emotions more, because kind of friends might be a bit more supportive or trusting. And I think it's not as much of an issue as it used to be. I think a lot more men come forward and there's definitely, is like this, persona that people have, like, they can't, they can't cry, like, they have to like be strong all the time. And I think that's unrealistic, and it shouldn't be an issue. But it definitely is, and I think that women definitely find it easier to kind of talk about mental health.

Researcher: So that's a brilliant answer a really, really lots of interesting stuff. But in there you kind of said that you thought it had changed a little bit for men and talking about it. In what way and what do you think's helped to cause that change?

P5: Um, I think that it's obviously still like a quite a big issue, like what I mean by it's changed is that there are a lot more men specifically that want to come forward and say it because they've seen the effects they can have, like, like, people, like the statistics for men and women dying from suicide, like men are like, six or seven times more likely. So, I think they've noticed that it's a real issue and there's some serious consequences if they don't get help. And I think that's kind of one of the main reasons. Like I said, with more people kind of getting on social media, I think a lot more like, boys and men are spending more time and they're finding ways that they can get help like websites and kind of speaking to more people. And they kind of find, I guess, release from life by going on social media and kind of just like doing things that they enjoy on them. And that's kind of helped them mentally as well, I guess.

Researcher: So, this is an instance perhaps where social media can be helpful, rather than harmful?

P5: It is, it can be helpful, but it is also quite detrimental if you attach yourself to it.

Researcher: Yes, I suppose if you're looking for all of your validation as a person to come from social media, and you're not getting it, and as you said, you're not getting those likes, then it's all going to be a little bit. Yeah, absolutely. Right, we're nearly there. How might you recognise if one of your friends was feeling anxious? For example?

P5: Um, maybe if like, you're going to a place or going to speak to other people. Sorry, if they might be like, Oh, can we just stay here for a few more minutes, or I don't want to go and talk to them, or they kind of hang back behind on them. And like, on their phone the whole time, when you're trying something new, that kind of thing, like, just noticing a difference in their normal behaviour you might listen to, or they might not stop crying or something like that. But if they just act slightly different to how they used to, it could just be that was kind of makes you think this. Or they need a bit of help.

Researcher: Yeah. Okay. What about if somebody was feeling depressed? Very sad, how might that manifest itself, how might show itself?

P5: Um, I mean, like, it's quite extreme, people can like hurt themselves because of that. So, like, people can see like scarring, that kind of thing. And I know, it's quite extreme, but I guess that's kind of what depression is, like people feel like they're so sad, they can't be able to try anything better. Like, if someone doesn't show up, or like, they're, you're finding, they're more like, secluded to themselves, they don't want to see other people, spending more time on their own. They're not really going out as much, they're not doing group activities and sports. Just if they kind of are. I don't know, being, being alone. And that's a real good indicator. It might be depression, I guess.

Researcher: So good. So, there's that kind of withdrawal from society? or from your group of friends? Is that what you mean? Yeah. Okay. What about somebody who's feeling lonely? How might, how might? How might you recognise that?

P5: I mean, something similar, like, just kind of being withdrawn, like they don't feel like they can talk to anyone or see anyone but it's more of like, this is quite a specific situation, I

guess, but if you're out with like, specific friends or in your friend group. They might feel like they're not part of it. Or they just don't have the same connection to their friends as the friends do to each other. They might feel like they're being left out or say, like, a girl and a boy that are like dating, they might feel like, why is this not me? Why am I not? Why don't I have a girlfriend, they'll kind of get like jealous. And loneliness is really the most common one. Because people, even if it's not true, people kind of second guess their friends and kind of, do you really care? I'm saying that's really common these days.

Researcher: Okay, all right. And the last one, how might you know, apart from like, the obvious signs of someone shouting or whatever? How might you know someone's angry?

P5: Um, like, I think a lot of people are trying to hide their anger. So, if there's like a situation they just kind of remove themselves from the situation like you can kind of tell that they're angry because they're upset but I think people deal with that anger or internally now the next thing obviously if they get physical or like you said, shout it's quite obvious. I guess more subtle examples are like if they're kind of twitching like kind of a bit like on edge, they're sweating, they've gone red, that kind of thing. By, like, cartoony things, like when they go red. Yeah.

Researcher: Yeah. Okay. Um, is there anything else that you think that I need to know about young men and mental health that you want to share?

P5: Um, I think that a lot of help would be appreciated. But I still think specific, specific things can be touched on school like specific lessons. Because people might think I, they feel I don't feel happy mentally, but they don't know what it is. And I also think that by just checking on someone, you don't even have to, like, maybe go too far. Just asking someone if they’re alright, it can make a big difference. But if they're struggling, I think you just even if you don't have any signs, you just check anyway, because we deal with themselves, and they deal with their issues. internally. It's something that needs to be dealt with.

Researcher: Lots of the boys that I've talked to said very similar things to you, in terms of, they feel that the PSHE is good, but it's not enough.

P5: I'm not like annoyed schools I know, like funding's a real big issue, and they might not be able to like, the teachers aren't like qualified, but I think it could make quite a big difference to some people. And even if it's just a few people that it helps that's better than it used to be. So.

Researcher: Absolutely, absolutely. I'm with you. 100%. P5, what thoughtful, intelligent responses. Thank you very, very much. I really, you've given me excellent, excellent data. So, thank you very much for your time. Enjoy the rest of your summer break. Okay. All right. It was lovely to meet you P5. Take care.

P5: Good luck with the rest of your research. Bye.

Appendix K: Example of Coding

Initial Coding

Participant/Line	**Perceptions of Mental Health**	**Barriers to Help Seeking**	**Facilitators to Help Seeking**	**Knowledge of Sources of Information and Support**
12-14	Um, like, issues that people will have internally, and they sometimes feel scared to share it with other people, and they kind of deal with it themselves and keep it to themselves, and it like, it affects their mental and physical health.			
17-19	Well, if you've got like an eating disorder, it might, your brain might trick you into not liking certain foods or that kind of thing. So it kind of can affect you physically, if your brain is telling you to do something different.			
22	Yeah, your brain health's bad then everything can be bad.			
25-27				Kind of PSHE lessons and they like, run you through the main issues, the, the facts of how you can get