An exploration of caregivers' and peers' support-giving responses to adolescents showing signs of depression.

A thesis submitted to the

The University of Dublin, Trinity College Dublin

in partial fulfilment of the requirements for the degree of

Doctor of Philosophy in Psychology

in the

School of Psychology

Trinity College Dublin

by

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B.A. (First Class Hons.), P.Grad.Cert.

Awarded: June 2020.

Declaration

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Sadhbh Josephine Byrne

Summary

Global concern has been growing about adolescents' mental health. Internationally, it is estimated that approximately 13-20% of young people will experience mental illness in any given year (Patel, Flisher, Hetrick, & McGorry, 2007; Polanczyk, Salum, Sugaya, Caye, & Rohde, 2015). The adolescent period in particular is associated with a marked increase in the onset of mental disorders (Hankin, 2015), of which depression is among the most prevalent (Lewinsohn & Essau, 2002; Lewinsohn, Rohde, & Seeley, 1998; Thapar, Collishaw, Pine, & Thapar, 2012). Adolescent depression is linked to significant impairment, recurrence in adulthood, heightened risk of suicide, and increased all-cause mortality (Schubert, Clark, Van, Collinson, & Baune, 2017; Shore, Toumbourou, Lewis, & Kremer, 2018). Compounding the significance and complexity of this issue is the fact that most adolescents experiencing depression do not seek or receive professional help (Sheppard, Deane, & Ciarrochi, 2018; Thornicroft et al., 2017). Multiple strategies have been developed to address this 'treatment gap'. However, the provision of support from family and friends appears to have been somewhat overlooked, despite evidence that this 'informal' support may play an important role in determining illness outcomes. The specific nature and different types of support that caregivers and peers provide remain unclear. In addition, the factors that influence different responses have yet to be addressed. The current study thus provides a unique and timely contribution to Irish and international research by investigating caregivers' and peers' responses to adolescents showing signs of depression. The study draws on relevant theories including the Theory of Planned Behaviour (Ajzen, 1991) and the Attribution-Empathy Model of Helping Behaviour (Betancourt, 1990). The research questions are:

1. *How do caregivers and peers respond to the expression of depressive symptoms in an adolescent character portrayed in a vignette?*
2. *Are there significant differences between caregivers' and peers'*

responses?

3. *Do caregivers' and peers' responses differ according to sex?*
4. *Do adolescents' responses differ according to age?*
5. *What is the relationship between each of the theoretically-grounded factors included in the conceptual framework of this study (namely: attitudes, norms, perceived behavioural control, previous experience engaging in the behaviour, perceived controllability, sympathy, anger, trait empathy, identification of depression, and level of contact) and the types of support-giving responses offered by caregivers and peers towards the character depicted in the vignette?*

This cross-sectional study employed a mixed within-between groups design. Participants were 12- to 18-year-old adolescents (*n* = 535, 47.9% female), and adults who were primary caregivers of adolescent children (*n* = 321, 73.8% mothers). Data were collected through the use of a questionnaire constructed for the current study, which comprised a selection of instruments each measuring a key study variable. As no standardised measure of support-giving intentions was identified, the Modes of Intended Mental Health Support (MIMHS) scale was developed, and initial exploratory factor analyses were conducted.

The results of the study confirm that informal support-giving regularly occurs. Approximately 40% of adolescents and 50% of caregivers stated that someone in their family or close circle of friends had, in the past year, experienced a problem similar to that described in the vignette. Of these participants, approximately 85% of adolescents and over 90% of caregivers stated that they had done something to try and help this person. Other key results include the finding that caregivers' responses reflected greater mental health literacy than those of adolescents, with adolescents' responses becoming more similar to those of caregivers with increasing age. Sex differences were detected in both caregivers' and adolescents' responses – for example, girls and female caregivers felt significantly greater sympathy and less anger towards the adolescent vignette characters. Caregivers and adolescents had very different beliefs about the helpfulness and harmfulness of several support-giving responses, including suicide risk assessment. Problematic support-giving responses were also endorsed by participants; for example, young people tended to encourage ‘insular’ support, whereby adults are not notified or contacted for help. Some caregivers respond to the presentation of depressive symptoms by attempting to minimise adolescents’ problems. Finally, the results of the study indicated that the ability to label a cluster of symptoms as ‘depression’ is associated with increased intentions to encourage or facilitate professional support.

The results of this study thus provide foundational knowledge that can be used to inform future theory and research on this topic. The results also have important implications for guiding efforts to improve the support that caregivers and peers may provide to young people experiencing symptoms of depression. In particular, several factors are highlighted which may be potentially modifiable, and therefore suitable to target through intervention. This study addresses a critical gap in the literature, and provides valuable insight into informal support-giving behaviour in the context of adolescent depression.

Acknowledgements

I wish to gratefully acknowledge funding for this research from the Irish Research Council Government of Ireland Postgraduate Scholarship programme. I am also very thankful for the assistance and cooperation of all participating schools. Thank you to the school staff, who volunteered their valuable time in order to facilitate my visits. An enormous thank you to all participants in this study, for contributing your views and your time, and for valuing this topic.

I am hugely, hugely grateful for my two wonderful supervisors, Lori and Liz, who have mentored and supported me with so much patience, generosity, and kindness. It has been a long and difficult road, but I feel very lucky to have had you both as my teachers and guides, and honoured to have had the opportunity to learn from and work with you. Thank you for your academic wisdom but most especially for your understanding and reassurance.

Thank you to Jill, for all your hard work. I thoroughly enjoyed our long and rambling psychology chats, and your sunny disposition made our road trips to the middle of rural Ireland an absolute pleasure! I really appreciate the time you gave to this project and I am excited to see what the future holds for you.

Thank you to all the staff of School of Psychology, as I have received so much help, advice and encouragement from you over the eight years I spent in Trinity. To Holly, Sarah, Derina, Eva, and the NUIG gang; to Louise, Dovile, Eavan, Mairéad and all the other Children's Research Centre folk; and to Shane, Ann-Marie, Lisa, Kathryn, Emily, Sinéad, and all the other psych postgrads – thank you for your company as we shared this road together. Big thanks also to Rhona, Glen, Audrey, and Holly, the lovely crew with whom I shared the postgraduate office in Áras an Phiarsaigh.

Thank you to all my brilliant friends, who cheered me on every step of the way. I'm exceptionally lucky to have such good friends, who are a wholly positive presence in my life and show me so much love. To my siblings and my huge and loving extended family for being so supportive and encouraging. A special thank you goes to auntie Teresa for driving me to some of the schools and visiting me often in Dublin for lunch and a hug, and to Jessica and Ciara for your help with data entry. I'm so fortunate to be able to count on you always.

I have to give a special shout out to Iseult for being my Ph.D. sister. It says a lot that our brains basically began to operate in sync over the past few years, and that some people thought we were actually sisters. Thank you for understanding the ups and downs, for all the coffee breaks and conversations, for the visits to my office, the timed writing Saturdays, and lest we forget, for getting me through the stats course! I'm really grateful that we got to do this all together.

To my Mam and Dad. Thank you for your example and for passing on your work ethic, without which I could not have completed this Ph.D. Thank you for your unwavering belief in me, even when I didn't believe in myself. Thank you for always being there. I am really lucky to have you as my parents, and I love you very much.

To Oliver – words can't really capture how grateful I am for you. Thanks for putting up with me. I love you and I'm excited for our next chapter.

Finally - this work is dedicated to my beautiful, strong, wise, kind grandmother, Mary Josephine Mulhall (18/08/1921-12/01/2017), who supported me through my educational journey with steadfast encouragement and pride, and who loved me so very much.

— Sadhbh Josephine Byrne

Addendum, June 2020: I would also like to acknowledge the immense support and encouragement I have received from my colleagues in the suicide prevention team at Orygen, Melbourne, Australia – thank you for being my Aussie family, for showing me so much care and kindness, and simply for being such lovely friends. A very, very special thank you to Associate Professor Jo Robinson, who inspires me greatly with her passion and dedication, provides me with so many opportunities for growth, and has extended so much compassion to me during tough times.

Publications Arising from this Thesis

Oral Presentations

- **Byrne, S.,** Swords, L., & Nixon, E. (2018). Early detection of symptoms of depression: The role of parents and peers. Symposium: Youth suicide prevention across diverse settings. Paper presented at World Psychiatric Association Congress 2018, 28/02/2018, Melbourne, Australia.
- **Byrne, S.,** Swords, L., & Nixon, E. (2017). Exploring the factors associated with Irish parents' and peers' support-giving responses to an adolescent with depression. Paper presented at International Association for Youth Mental Health Conference 2017, 25/09/2017, Dublin, Ireland.

Poster Presentations

- **Byrne, S.,** Swords, L., & Nixon, E. (2015). Parents’ and peers’ responses to adolescent depression: The development of the Intentions to Provide Mental Health Support scale. Poster session presented at International Association for Youth Mental Health Conference 2015, 09/10/2015, Montréal, Canada.
- **Byrne, S.,** Swords, L., & Nixon, E. (2015). Development of the Intentions to Provide Mental Health Support scale: Measuring parents’ and peers’ responses to adolescent depression. Poster session presented at Association for Child and Adolescent Mental Health Special Interest Group in Youth Mental Health Research Conference 2015: Transformations in Youth Mental Health, 18/09/2015, St Patrick’s University Hospital, Dublin.
- **Byrne, S.** (2015). Helping a young person in distress: Factors associated with parents’ and peers’ responses to adolescent depression. Poster session presented at Structured PhD in Child

and Youth Research – Research Symposium, 15/06/2015, Trinity College Dublin.

- **Byrne, S.** (2015). Helping a young person in distress: Factors associated with parents' and peers' responses to adolescent depression. Poster session presented at Trinity College Dublin Postgraduate Research Showcase, 08/03/2015, Trinity College Dublin
- **Byrne, S.** (2014). Parental and peer support in youth mental health: An exploration of the underlying factors associated with help-giving responses. Paper presented at Trinity College Graduate Students' Union Mental Health Week Research Forum, 22/10/2014, Trinity College Dublin.

Non-Peer Reviewed Works

- **Byrne, S.** (2016, November 21). Support givers: exploring the role parents and peers play for young people with depression. *Women Are Boring: Fascinating Research by Interesting Women*. [Blog post]. Retrieved from: https://womenareboring.wordpress.com/2016/11/21/support-givers-exploring-the-role-parents-and-peers-play-for-young-people-with-depression/
- **Byrne, S.** (2016, October 10). #LoveIrishResearch Blog Marking World Mental Health Day. *Irish Research Council*. [Blog post]. Retrieved from: http://www.research.ie/event/2016-10-10/loveirishresearch-blog-marking-world-mental-health-day

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Chapter 1 Introduction and overview of thesis

1.1 Introduction

The study documented in this thesis is an exploration of caregivers' and peers' responses to adolescents showing signs of depression. Depression is a leading cause of global burden of disease (Ferrari et al., 2013; World Health Organization, 2017), and is one of the most common mental disorders experienced by adolescents (Lewinsohn & Essau, 2002; Lewinsohn et al., 1998; Thapar et al., 2012). Adolescent depression is associated with a broad spectrum of future adverse outcomes – from reduced academic attainment, social functioning, and quality of life, to increased rates of substance misuse, unplanned pregnancy, and intimate partner violence (Fletcher, 2009; Jaycox et al., 2009; Jonsson et al., 2017; Marmorstein, 2009; G. F. H. McLeod, Horwood, & Fergusson, 2016). Depression in adolescence is also associated with persistence in adulthood; 40% of all adults diagnosed with Major Depressive Disorder experienced their first depressive episode before the age of 20 years (W. W. Eaton et al., 2008), and 50% of those who have experienced depression before the age of 18 years will endure further depressive episodes in adulthood (R. C. Kessler, Avenevoli, & Merikangas, 2001). Finally, adolescent-onset depression has been linked to suicide (Weissman et al., 1999), which is one of the leading causes of death of people aged 15 to 44 years in Ireland (Central Statistics Office Ireland, 2018).

Given the clear enormity of this issue, it is not surprising that research on adolescent depression has proliferated in recent decades. Much of this research has attended specifically to the epidemiology, aetiology, and sequelae of depressive disorders in adolescence (for example: Bos, Peters, van de Kamp, Crone, & Tamnes, 2018; Breslau et al., 2017; Lau & Waters, 2017; Tak, Brunwasser, Lichtwarck-Aschoff, & Engels, 2017). Studies have also concentrated on the development and testing of treatments for adolescent depression; these have primarily focused on psychological (Hetrick, Cox, Witt, Bir, & Merry, 2016; Weisz, Jensen-Doss, & Hawley, 2006; Weisz, McCarty, & Valeri, 2006) and pharmacological interventions (Cipriani et al., 2016; Qin et al., 2014; Walkup, 2017; Zhou et al., 2014). Other modalities, such as physical exercise (A. L. Dunn & Weintraub, 2008; K. E. Johnson & Taliaferro, 2011) and mindfulness meditation (C. A. Burke, 2010; Zoogman, Goldberg, Hoyt, & Miller, 2015) are also attracting increasing attention. All of these treatments, typically, are formally prescribed, implemented, and/or overseen by (mental) health professionals.

An area of research that has been comparatively neglected, however, is the ‘informal’ support that may be offered to a young person by members of their social network. As propounded by Bronfenbrenner’s bioecological theories, a young person does not exist in a vacuum, but rather is continuously orbited by other individuals in their microsystem, with whom they interact in a variety of meaningful ways (Bronfenbrenner, 1986b, 1994; Bronfenbrenner & Morris, 1998). Social support from these individuals is hugely influential in assisting young people to navigate their worlds and cope with difficulties they may experience. Indeed, a large body of research has revealed that receipt of social support is associated with improved mental and physical health (Uchino, 2006; Werner-Seidler, Afzali, Chapman, Sunderland, & Slade, 2017). Furthermore, a recent meta-analysis demonstrated that perceived social support plays a protective role against the development of depressive symptoms (Rueger, Malecki, Pyun, Aycock, & Coyle, 2016). Strikingly, however, little research has investigated the nature of this support – information on the type of responses that may be offered to an adolescent with depression by informal supporters is sparse. In addition, the factors influencing the provision of different types of support are also neglected. Relatedly, limited literature is available regarding informal supporters’ understanding and interpretation of an adolescent’s presentation of depressive symptoms.

1.2 Aim of thesis

The current study therefore aims to address these substantial and conspicuous gaps. Specifically, the aim of this thesis is to explore caregivers' and peers' responses to adolescents with depression. The thesis aims to contribute to increasing the current understanding of informal support in adolescent depression, and to elucidate some of the factors that may be associated with different types of informal support. It is hoped that understanding the relationship between each variable and participants' support-giving responses will assist efforts to improve the support that young people in distress receive. This is achieved through the development of a conceptual framework, grounded in theory, which brings together key concepts from various theoretical accounts, selected for their pertinence to the aim of the study. The study adopts a quantitative mixed within-between groups design, in order to answer the following research questions:

1. *How do caregivers and peers respond to the expression of depressive symptoms in an adolescent character portrayed in a vignette?*
2. *Are there significant differences between caregivers' and peers' responses?*
3. *Do caregivers' and peers' responses differ according to sex?*
4. *Do adolescents' responses differ according to age?*
5. *What is the relationship between each of the theoretically-grounded factors included in the conceptual framework of this study (namely: attitudes, norms, perceived behavioural control, previous experience engaging in the behaviour, perceived controllability, sympathy, anger, trait empathy, identification of depression, and level of contact) and the types of support-giving responses offered by caregivers and peers towards the character depicted in the vignette?*

1.3 Organisation of this thesis

This thesis is organised into nine main chapters, which proceed from this Introduction. In Chapter 2, the context and rationale for this study is presented, through firstly reviewing the critical problem of adolescent depression and examining the role that informal support may play in this context. The chapter then presents an argument for the selection of caregivers and peers as the specific providers of informal support to be explored in the current study, and reviews the current literature available on caregivers and peers' support-giving. The chapter concludes by establishing the importance of investigating differences in caregivers' and adolescents' support-giving behaviour according to participant sex, as well as differences in peers' responses according to their age.

Chapter 3 builds on Chapter 2 by conducting a review of several theoretical frameworks which relate to support-giving behaviour, identifying the factors that each theory asserts to explain behaviour of this kind. This is undertaken with a view to developing a conceptual framework for the current study, which is presented at the end of the chapter, see Figure 1.

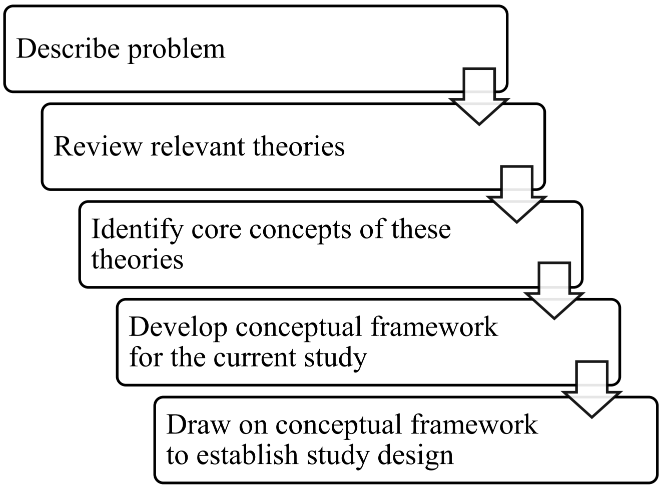

Figure 1: Underlying tasks of Chapters 1 to 3

Chapter 4 examines the extant evidence for these theoretically-grounded variables contained within the conceptual framework, specifically in relation to their association with caregivers' and peers' responses to an adolescent with depression. The methods employed in the current study are detailed in Chapter 5, which also describes the small pilot study conducted to assess the acceptability and feasibility of these methods. Due to the lack of research investigating this topic, there is no standardised means of assessing different modes of support-giving. As such, Chapter 6 provides an account of the development of the Modes of Intended Mental Health Support (MIMHS) scale. Chapter 7 presents the results that pertain to the first research question of this study, “How do caregivers and peers respond to an adolescent showing signs of depression?”, and is followed by Chapter 8, which details the results that relate to the second research question, “What is the association between these theoretically-identified factors and the different types of support-giving responses offered by caregivers and peers?” The final chapter of this thesis, Chapter 9, discusses the key results of the study with reference to the literature, and considers the theoretical and practical implications of the study’s contributions. Limitations of the study are identified, together with potential future directions for this research topic.

Chapter 2 Adolescent depression and the role of ‘informal’ support

2.1 Introduction

This chapter provides the rationale for the focus of the current study. The chapter commences by outlining the significance of adolescent depression and the problem of the ‘treatment gap’, before reviewing the potential role of informal support in addressing this gap. The reasons underlying the selection of caregivers and peers as the focal providers of informal support are then presented. Current knowledge of the support that caregivers and peers provide is identified. The utility of comparing caregivers’ and adolescents’ responses according to participant sex is discussed, as is the value of exploring differences in adolescents’ responses according to participant age.

2.2 Adolescent depression

Adolescence is a period of development characterised by a cascade of hormonal and biological changes (Blakemore, Burnett, & Dahl, 2010; Steinberg & Morris, 2001). It is recognised as “a life phase in which the opportunities for health are great, and future patterns of adult health are established” (Sawyer et al., 2012, p. 1630). Concurrently, however, adolescence is regarded as a window of vulnerability for the development of psychopathology (Cicchetti & Rogosch, 2002; Paus, Keshavan, & Giedd, 2008), and is represented by a peak in the onset of mental health problems (R. C. Kessler et al., 2007). A recent UNICEF review of available data across 31 countries found that the proportion of children and adolescents with mental health problems is increasing over time, with approximately one in four adolescents reporting that they experience two or more psychological symptoms, more than once a week (Bruckauf, 2017). Although infectious diseases still pose a significant health risk to young people living in developing countries (Christensen, Reynolds, &

Cuijpers, 2017), Irish data show that the majority of illness burden in adolescence is caused by mental illness (National Clinical Programme for Paediatrics and Neonatology, 2016). The *My World Survey*, the largest study of youth mental health in Ireland to date, similarly concluded that "the number one health issue for [Irish] young people is their mental health" (Dooley & Fitzgerald, 2012, p. vii). European data also suggest that "mental disorders are the core health challenge of the 21st century" (Wittchen et al., 2011, p. 670).

Of all mental disorders that affect adolescents, depression is one of the most prevalent, in Ireland (Coughlan et al., 2014) and worldwide (Birmaher et al., 1996; E. J. Costello, Copeland, & Angold, 2012; Garber, 2000; Lewinsohn & Essau, 2002; Sund, Larsson, & Wichstrøm, 2011). In addition, a considerable number of young people experience individual symptoms of depression (Kubik, Lytle, Birnbaum, Murray, & Perry, 2003) or a 'subclinical' constellation of symptoms (G. I. Olsson, Nordström, Arinell, & von Knorring, 1999; G. I. Olsson & von Knorring, 1997; Saluja et al., 2004; Wesselhoeft, Sørensen, Heiervang, & Bilenberg, 2013), further increasing the magnitude of this problem. Given the range and significance of the developmental tasks associated with the adolescent period (Steinberg & Morris, 2001), the onset of psychopathology can have a deleterious and disruptive effect on a young person's social, cognitive, affective, and behavioural development (Cicchetti & Rogosch, 2002; Cicchetti & Toth, 1998). Indeed, adolescent depression is associated with many negative outcomes, including high risk of completed suicide, of recurrence in adulthood, and of impaired adult functioning (Balázs et al., 2013; Beautrais, 2000; V. Dunn & Goodyer, 2006; Early, Gregoire, & McDonald, 2002; Kovacs, 1984; Thapar et al., 2012). This resonates in the Irish context: in 2017, UNICEF reported that Ireland has the fourth highest rate of youth suicide among high-income countries (UNICEF Office of Research, 2017), and in 2015, 18.9% of deaths of people aged

15 to 44 years in Ireland were attributed to intentional self-harm (Central Statistics Office Ireland, 2017b)[1].

2.3 Adolescent help-seeking

The negative outcomes associated with depression become increasingly concerning when one considers the fact that most individuals (whether adolescents or adults) experiencing this disorder do not receive treatment (Kocsis et al., 2008; Kohn, Saxena, Levav, & Saraceno, 2004; Neufeld, Dunn, Jones, Croudace, & Goodyer, 2017; L. P. Richardson, Russo, Lozano, McCauley, & Katon, 2010; Sheppard et al., 2018; Thornicroft et al., 2017), a situation that has been termed the ‘treatment gap’ (Kohn et al., 2004). Evidence suggests that, in addition to adverse effects on daily functioning (Luciana, 2016; Vijayakumar et al., 2015), untreated symptoms of depression can steer the illness onto a chronic course, increasing the chances both of symptom reoccurrence and of the individual engaging in maladaptive behaviours such as drug and alcohol use (Altamura, Buoli, Albano, & Dell’Osso, 2010; Altamura, Dell’Osso, Vismara, & Mundo, 2008; Birmaher et al., 1996; Gotlib, Lewinsohn, & Seeley, 1995; Harrington, 1990; Judd, Paulus, Wells, & Rapaport, 1996; Kisely, Scott, Denney, & Simon, 2006; Kovacs, 1984; Lewinsohn et al., 1998; Scott, Eccleston, & Boys, 1992; Weller & Weller, 2000).

The reasons for the under-treatment of adolescent depression are multiple and complex (Thornicroft et al., 2017). However, one clear contributing factor is that young people do not typically seek help for mental health difficulties of any kind (Boldero & Fallon, 1995; Chambers & Murphy, 2011; Garland & Zigler, 1994; Rickwood & Braithwaite, 1994; Rickwood, Deane, Wilson, & Ciarrochi, 2005), including depression and suicidality (Cheung, Dewa, Cairney, Veldhuizen, & Schaffer, 2009; O’Donnell, Stueve, Wardlaw, & O’Donnell, 2003). For example, a recent Irish study found that the majority of young people

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[1] It is worthy of note that these statistics only account for deaths that could be definitively attributed to intentional self-harm.

identified as having a serious emotional or mental health problem had never sought any professional help (L. Doyle, Treacy, & Sheridan, 2017). Furthermore, many studies have demonstrated that young people's intentions to seek help tend to decrease with increasing symptom load (Ciarrochi, Deane, Wilson, & Rickwood, 2002; Deane, Wilson, & Ciarrochi, 2001; Dey & Jorm, 2017; Schaffalitzky et al., 2015; C. J. Wilson & Deane, 2010b; C. J. Wilson, Deane, & Ciarrochi, 2005; C. J. Wilson, Rickwood, & Deane, 2007; Yakunina, Rogers, Waehler, & Werth, 2010). This phenomenon has been termed 'help-negation' (Deane et al., 2001; Dey & Jorm, 2017; C. J. Wilson & Deane, 2010a, 2010b; Yakunina et al., 2010), and is thought to be a consequence of the cognitive, social, and behavioural impairments associated with severe depression and suicidal ideation (C. J. Wilson, Thomas, & Furlong, 2017). In line with this hypothesis, a recent study demonstrated that neuroendocrine changes associated with depression were predictive of lower help-seeking intentions (S. Thomas & Larkin, 2018). Taken together, this evidence suggests that the young people in most imminent need of help are those least likely to seek assistance.

In response, a number of interventions have been developed with the aim of increasing help-seeking behaviour among people experiencing signs of depression (Corrigan, Druss, & Perlick, 2014; Dumesnil & Verger, 2009; Gulliver, Griffiths, Christensen, & Brewer, 2012; Jorm et al., 2003; Niederkrotenthaler, Reidenberg, Till, & Gould, 2014; Xu et al., 2018). A review identified that these interventions are most commonly psychoeducational in nature, and that while some improvements in help-seeking attitudes have been detected, these interventions do not tend to result in changes or increases in individual's actual help-seeking behaviour (Gulliver et al., 2012). Mixed or negative results of help-seeking interventions have also been reported (Siegel, Lienemann, & Rosenberg, 2017), with one study describing an increase in participants' self-stigma (Lienemann, Siegel, & Crano, 2013) and another documenting a negative impact on participants' perceived family functioning (Keeler & Siegel, 2016). Indeed, the most recent systematic review and meta-analysis concluded that "interventions improved formal help-seeking behaviours if delivered to people with or at risk of mental health problems, but not among children, adolescents, or the general public" (Xu et al., 2018, p. 1). As such, it appears that it may be necessary to consider an alternative approach to addressing the 'treatment gap' in adolescent depression (F. Rice, Eyre, Riglin, & Potter, 2017).

2.4 The role of 'informal' support

Evidence suggests that one such approach may involve harnessing adolescents' social networks. This is supported by the health communication literature, which indicates that interpersonal relationships are powerful vehicles for the delivery of persuasive health messages (Welch Cline, 2003). For example, members of a young person's social network may act as 'referral agents', encouraging or facilitating engagement with professional mental health services (Aldrich, 2017; S. H. Lee, Choi, & Park, 2015). Empirical evidence supports this proposed role; in one study, 94% of adolescent participants attending their initial child and adolescent mental health services (CAMHS) appointment stated that other people had influenced their decision to engage with support (Wahlin & Deane, 2012). Having social support and encouragement to seek help have been cited as facilitators of help-seeking for mental illness by young people (Gulliver, Griffiths, & Christensen, 2010), and receiving recommendations for professional help is further associated with more positive expectations about mental health services (Vogel, Wade, Wester, Larson, & Hackler, 2007). Given that the fear of negative reactions from peers is a common reason given for not seeking help (Jorm, Morgan, & Wright, 2008b), support and encouragement from others may play an important role in assuaging these concerns.

Beyond merely referring on to 'formal' mental health services, however, people close to a young person experiencing depression may also adopt an 'informal' care role, and directly provide support to that young person (Magliano et al., 1998; Roick et al., 2007; Warren & Byrom, 2006; Yesufu-Udechuku et al., 2015). Indeed, the notion that family, friends, and other members of the community, including 'folk healers', may play an important role in supporting people through health difficulties has been prominent in human societies across history and cultures (Kleinman, Eisenberg, & Good, 1978). The role fulfilled by 'informal' supporters may be especially relevant in the Western world of the 21st Century, in which societies have (for the most part) engaged in psychiatric deinstitutionalisation, and instead promote community-based care (Ahmed, Bruce, & Jurcik, 2018). This informal support has been termed the 'social scaffold' (Patton & Borschmann, 2017).

Aligning with this is the concept of 'mental health first aid' (MHFA), which is defined as "the help provided to a person developing a mental health problem or in a mental health crisis" (Kitchener & Jorm, 2008, p. 55). This initial assistance, provided by a layperson, is differentiated from ongoing carer roles and from professional support (Jorm & Ross, 2018). The general concept of first aid for mental health-related issues was initially identified in the suicide prevention literature, where twenty years ago researchers asserted that "there is a need for some type of temporary emergency treatment similar to the medical community's highly successful Cardio-Pulmonary Resuscitation (CPR) training, a form of 'Mental Health CPR' which can simply and rapidly teach someone to recognize suicidal warning signs, to intervene swiftly and effectively in order to delay any suicide attempt, and to arrange for competent professional follow-up" (Hennig, Crabtree, & Baum, 1998, p. 171). Subsequently, the MHFA training programme for community members was established, which aimed to teach skills in supporting people with mental health problems (Kitchener & Jorm, 2002). As Aldrich (2017, p. 404) concluded, "If [young people] are unable or unwilling to seek professional help on their own, perhaps it is time to shift prevention effort energies to [informal] intervention".

The relevance of informal support to the current study is affirmed by studies that have demonstrated that if adolescents *do* seek help, they first turn to family and friends (Raviv, Raviv, Vago-Gefen, Fink, & Schacter Fink, 2009; Raviv, Sills, Raviv, & Wilansky, 2000; Rickwood et al., 2005; Wills, 1992). One study of undergraduates found that "over 90% of students overall indicated that they talked to friends and nearly 80% of students indicated they talked to their family", contrasting with 7% who spoke to a school counsellor or another professional (Oliver, Reed, Katz, & Haugh, 1999, p. 116). It is therefore important to understand the responses received by a young person when they seek help from a family member or friend. Moreover, it has been suggested that members of a young person's social network may be able to detect signs of distress, and reach out and provide help, *before* it is sought by the young person themselves (Angold et al., 1998; E. J. Costello & Janiszewski, 1990; Jorm et al., 2008b). This is particularly important because self-identification of symptoms can be negatively impacted by perceived stigma (Schomerus et al., 2018; Stolzenburg et al., 2017; Stolzenburg, Freitag, Schmidt, & Schomerus, 2018). The detection of symptoms by others could therefore facilitate earlier intervention, which is thought to decrease the likelihood of recurrence in depressive disorders (E. J. Costello, 2016). Owens et al. (2011, p. 1-2) state "Relatives, friends, and colleagues may be the only people to know that a person is distressed, and the burden of care lies entirely with them, until such time as the person decides, or is persuaded, to consult a doctor". Even when this decision is made, waiting lists are often in operation, meaning that this period of time, prior to engagement with mental health services, can often be lengthy. In the United Kingdom, Hodgekins, Clarke, Cole et al. (2016) found a mean duration of help-seeking delay of 1.36 years for 14- to 25-year-old young people accessing a specialist youth mental health service, with a further delay of a mean 2.27 years duration between seeking help and accessing appropriate services. Participants in a study by Coyne et al. (2015) reported a waiting period of up to 18 months before accessing CAMHS in Ireland. In January 2019, *The Irish Times* reported a waiting list of more than three years in southwest Dublin, and that there had been no movement on the waiting list for 11 months at the time of writing (Cullen, 2019). This evidence suggests that support from parents and peers may be required to 'bridge the gap' between symptom emergence and professional care for a considerable period of time, which is problematic for many reasons. While the effect of treatment delay on young people experiencing psychotic symptoms has received some focus (e.g. Dell'Osso & Altamura, 2010;

Nordentoft, Jeppesen, Petersen, Bertelsen, & Thorup, 2009), the impact of the duration of untreated illness (DUI) on affective disorders, such as depression, in adolescents is at present relatively unknown (Bukh, Bock, Vinberg, & Kessing, 2013; Ghio et al., 2015; Hodgekins et al., 2017). It is therefore vital to understand the help that is offered by these 'informal' supporters throughout this time.

However, it appears that informal support is often overlooked (Crombie, Irvine, Elliott, & Wallace, 2007): as stated by Ali, Krevers, and Skärsäter (2015, p. 407), "family and friends often assume great responsibility for the person with mental illness, and their support is often taken for granted". This neglect of informal support is also echoed in the academic literature; a World Health Organization (WHO) report commented that, "in only a few cases in the literature is the term 'help-seeking' used in a more comprehensive way to refer to the use of both formal supports and informal supports… [which] further underscores the need to pay attention to social supports outside of professional care-giving settings" (G. Barker, 2007, pp. 1–2). The WHO further highlighted the importance of this 'informal' support when it was declared that the theme of World Mental Health Day 2016 was 'psychological first aid', which the organisation defined as, "basic pragmatic support by people who find themselves in a helping role" (World Health Organization, 2016).

2.5 Why focus on caregivers and peers?

Thus far, it has been determined that informal support is worthy of further study with regards to adolescent depression. However, there are many individuals who may provide such 'informal' support; it is argued here that caregivers[2] and peers form the two most relevant and important groups of individuals in this specific context.

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[2] In this thesis, the term 'caregivers' is used to describe parents and other legal guardians.

2.5.1 Caregivers as support-givers

Research has traditionally examined parents and their behaviour as contributors of risk for the development and maintenance of adolescent depression (Burbach & Borduin, 1986; B. D. McLeod, Weisz, & Wood, 2007; Mitchell, McCauley, Burke, Calderon, & Schloredt, 1989; G. Parker, 1981; Restifo & Bögels, 2009; Sander & McCarty, 2005; Strayhorn & Weidman, 1988; Yap & Jorm, 2015; Yap, Pilkington, Ryan, & Jorm, 2013). In contrast, parenting as a protective factor had been relatively neglected until recently (DeVore & Ginsburg, 2005; Shirtcliff, Skinner, Obasi, & Haggerty, 2017; Ungar, 2004; Whittle et al., 2014), and parents' behaviour post-onset of their child's depression has been further overlooked. However, the provision of support is one of the important roles of any close relationship (Finkel, Simpson, & Eastwick, 2016), including that between parent and child.

Parental support has been conceptualised as "the perceived support and closeness received from a parent in helping an adolescent deal with a problem" (Lakon, Wang, Butts, Jose, & Hipp, 2017, p. 2). Caregivers are thought to possess inherent motivation to provide help to their child if they are experiencing mental health difficulties (Yap, Pilkington, Ryan, & Jorm, 2013), and report taking significant responsibility for their child's mental health care (Andershed, Ewertzon, & Johansson, 2017; Milliken & Rodney, 2003). Indeed, qualitative interviews with Taiwanese parents found that "responsibility is the core category by which parents conceive of their caregiving… they recognise their duty to take care of their children" (Yen et al., 2010, p. 210). The reported 'innateness' of parental responsibility suggests that care provision forms part of the internalised and socially-enforced 'role' of a parent (Eekelaar, 1991), supporting the selection of caregivers as key informal supporters for consideration in the current study.

Parents or other caregivers are often the first to detect the emergence of early symptoms of mental disorders in their children (Boulter & Rickwood, 2013; Dulcan et al., 1990) and wield significant influence on the trajectory of a young person's mental illness (Carpentier, Lesage, & White, 1999). They frequently initiate treatment-seeking (Hassett, Green, & Zundel, 2018); indeed, Mayberry and Heflinger (2013, p.105) state “family caregivers are the brokers of mental health treatment for children”. Jigsaw, the National Centre for Youth Mental Health in Ireland, report that 39.4% of referrals to the Jigsaw youth mental health service come from parents (Jigsaw, 2018)[3]. Research in first-episode psychosis has found that parental involvement in seeking professional care increases the chances of a young person receiving appropriate treatment (Addington, Van Mastrigt, Hutchinson, & Addington, 2002; Judge, Perkins, Nieri, & Penn, 2005; McCann, Lubman, & Clark, 2011). Young people also report seeking help for mental health problems as a result of parents’ advice (de Haan, Peters, Dingemans, Wouters, & Linszen, 2002; M. A. Lindsey et al., 2006; McCarthy, Downes, & Sherman, 2008; Tierney, 2008; Wisdom & Agnor, 2007). One study reported that 40-55% of 15- to 17-year-olds stated that help-seeking behaviour was influenced by their family (Rickwood, Mazzer, & Telford, 2015). Studies have shown that young people place value on their parents’ opinions when making serious decisions (Ackard, Neumark-Sztainer, Story, & Perry, 2006; Logan & King, 2001). The fact that even help-seeking adolescents often require adult gatekeepers to facilitate access to formal mental health care is amplified in significance when one recalls that the majority of adolescents do not seek help. Consequently, caregivers are seen as fundamentally important to young people’s mental health service access (Logan & King, 2001), thus bearing significant influence on the illness trajectory of their adolescent children.

In comparison to their facilitation of their child’s service engagement, caregivers’ role in *directly* providing support to their adolescent children has not been as thoroughly-researched. However, the literature that does exist suggests that parents’ support is key to adolescents’ wellbeing and recovery (Stice, Ragan, & Randall, 2004), and

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[3] Public child and adolescent mental health services in Ireland do not accept parents as referral agents (Health Service Executive, 2015; National Clinical Programme for Paediatrics and Neonatology, 2016). To access services, one requires referral from a general practitioner (GP).

a recent systematic analysis found that children and adolescents consider caregivers to be a primary source of help for depression (Georgakakou-Koutsonikou & Williams, 2017). Jorm, Wright, and Morgan (2007) thus deem parents' responses as critical in terms of the outcome of a young person's mental disorder. As such, it is crucial to understand parents' support-giving responses – as stated by Honey, Alchin, and Hancock (2014, p. 195) "to comprehend and optimise parents as a recovery resource, it is necessary to understand what parents actually do: the scope and diversity of the [behaviours] they engage in to try support young people with mental illness".

2.5.2 Peers as support-givers

In addition to caregivers, peers are an important potential source of 'informal' support for adolescents (Colarossi & Eccles, 2000; del Valle, Bravo, & López, 2010; DuBois et al., 2002; Guan & Fuligni, 2015; Jivanjee & Kruzich, 2011; Young, Berenson, Cohen, & Garcia, 2005). In fact, "as youth mature from childhood to adolescence, the foci of their relationships shift from family to friends" (Buchanan & Bowen, 2008, p. 399), and as such some research indicates that during adolescence, peers actually surpass family as the primary providers of social or emotional support (Bokhorst, Sumter, & Westenberg, 2010; B. B. Brown & Larson, 2009; del Valle et al., 2010; Furman & Buhrmester, 1992; Helsen, Vollebergh, & Meeus, 2000; Levitt et al., 2005). Doyle et al. (2017) report that the most commonly-named person that participants felt they could talk to about issues that bothered them was a friend (83%), followed by their mother (65%). Furthermore, research has determined that having supportive friends is crucial to young people's attainment of optimal physical and mental health (Viner et al., 2012).

Adolescents are also in a unique position to observe their peers' behaviour (D. P. Olsson & Kennedy, 2010; Owens et al., 2009; Swenson & Rose, 2003, 2009), as adolescents spend increasing time with peers rather than with family (R. Agnew, 2003; Larson, Richards, Moneta, Holmbeck, & Duckett, 1996; Richards, Crowe, Larson, & Swarr, 1998;

Sheeber, Hops, & Davis, 2001). For example, a participant in one study of university students stated, “Often I (and other friends) become aware of problems first. We have previously had to alert my friend’s family to relapses or particularly worrying episodes, as we were scared for her well-being and were aware of the fact that no one else knew…” (Warren & Byrom, 2006, p. 22). This was echoed in another study of young adolescent supporters of peers engaging in self-harm, when one participant shared, “…she said that if I wasn’t there, she probably would have died…” (Fisher, Fitzgerald, & Tuffin, 2017, p. 149).

Jorm, Wright, and Morgan (2007, p. 69) discuss how “in many ways it is unreasonable to expect adolescents to have the knowledge and skills to support peers”, and Hart, Mason, Kelly, Cvetkovski, and Jorm (2016, p. 2) state that the provision of mental health support to adolescents “is ideally provided by adults, who have a greater capacity to solve problems, take on caring responsibilities and provide practical support”. However, the capacity to provide care to others emerges early in childhood (Eisenberg, 1992; Hepach, Vaish, Grossmann, & Tomasello, 2016; Kärtner, 2017), and children as young as 18 months offer help to other people in need (Warneken & Tomasello, 2006). Furthermore, a recent study with undergraduate university students, with a mean age of 19.9 years, found a third of the sample had previously acted as supporters for friends or family members experiencing suicidal ideation (Garcia-Williams & McGee, 2016), and Mason et al. (2015) found that 97.5% of adolescents offered help when they had contact with an individual experiencing mental health difficulties. These findings are consistent with the literature (King, Vidourek, & Strader, 2008; Mishara, 1982), suggesting that mental health support-giving is routinely performed by adolescents.

In fact, studies have demonstrated that adolescents are both more willing (Curtis, 2010) and more likely in practice (Lubman, Cheetham, Blee, Berridge, & McKay-Brown, 2017) to seek help for a friend experiencing mental health problems, than to seek help for their own issues. Moreover, a series of studies by Ali and colleagues (Ali, Ahlström, Krevers, Sjöström, & Skärsäter, 2013; Ali, Ahlström, Krevers, &

Skärsäter, 2012; Ali et al., 2015) present findings that friends who act as informal carers for people with mental illnesses feel responsibility and a sense of duty towards the person equal to that of family members; this corroborates the results of a study of UK university students who acted as informal supporters (Warren & Byrom, 2006). In a philosophical analysis of the duties of friendship, Annis (1987, p. 352) states "it isn't merely that it is nice for friends to help, to provide psychological support, but that we expect friends to act this way". Indeed, Annis goes on to assert that concern for a friend's welfare and providing comfort and support are 'constitutive' of being a friend (Annis, 1987). Raviv, Raviv, Edelstein-Dolev, and Silberstein (2003, p. 330) similarly state that "turning to a friend is perceived as routine, and often is not even defined as help-seeking by either the seeker or the helper".

Additionally, the literature uniformly suggests that peer support is preferred by the minority of distressed adolescents that do seek help (Chambers & Murphy, 2011; Fortune, Sinclair, & Hawton, 2008; C. R. Lindsey & Kalafat, 1998; Offer, Howard, Schonert, Ostrov, & Ostro, 1991; Sheffield, Fiorenza, & Sofronoff, 2004; Sullivan, Arensman, Keeley, Corcoran, & Perry, 2004). This preference to turn to peers as a source of information and support is amplified in late adolescence (e.g. Bokhorst, Sumter, & Westenberg, 2010), when, concurrently, prevalence rates of depression increase (Health Service Executive, 2013; Lewinsohn et al., 1998; Schubert et al., 2017). Stanton-Salazar and Spina (2005, p. 387) conclude that "simply put, adolescents in general depend heavily on their friends for multiple forms of social support and for staying psychologically healthy".

2.6 Current knowledge of caregivers' and peers' support-giving

It has been established that caregivers and peers are important providers of support for young people experiencing mental health difficulties. In the current section, the extant literature on the nature of caregivers' and peers' support-giving is reviewed.

2.6.1 Caregivers

A significant body of literature exists on family caregivers of adult children (J. Reid, Lloyd, & de Groot, 2005) or children with other disabilities (James, 2013). However, Stapley, Midgley and Target (2016, p. 619) state "there has been a dearth of research exclusively focusing on the experiences of parents of young people with one particular common mental health problem: depression… no published studies to date have exclusively focused on the parents of adolescents with depression to explore these parents' responses to their teenage child's depressive symptoms." A similar paucity of research on parents' responses has been reported in relation to other mental illnesses, such as anorexia nervosa (Honey & Halse, 2005). The research that does exist regarding parental responses to adolescent mental illness appears to focus predominantly upon referral to formal mental health services (e.g., Chen, Gearing, Devylder, & Oh, 2016). Moreover, this research is often contradictory in nature. For example, despite some findings that formal sources of help are not endorsed by parents (e.g. Jorm et al., 2007), other studies have reported the clear majority (91.4%) of parents endorsing a GP visit (Jorm et al., 2008b), or naming medical doctors as the most common first contact for help (Shanley, Reid, & Evans, 2008).

Other research has suggested that, while parents report that they would seek professional help for their child if required, personal sources of support were preferred, such as asking other family members or friends for advice (Raviv, Maddy-Weitzman, & Raviv, 1992). Parents also prefer informal sources when seeking support regarding parenting, more generally (Redmond, Spoth, & Trudeau, 2002). However, Cohen, Kasen, Brook, and Struening (1991) suggested that rather than a dichotomy existing between parents who seek 'formal' help and those that seek 'informal' help, parents either sought help of some form (both informal and formal) or did not seek help at all. This pattern of obtaining both informal and formal support (sometimes simultaneously) is corroborated by other research (Cohen & Hesselbart, 1992; Shanley, Reid, & Evans, 2008; Srebnik et al., 1996). A recent study suggested that parents who perceived a high number of barriers to professional care were more likely to seek help from family and friends (Thurston et al., 2017), suggesting, should these barriers not exist, formal mental health services would be the preferred option. On the whole, there are many discrepancies and little consensus in the literature on parental facilitation of adolescents' access to and/or engagement with professional mental health services.

Research that examines the 'informal' support that parents *themselves* may offer to a young person in distress is sparse. The literature suggests that parents may encourage "behaviour they believe to be beneficial for the young person and their mental health, such as attending and complying with treatment, eating and exercising well, and engaging in positive social behaviour and age-appropriate activities like attending school or work" (Honey, Fraser, Llewellyn, Hazell, & Clarke, 2013, p. 64) and other positive coping strategies (Honey et al., 2014). Other responses may include parents discouraging activities that they believe are detrimental to their child's mental health, such as engaging in self-harm, using alcohol or other drugs, or isolating oneself socially (Honey et al., 2013; Honey & Halse, 2005). Yet, this information is gleaned from just a handful of qualitative studies, carried out by one research team in Australia and focused on parents of young adults; as such, its generalisability to the current context is unclear.

2.6.2 Adolescents

While the literature is clear that peers are perceived as a principal source of support for adolescents in distress (e.g., Sheffield et al., 2004), knowledge of what adolescents actually do to support peers is comparatively scant (Kelly, Jorm, & Rodgers, 2006; Yap & Jorm, 2011b; Yap, Reavley, & Jorm, 2012). One qualitative study of adolescent female supporters of peers engaging in self-harm reported that "participants described asking peers if they were okay, inviting a discussion of troubles, providing physical comfort, reassurance, distraction from the problem at hand, using humour, discussing a disclosure of self-injury with another friend for the purpose of identifying a helpful response, suggesting the student speak with the Guidance Counsellor, and confronting a peer suspected of self-injuring and demanding an explanation. Other actions taken were discussing the situation with the supporter's parent and making a referral to a responsible adult (e.g., the young person's parents, school counsellor, year level dean)" (Fisher et al., 2017, p. 148). Notably, all participants in this study reported speaking to their parents about their friends' self-harm, but all displayed reluctance to involve an adult with more 'specialised' expertise on self-harm: the researchers' analysis suggested that "the supporter aspired to be the one to provide the helping effort, with some participants referring to this as their responsibility given their friendship connection, or as their 'job' to fulfil" (Fisher et al., 2017, p. 153).

This is echoed with some level of consensus regarding peers' facilitation of professional support; specifically, the literature suggests that this does not occur. Dunham (2004, p. 57), drawing an overarching conclusion from studies conducted in 1980s and 1990s (Ciffone, 1993; Kalafat & Gagliano, 1996; Mishara, 1982; Nelson, 1988; Overholser, Huston-Hemstreet, Spirito, & Vyse, 1989), states "peers in this population tend not to notify adults about such disclosures", referring to a young person's disclosure of suicidal ideation. An overview of the contemporary literature appears to corroborate this statement, suggesting that only approximately one-fifth of adolescents seem to consistently state that they would tell an adult (Kelly et al., 2006) or a professional (Jorm et al., 2007a). In one study, only 10% of adolescent participants said that they would encourage their friend to tell 'someone' (Jorm et al., 2007a). However, incongruent results are presented by adolescent participants in Jorm, Morgan, and Wright's (2008b) study, who strongly endorsed engaging the help of a professional. Further analysis of the results of this study, however, reveal that less than half of participants spontaneously reported this response, and one-fifth actually stated that they did not believe in its helpfulness. The developmental context of adolescence may preclude involving adults, as young people spend more time and form closer relationships with their peers, and seek independence from adults

(B. B. Brown & Larson, 2009; Smetana, Campione-Barr, & Metzger, 2006).

In essence, the small body of literature on peer support-giving that does exist is nascent, and based primarily in Australia (L. M. Hart et al., 2018; Jorm et al., 2008c, 2007a; Kelly et al., 2006; Lubman, Cheetham, Jorm, et al., 2017; Mason et al., 2015; Yap & Jorm, 2011b), and the United States (Aldrich, 2015, 2017, 2018; Dunham, 2004; Garcia-Williams & McGee, 2016; King et al., 2008; Lawrence & Ureda, 1990; D. P. Olsson & Kennedy, 2010), with a handful of studies in the United Kingdom (Byrom, 2017; Davies, Beever, & Glazebrook, 2018; Davies, Wardlaw, Morriss, & Glazebrook, 2016), one in New Zealand (Fisher et al., 2017) and one in Sri Lanka (Amarasuriya, Reavley, Rossetto, & Jorm, 2017). Some of this research has examined how adolescents or young adults respond when a peer makes a disclosure of distress or suicidal ideation (Aldrich, 2017; Dunham, 2004). Yet, as has been identified, a disclosure of distress only occurs in a small minority of cases (Chambers & Murphy, 2011). Another study discussed peer support-giving specifically in relation to self-harm (Fisher et al., 2017). However, emotional distress, and depression without suicidal intent or self-injury, have been relatively neglected in the literature (Kelly et al., 2006). If adolescents have the capacity to identify symptoms and appropriate sources of help, peers may potentially be able to engage early, before self-harm or suicidality occurs. Moreover, studies have primarily focused on university students (Aldrich, 2015, 2017, 2018; Amarasuriya et al., 2017; Byrom, 2017; Davies et al., 2018, 2016; Dunham, 2004; Garcia-Williams & McGee, 2016; King et al., 2008). This further emphasises the importance of exploration of peer responses to adolescent depression.

2.7 Sex and/or gender differences in caregivers’ and peers’ responses

Further to the investigation of the nature of caregivers’ and peers’ responses, literature indicates that these responses may differ according to participants' sex and/or gender[4]. Firstly, the prevalence of depression is much higher among females than males, beginning in adolescence and persisting throughout adulthood (Boyd et al., 2015; Bruckauf, 2017; Bulhões, Ramos, Severo, Dias, & Barros, 2017; Kuehner, 2003, 2017; Salk, Hyde, & Abramson, 2017; Salk, Petersen, Abramson, & Hyde, 2016). In addition, emotional problems have been increasing among girls, but the same trend has not been observed among boys (Fink et al., 2015; Van Droogenbroeck, Spruyt, & Keppens, 2018). Secondly, adolescent boys are significantly less likely to seek help for their mental health issues (Andrews, Hall, Teesson, & Henderson, 1999; Arora, Metz, & Carlson, 2016; Barnett et al., 1990; Chan & Hayashi, 2010; Haavik, Joa, Hatloy, Stain, & Langeveld, 2017; S. M. Rice, Purcell, & McGorry, 2018; Sen, 2004), meaning that, in order to engage with professional support, they may be more dependent upon caregivers' and peers' support. Thirdly, across scenarios and contexts, women perform better in tasks where they are asked about what others' think and feel, and are also specifically more capable at 'reading the minds' of female targets (Wacker, Bölte, & Dziobek, 2017). More specifically, intentions and actions relating to providing help to mentally ill persons are found to be generally better among females (Davies et al., 2016; Jorm, Blewitt, Griffiths, Kitchener, & Parslow, 2005; Leahy, 2009; D. P. Olsson & Kennedy, 2010; A. Rossetto, Jorm, & Reavley, 2014a; Yap et al., 2012; Yap, Wright, & Jorm, 2011a). As such, the impact of sex and/or gender on caregivers' and peers' responses to a young person showing signs of depression is further reviewed below.

2.7.1 Caregivers

The gender of the adolescent child is likely to affect the everyday closeness of the parent-child relationship. Adolescent girls are typically socialised to seek emotionally close relationships with their parents, while

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[4] As the studies described here have not measured both sex and gender, it is not possible to confirm whether observed differences can be attributed to (biological) or (socialised) gender. For this reason, both terms are used.

adolescent boys are encouraged at an earlier stage to be independent (Leaper, Anderson, & Sanders, 1998; Operario, Tschann, Flores, & Bridges, 2006). Girls also have greater attachment security with both mothers and fathers than do boys (Buist, Dekovi, Meeus, & van Aken, 2002; Choi, Hutchison, Lemberger, & Pope, 2012; Ruhl, Dolan, & Buhrmester, 2015), and receive more support from their parents (Kristjánsson & Sigfúsdóttir, 2009). Furthermore, research has shown that mothers use emotion-related language, and discuss negative emotions and problems, more frequently with daughters than with sons (Sarıtaş, Grusec, & Gençöz, 2013; Waller & Rose, 2010), thus suggesting that parents (especially mothers) may have greater insight into a daughter's mental state than that of a son. Interestingly, it has been demonstrated that parental support plays a more important role in determining adolescent girls' psychosomatic health issues, than those of boys (Kjellström, Modin, & Almquist, 2017).

The caregiver's gender is also likely to bear influence; for example, while the majority of adolescents in Ackard et al. (2006)'s study reported feeling cared about 'quite a bit' or 'very much' by both their mothers and their fathers, more adolescents felt 'not at all or a little' cared for by their fathers (12.9% adolescent girls, 10.4% adolescent boys) than by their mothers (5.1% adolescent girls, 4.7% adolescent boys). Fathers are perceived as providing the least emotional support (in comparison to mothers and friends) (Colarossi & Eccles, 2003; del Valle et al., 2010). In addition, children report greater satisfaction with the level of emotional and instrumental support received from their mother than from their father (Matthewson, Smith, & Montgomery, 2011). A recent study with female adolescents in the Netherlands found that those who experienced lower paternal emotional support had higher levels of both depression and anxiety symptoms than those who experienced higher paternal emotional support (Rasing et al., 2019). Sex may also affect how comfortable or experienced parents are with discussing mental health related issues with their children. Adolescents typically engage in greater self-disclosure with their mothers than with their fathers (Almeida & Galambos, 1991; Noller & Bagi, 1985; Norrell, 1984). Taken together, these observed and perceived differences in caregivers' and adolescents' everyday interactions may in turn affect caregivers' responses to symptoms of depression presented by their child.

Caregivers' sex may determine their ability to recognise the signs of depression in their adolescent children, as adult women have greater MHL than adult men in general (Angermeyer & Dietrich, 2006; Gibbons, Thorsteinsson, & Loi, 2015; Jorm, Nakane, et al., 2005; Swami, Persaud, & Furnham, 2011), and also recognise mental health disorders in children more frequently than men (Pescosolido et al., 2008). Research specifically with adults who are parents has shown that fathers have poorer physical (Dey, Wang, Jorm, & Mohler-Kuo, 2015) and mental (Mendenhall & Frauenholtz, 2013) health literacy than mothers. The sex of the adolescent child may also play a role in the recognition of symptoms, as it may affect what kind of behaviours are seen as problematic or worrying. For example, parents might be more accepting of a girl who is very withdrawn, quiet, or shy, than a boy who displays the same behaviour (Engfer, 1993; Hastings & Rubin, 1999). As such, caregivers of boys with depression have been found more likely than caregivers of girls with depression to respond angrily to adolescent sadness (Shortt et al., 2016). Mothers are more likely to express intentions to seek professional help for boys than girls, which has been attributed to boys being more likely to develop behaviourally disruptive disorders, which are more burdensome on the family (Raviv et al., 2003). Caregivers have also reported difficulty identifying internalising symptoms (Mesman & Koot, 2000; Sourander, Helstelä, & Helenius, 1999; van de Looij-Jansen, Jansen, de Wilde, Donker, & Verhulst, 2010), which Broderick et al. (2016) hypothesise may explain why parents more frequently report mental health problems among boys than girls. However, fathers have been shown to be particularly unresponsive to daughters who are both shy and poorly accepted by peers (S. R. Miller, Brody, & Murry, 2009). Girls with depressive disorder have been shown to receive more punitive and minimising responses from fathers, in comparison to non-depressed girls (Shortt et al., 2016), as well as less perceived paternal warmth and emotional availability (Demidenko, Manion, & Lee, 2015).

Caregivers' responses to their adolescent child's mental health problems may be affected by sex differences in parental self-stigma and relatedly, guilt and self-blame. Research has found that self-stigma may be greater for mothers than fathers (Francis, 2012). The literature on parental responsibility for children's mental health problems has traditionally focused on maternal culpability (Blum, 2007; Caplan, 1989; Caplan & Hall-McCorquodale, 1985b, 1985a; Phares, 1993), and it appears that some mothers may still fear being accused of causing their child's mental health problems (Hoskins & Lam, 2001). The stigma attached to this may impact caregivers' attitudes towards the provision of support to their child (L. A. Richardson, 2001).

2.7.2 Adolescents

Previous Irish studies have documented differences between male and female adolescents' knowledge of mental health and mental illness. Girls have been found to have higher levels of mental health literacy (S. Byrne, Swords, & Nixon, 2015; Chambers & Murphy, 2011; Lawlor et al., 2008) and are more likely to perceive depression as a serious condition (E. Doyle, O'Sullivan, Nearchou, & Hennessy, 2017). Contrastingly, boys have been found to be less accepting of peers with mental health disorders (Dolphin & Hennessy, 2014; O'Driscoll, Heary, Hennessy, & McKeague, 2012) and to have higher levels of stigma (Dolphin & Hennessy, 2016; Silke, Swords, & Heary, 2017) than girls. These Irish findings echo those of studies conducted elsewhere (Burns & Rapee, 2006; Coles et al., 2016; Cotton, Wright, Harris, Jorm, & McGorry, 2006; Georgakakou-Koutsonikou & Williams, 2017; Hadjimina & Furnham, 2017; Marshall & Dunstan, 2013; Melas, Tartani, Forsner, Edhborg, & Forsell, 2013; Ng & Chan, 2000; D. P. Olsson & Kennedy, 2010; B. Williams & Pow, 2007).

In terms of support-giving responses, girls have been found to more frequently engage in helping and prosocial behaviour more generally (Carlo, Crockett, Randall, & Roesch, 2007; Hine, 2017; Van der Graaff et al., 2014; Van der Graaff, Carlo, Crocetti, Koot, & Branje, 2018). In the context of mental health support specifically, girls have been shown to be more likely than boys to engage in helping responses that seek the involvement of an adult (Kelly et al., 2006), a professional (Cotton et al., 2006), or 'another person' (Yap et al., 2012). These have been considered some of the most functional helping responses in studies of adolescent peer support (Dunham, 2004; Jorm et al., 2008c, 2008b). Boys are less likely to recommend assessing for suicide risk (Jorm et al., 2008c), and are more likely to suggest unhelpful responses such as talking firmly, suggesting drinks, keeping the person busy, and increasing physical activity (Yap et al., 2012). These responses are not typically endorsed by mental health professionals as being beneficial to a young person with depression (Jorm et al., 2008c, 2008b). Interestingly, in Kelly et al.'s (2006) study, male participants did not vary their helping responses depending on symptoms being displayed (indicative of either conduct disorder versus major depressive episode), suggesting that they did not tailor their responses according to the symptom profile presented.

However, it may be the case that only certain support behaviours are associated with sex differences. Dunham (2004) found that a similar number of both young men and young women (58.7% and 58%, respectively), when presented with a hypothetical suicidal peer, would help the peer by talking to them alone. Similarly, Yap et al. (2012) found that the number of boys who said they would 'listen or talk to the person' was comparable to the number of girls who said the same (48% and 49%, respectively). It is noteworthy that the literature is also mixed with regards to sex differences in adolescents' confidence in their support-giving abilities; some studies have found that girls are more confident than boys (Jorm et al., 2007a; Lubman, Cheetham, Blee, et al., 2017), with others reporting the opposite (Yap et al., 2012).

Sex differences can be observed in adolescents' normal interactions with friends, which may then extend to their support-giving responses when a friend or peer is experiencing mental health issues. Adolescent friendships are typically characterised by homophily, particularly with regards to sex (Mjaavatn, Frostad, Jan Pijl, & Jan Pijl, 2016; Selfhout, Branje, & Meeus, 2007). Girls therefore typically form friendships with other girls, and their friendships emphasise dyadic and small-group interactions; while boys also tend to befriend other boys, their friendships tend to be based on shared activities and also larger in size, perhaps due to the more frequent participation of boys in team sports (Chu, 2005; M. L. Clark & Ayers, 1993). These characteristics affect the emotional valence of adolescents' friendships: research has demonstrated that girls' friendships are more emotionally intimate, and involve the sharing of confidences (Chow, Ruhl, & Buhrmester, 2013; Frey, Rothlisberger, & Röthlisberger, 1996; Maccoby, 1990). Girls are also more likely than boys to emphasise helping, self-disclosure, and empathy in friendships (M. L. Clark & Ayers, 1993; Kenny, Dooley, & Fitzgerald, 2013; Maccoby, 1990; Ralph & Epkins, 2015; Rose & Asher, 2004). It could be argued that girls are thus more likely to pick up on symptoms of mental distress in a friend; indeed, girls are more accurate reporters of friends' affective depressive symptoms than are boys (Swenson & Rose, 2003). Increased and more accurate identification of symptoms may also be ascribed to the higher prevalence of depression among adolescent girls (Bruckauf, 2017), as it is likely that adolescent girls have more social experience with depression than their male peers. Girls view seeking and providing support among friends as a normative coping response (Sears, Graham, & Campbell, 2009), and perceive higher levels of support from their peers than do boys (Cheng & Chan, 2004; Frey et al., 1996; Furman & Buhrmester, 1992; Rueger, Malecki, & Demaray, 2008), which may affect how girls then reciprocate this support, as reciprocity is highly important to adolescent friendships (Chow, Ruhl, & Buhrmester, 2014). In comparison to girls' intimate and emotionally reliant friendships, boys are often socialised to see the assertion of autonomy as masculine (Taylor, 2015). This may then affect how peers respond to the signs of distress in a male adolescent – young people are less likely to report that they would encourage a male peer to seek professional help (Yap & Jorm, 2012). In line with this, males receive poorer quality support from young people with whom they are close (Yap et al., 2011a).

Adolescent girls have also been shown to engage in more co-rumination with friends than boys, and this increases with age (Rose, 2002). Co-rumination is defined as "excessively discussing personal problems within a dyadic relationship and is characterised by frequently discussing problems, discussing the same problem repeatedly, mutual encouragement of discussing problems, speculating about problems, and focusing on negative feelings" (Rose, 2002, p. 1830). Co-rumination has been associated with internalising symptoms (Dirghangi et al., 2015; Stone, Hankin, Gibb, & Abela, 2011), and partially mediates the relationship between gender and depression (Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008; Rose, 2002); it is therefore said to be "advantageous for friendship quality, but disadvantageous for mental health" (Bastin, Vanhalst, Raes, & Bijttebier, 2018, p. 1037). It is thus interesting to note that some adolescent girls suggest listening and talking to a peer as a beneficial help-giving response (e.g. Cotton et al., 2006); it is unclear whether girls may be referring to negative behaviours such as those characterised in co-rumination. Therefore, although previous research has characterised these kinds of responses, when offered by young people, as helpful, or indicative of girls' greater MHL, we must interpret this with caution, and bear in mind the potential 'cost of caring' associated with such responses (Naidoo, Naidoo, Yende-zuma, & Gengiah, 2015; R. L. Smith & Rose, 2011).

2.8 Age differences in adolescents' responses

Similarly, it appears that an exploration of whether adolescents' responses differ based on age would add value to the current study. Age is fundamentally important in all studies that relate to adolescents, because of the vast range of developmental tasks associated with this life stage, and the resulting differences apparent between young people at different points of the adolescent journey (Gregory, 2017). In addition, the prevalence of depressive disorders in adolescence increases with age (Bruckauf, 2017); 83% of inpatient admissions to child and adolescent mental health services in a one-year period were for adolescents aged 15-17 years (Health Service Executive, 2013). Young people undergo many changes (physically, psychologically, and socially) throughout the adolescent period (Dahl, Allen, Wilbrecht, & Suleiman, 2018; Sawyer et al., 2012). In addition, adolescence is a period of individuation, increasing independence from parents and family, and increasing dependence on friends (Bokhorst et al., 2010; Smetana, 2010). These facts in conjunction suggest that the experiences of a 12-year-old and an 18-year-old (both 'adolescents') are likely to be very different. As such, the responses that these two individuals might offer to a peer experiencing mental health difficulties might also be diverse.

With increasing autonomy in late adolescence, the expectations of friendship, important even to pre-teens (MacEvoy & Asher, 2012), grow ever higher (Boldero & Fallon, 1995). Adolescent friendships have been shown to increase in salience, complexity, and intimacy with age (B. B. Brown & Larson, 2009; Buhrmester, 1990; Buhrmester & Furman, 1987; McNelles & Connolly, 1999), which may mean that older adolescents may be more likely to identify the presence of worrying symptoms in peers. However, the literature is mixed with regards to whether friends play an increasingly greater role in the provision of emotional support throughout adolescence. Some research suggests that from middle childhood to adolescence there is a steady increase in the level of perceived emotional support received from friends, with a decline in mid to late adolescence (Furman & Buhrmester, 1992; Helsen et al., 2000; Hunter & Youniss, 1982). However, other, more recent, studies suggest that this remains static, so that there are no age differences in the overall positive and negative qualities of adolescent friendships (Kenny et al., 2013; La Greca & Harrison, 2005; Malecki & Demaray, 2002). There seems to be some consensus that friends' support exceeds the level of support perceived from parents between the ages of 15 and 18 years (Bokhorst et al., 2010; Helsen et al., 2000). This may potentially influence adolescents' responses, such that in early adolescence, the provision of support is still perceived by young people as being the responsibility of a friend's parent/caregiver, whereas by late adolescence there is acceptance that this is part of 'what friends do'. Refuting this, however, are the findings of one study with younger (13- to 15-year-old) adolescent girls, which found that they perceived the provision of support to be one of the responsibilities of a friend (Fisher et al., 2017).

Adolescents' age may also affect their social experience of mental illness. Many mental illnesses tend to emerge in later adolescence (R. C. Kessler et al., 2007; Lewinsohn et al., 1998; Schubert et al., 2017). In particular, prevalence rates of depression increase over the adolescent period (Birmaher et al., 1996; Thapar et al., 2012). Recent Irish research has demonstrated a decrease in young people's well-being across the secondary school time period (J. Burke & Minton, 2019); similar trends have been reported in England (Rees, Goswami, & Bradshaw, 2010). Therefore, it accords that older adolescents may be more likely than younger adolescents to interact with and be exposed to same-age peers experiencing mental illness. However, mental health issues can affect children from early childhood (Bufferd, Dougherty, Carlson, & Klein, 2011; Hankin, 2015; Hankin et al., 2015; R. C. Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012; Luby, Gaffrey, Tillman, April, & Belden, 2014), and moreover, children are not solely exposed to same-age peers, meaning that even young children are likely to have some contact with individuals experiencing mental health problems. Thus, it is also possible that these observed age-related increases do not reflect *actual* increases in exposure to mental illness, but instead increases in the ability to recognise and understand mental illness (Dixon, Murray, & Daiches, 2013; Fox, Buchanan-Barrow, & Barrett, 2008, 2010; Wahl, 2002; A. Wright et al., 2005). Should younger adolescents not identify the symptoms of mental illness in others, they may perceive their exposure to mental illness to be very low. This may also affect younger adolescents' recognition of their own issues as relating to their mental health.

These age-related increases in the recognition of mental illness are echoed in adolescents' intentions to provide support to people experiencing mental illness, which generally increase among older youth, and reflect more advanced understanding of appropriate supports (Davies et al., 2016; Reavley, Mccann, & Jorm, 2012; A. Wright et al., 2005; Yap et al., 2011a). However, the literature in this area is not wholly consistent. For instance, in one Irish study, 15- to 16-year-old adolescents reported greater anger than 10- to 11-year-old children towards a depressed vignette character (O'Driscoll et al., 2012), but another Irish study found that acceptance of adolescent peers with mental health problems increases with age (Swords, Heary, & Hennessy, 2011). Thus, it appears that age trends in responses towards peers with depression may be nuanced and complex.

Emotional support skills have also been demonstrated to increase with age (Burleson, 1982, 2003a; Denton & Zarbatany, 1996), with older adolescents using more sensitive message strategies (Ritter, 1979). It has been demonstrated that "adolescents become increasingly aware of the effects of their emotional communication" (von Salisch, 2018, p. 1). Furthermore, engagement in prosocial behaviour is increased in older adolescents, perhaps due to enhanced perspective-taking abilities which facilitate advanced moral reasoning (Eisenberg, Morris, McDaniel, & Spinrad, 2009; Spinrad & Eisenberg, 2017). All in all, age-related developments in underlying cognitive abilities and in socioemotional competence are likely to play a primary role in determining adolescents' awareness of the emotional states of others, and their responses to others' distress (Camras & Halberstadt, 2017; Rose-Krasnor, 1997).

2.9 Gaps in current knowledge

In sum, despite the prevalence of adolescent depression, the negative outcomes associated with untreated depression, and the significant role that informal support may play in addressing the 'treatment gap', "the role of family and friends in overcoming mental health treatment barriers is poorly understood" (Thériault & Colman, 2017, p. 485). Furthermore, the nature of support directly provided by caregivers and peers remains unknown. Consequently, any differences between caregivers' and peers' responses are also undetermined, as are any variations in responses according to participants' sex or age.

It is therefore congruent that the perceptions and experiences of carers and family members of people with mental health problems have been declared a mental health research priority for Europe (Wykes et al., 2015), in order to address this gap in the literature. Similarly, the results of a survey of patients, carers, and healthcare professionals proposed that one of the top 10 priorities for depression research is, "What are the best ways to help friends and family members to support people with depression?" (MQ: Transforming Mental Health, 2016). The current study thus responds to these calls for further investigation of parents' and peers' support-giving responses.

2.10 Conclusion

In conclusion, it is clear that adolescent depression is a significant issue, and that the impact of this issue is exacerbated by the so-called 'treatment gap'. While informal support appears to play an important role by providing a 'scaffold' for young people with depression, our understanding of support-giving behaviour is limited. The responses that caregivers and adolescents provide therefore require elucidation, as do any differences between caregivers' and adolescents' responses, thus shaping the first and second research questions of this study:

1. *How do caregivers and peers respond to the expression of depressive symptoms in an adolescent character portrayed in a vignette?*
2. *Are there significant differences between caregivers' and peers' responses?*

This chapter has also established that participants' sex may impact upon their responses to young people with depression. As such, the third research question of the study is:

3. *Do caregivers' and peers' responses differ according to sex?*

Similarly, literature suggests that adolescents' responses may vary based on participants' age. Accordingly, the fourth research question of the current study is:

4. *Do adolescents responses differ according to age?*

Moreover, the little research on this topic appears to be atheoretical in nature, although it is evident that understanding the factors that are associated with different types of support would be beneficial: “To support parents to develop effective practices, we first need to understand what influences the practices they use” (Honey et al., 2015, p. 842). As such, the next chapter of this thesis will aim to review several theories that pertain to informal support-giving, and identify the factors that comprise each theory, in order to build a conceptual framework for the design of the current study.

Chapter 3 Critical review of relevant theories and development of conceptual framework

3.1 Introduction

The previous chapter established that caregivers and peers are well-positioned to play an important role in providing support to a young person showing signs of depression, but that little is currently known about the nature of support offered by these helpers. Building on the previous chapter, this chapter will detail the review of theory undertaken for the purposes of identifying the conceptual framework for the current study. The purpose of this review is presented: specifically, that the development of the conceptual framework is an essential step in structuring and situating the current study. As such, in the following sections of this chapter, different theoretical perspectives will be examined, with the aim of elucidating key factors that underpin informal support-giving behaviour, which in turn will function as the building blocks of the conceptual framework, which is presented at the end of this chapter.

3.2 Purpose of theory review

Seemingly at odds with the abundance of evidence supporting the relevance and significance of 'informal' or social support for health, there is no comprehensive theory that aids our understanding of support-giving behaviour and its implementation in the specific context of responding to the symptoms of mental illness. As theory is necessary to contextualise and structure any piece of research (Smyth, 2004), it was decided that a range of theories germane to the topic of interest would be critically reviewed, to establish the factors that may assist our understanding of the antecedents of support-giving behaviour. This will serve to establish the *conceptual framework* for the current study, defined by Grant and Osanloo (2014, p. 13) as "the selected theories that undergird your thinking with regards to how you understand and plan to research your topic, as well as the concepts and definitions from those theories that are relevant to your topic”. By drawing together these theoretical perspectives, each characterised by a distinct body of literature, a ‘toolbox’ for the current study will be identified: the conceptual map will help to ascertain the key variables of this study, and to guide the kind of data to be accrued (Dickson, Adu-Agyem, & Emad Kamil, 2018).

The identification of key study variables is particularly important in order to assist in understanding the mechanisms that account for caregivers’ and peers’ responses to young people with depression. This may clarify the nuances of these responses, and enable the development of theoretically-grounded approaches to the provision of training for ‘informal’ supporters. Consideration of the support process from the perspective of the support-provider may also help to identify factors that predict helpful or unhelpful responses. This is valuable because unhelpful responses from others have been demonstrated to result in negative outcomes for the recipients of support (Burleson, 2003b), and that adolescents with mental health difficulties have been found to be particularly sensitive to the responses and feedback of peers (Prinstein, 2007). Additionally, it has been argued that these factors are likely to be modifiable and thus there is utility in their identification (A. Rossetto et al., 2014a).

Thus, by integrating concepts across multiple theories, it is hoped that the study can meaningfully address the problem identified in Chapter 2. Specifically, the following theoretical sources are reviewed: social support theories; theories of prosocial behaviour; theories of mental health service access; the theory of planned behaviour; ‘mental health literacy’ as a theory; and theories of exposure to mental illness.

3.3 Social support theories

The role of interpersonal relationships in remediating personal distress has long been studied by scholars of social support (Griffith, 1985). Indeed, an sizable body of work has demonstrated the significant impact of social factors on health (Monroe, 1983; Thoits, 2011; Vescio, Sechrist, & Paolucci, 2003; Wilkinson & Marmot, 2003), to the extent that researchers have coined the term 'the social cure' (Haslam et al., 2018; Jetten, Haslam, & Haslam, 2012; Jetten, Haslam, Haslam, & Branscombe, 2009). Theories of human development, such as Bronfenbrenner's bioecological theory (Bronfenbrenner, 1986a, 1994; Bronfenbrenner & Morris, 1998), also acknowledge the influence of social factors on adolescents' wellbeing.

However, this body of literature is characterised by a focus on the effects of *receiving* social support (Zee, Cavallo, Flores, Bolger, & Higgins, 2018), as identified by Jung (Jung, 1988), who noted "the study of social support has been directed primarily at the examination of the effects of social support on the recipient and has neglected the factors influencing the motivation of the provider". This was echoed by Dunkel-Schetter and Skokan (1990, p. 438), who stated that "historically, support has been studied more from the perspective of the recipient than that of the provider". An example of a social support theory of this nature, concerned with explaining the effect of receiving support on health, is the stress-buffering hypothesis (S. Cohen & McKay, 1984).

In social support research where the *provider* of support is considered, the postliminary effects of providing support are typically all that are addressed (e.g., Inagaki & Orehek, 2017), without examination of the personal antecedents (Feeney & Collins, 2015; Shumaker & Brownell, 1984). This is also a noted feature of the emotional support literature (K. R. Rossetto, Lannutti, & Smith, 2014). There are of course some exceptions, including recent studies which have examined the impact of providers' regulatory modes on their attempts to match support to the needs of the recipient (e.g., Cavallo, Zee, & Higgins, 2016). However, given that the provision of support is known to be a cognitively and socially challenging task (Aakhus & Rumsey, 2010; Bodie, 2011; Burleson, 1984; Samter, 2002), this general dearth of literature exploring its underlying mechanisms is problematic – although indicative, some argue, of a 'blind spot' in social psychology regarding the factors that determine behaviour (C. R. Agnew, Carlston, Graziano, & Kelly, 2010).

As such, social support theories did not directly contribute to the conceptual framework of the current study.

3.4 Theories of prosocial behaviour

Theories of helping and prosocial behaviour offer some relevant insights to the provision of support in this context. These models tend to focus on evolutionary concepts of altruism, cost-benefit analysis, and reciprocal exchange (Berkowitz, 1968; Davidov, Vaish, Knafo-Noam, & Hastings, 2016; Dovidio, 1984; Fritzsche, Finkelstein, & Penner, 2000; M. S. Greenberg, Block, & Silverman, 1971; Shumaker & Brownell, 1984; B. Simpson & Willer, 2008; Stewart-Williams, 2007; Van Rijsewijk, Dijkstra, Pattiselanno, Steglich, & Veenstra, 2016). However, research within this paradigm has been primarily conducted in controlled experimental settings, with the focus resting on single instances of instrumental helping among acquaintances or strangers, such as helping to pick up dropped papers (Callero, Howard, & Piliavin, 1987a, 1987b; Dunkel-Schetter & Skokan, 1990). As such, the generalisability of these theories to an adolescent's provision of support to a peer showing signs of depression may be limited. Yet, it appears that reciprocity, a facet of these theories, may be pertinent to this context: empirical evidence does suggest that the provision of emotional support is (at least in part) predicated upon an expectation of future reciprocation (Rafaeli & Gleason, 2009; Stanton-Salazar & Spina, 2005). As such, an individual's decision to provide support within the peer context may partially rest on the assumption that the support recipient will similarly recompense, in any future instance wherein the provider is distressed. However, it is unclear whether the assumption of reciprocity is associated with emotional support-giving in the context of mental health issues.

However, one theory of prosocial behaviour that may be relevant to the current study is the Attribution-Empathy Model of Helping Behaviour (AEMHB), see Figure 2, which suggests that helping is a function of (a) the helper's causal attributions for a person's need, (b) the perceived controllability of these attributed causes, (c) empathic emotions, and (d) what Betancourt (1990, p. 575) termed “empathic perspective… characterised by a concern for another person’s situation”, or what is sometimes referred to as ‘trait empathy’ (Betancourt, 1990).

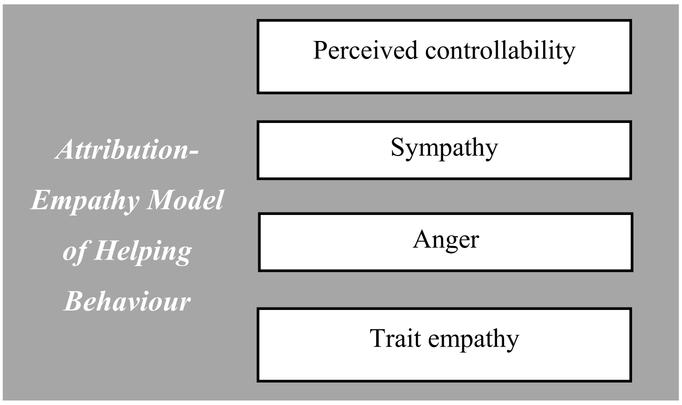

Figure 2: The Attribution-Empathy Model of Helping Behaviour

Empathy is demonstrably associated with prosocial behaviour more generally (Batson, 1991; Batson, Duncan, Ackerman, Buckley, & Birch, 1981; Batson et al., 1997; Eisenberg et al., 1989; Eisenberg & Miller, 1987; Toi & Batson, 1982; Van der Graaff et al., 2018), and has been shown to influence individuals’ provision of support on a peer helpline (Pudlinski, 2005). Additionally, attribution theory, which proposes a link between causal ascriptions and affect, and in turn between affect and behavioural responses (Weiner, 1980), supports the relationship between perceived controllability, emotional responses of anger and sympathy, and prosocial behaviour. Empirical evidence (Badahdah & Alkhder, 2006; Greitemeyer & Rudolph, 2003; Greitemeyer, Rudolph, & Weiner, 2003; Rudolph, Roesch, Greitemeyer, & Weiner, 2004; Schmidt & Weiner, 1988; Tscharaktschiew, 2016; Willner & Smith, 2008) further endorses these theoretical accounts. Of note, one study found that the empathic emotions of pity and anger fully mediated the relationship between beliefs about controllability and willingness to personally offer help to an individual experiencing mental illness (Obonsawin, Lindsay, & Hunter, 2013). Therefore, the factors comprising the AEMHB are included in the conceptual framework for the current study.

3.5 Theories of mental health service access

In order to attend to the specificities of the mental health context, it may be helpful to examine theories that address 'formal' mental health support access and engagement. Studies examining individuals' facilitation of another person's mental health service access tend to draw upon theories of help-seeking behaviour, framing this facilitation as help-seeking on another's behalf (Cauce et al., 2002; Zwaanswijk, Van Der Ende, Verhaak, Bensing, & Verhulst, 2005). These studies are based on recognition of the fact that members of the social network wield considerable influence on an at-risk individual's decision to seek professional mental health support (Cusack, Deane, Wilson, & Ciarrochi, 2004; Strohmer, Biggs, & McIntyre, 1984; C. J. Wilson & Deane, 2001). This was expressed, for example, by Logan and King (2001, 2002), who presented an elaborate linear model of parental facilitation of children's mental health service access. However, this model did not seem to cohere with real-world data which demonstrated non-sequential pathways, or some steps bypassed altogether (Pavuluri, Luk, & McGee, 1996). In comparison, the Network Episode Model (NEM) proposed a network-based account of multiple and dynamic influences on service use, and accounted for treatment system factors such as accessibility (Pescosolido, 1991, 1996; Pescosolido & Boyer, 1999; Pescosolido, Gardner, & Lubell, 1998). The NEM was adapted to account for the specific role that parents play in facilitating child mental health service access (E. J. Costello, Pescosolido, Angold, & Burns, 1998), emphasising the inference that parents should therefore form the target group of any intervention aimed at increasing children's mental health service use, and was later elaborated upon to form the Gateway Provider Model (GPM) (Stiffman, Pescosolido, & Cabassa, 2004).

The GPM highlights the importance of 'gateway providers' – individuals who are not mental health professionals, but whose beliefs and attitudes can shape the pathways that young people travel into and through the mental health service system. Parents are seen as key gateway providers (G. J. Reid et al., 2011; Shanley et al., 2008), but other adults such as teachers, child welfare officers and juvenile justice authorities are also considered (Bunger, Stiffman, Foster, & Shi, 2010; Holloway, Brown, Suman, & Aalsma, 2013). However, the GPM focuses solely on the role that these individuals play in facilitating access to formal mental health services, and as such neglects to recognise the 'informal' support that these individuals may directly offer. This was acknowledged by the authors when they stated, "of course, parental responsibilities for the care of children are much wider than simply providing access to professional services" (E. J. Costello et al., 1998, p. 168). As such, these theories are not employed in the conceptual framework of the current study.

3.6 Theory of Planned Behaviour

More general 'umbrella' theories of behaviour may also help to illuminate the mechanisms underlying support-giving behaviour in this context. One such theory is the Theory of Planned Behaviour (TPB) (Ajzen, 1991), see Figure 3, which represents a refinement and extension of the Theory of Reasoned Action (TRA) first proposed by Ajzen and Fishbein (1972). The TRA states that intentions to engage in any behaviour are influenced by the individual's (affective) attitudes and normative beliefs (Ajzen & Fishbein, 1972)[5]. The TPB, in comparison, submits that a third construct also plays a role: perceived behavioural control (PBC), which refers to the "beliefs a person has about being able to perform the action or not, due to skill sets or obstacles" (Aldrich, 2015, p. 333). Ajzen acknowledged that PBC was derived from the concept of self-efficacy (Ajzen, 1991), and studies have sometimes used self-efficacy as a proxy measure of PBC (e.g., Brayley et al., 2015).

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[5] It is noteworthy that attribution theories also consider beliefs and affect central to the determination of behaviour towards others with mental illness (Corrigan et al., 2003; Corrigan, River, et al., 2001).

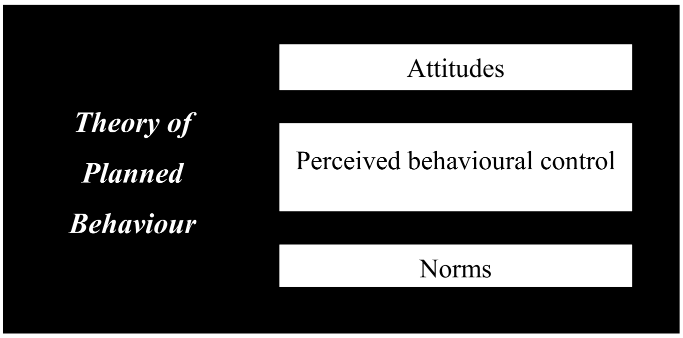

Figure 3: Theory of Planned Behaviour

The TPB is one of the most widely-tested models of the factors influencing health-related behaviour (for meta-analyses, see Armitage & Conner, 2001; McEachan, Conner, Taylor, & Lawton, 2011) and has also demonstrated utility in explaining individuals' help-seeking for their own mental health problems (Hess & Tracey, 2013; Hui, Wong, & Fu, 2014; Hyland, McLaughlin, Boduszek, & Prentice, 2012; Schomerus, Matschinger, & Angermeyer, 2009; Skogstad, Deane, & Spicer, 2006; J. P. Smith, Tran, & Thompson, 2008). It is important to note that in these studies, the TPB is used to explain behaviour with personal health benefits. It seems possible that support-giving behaviour may differ somewhat in its determinants. However, the TPB has been successfully employed in studies of prosocial behaviour (France, France, & Himawan, 2007; Hyde & White, 2009; Kaiser, 2006; Kaiser, Hübner, & Bogner, 2005; Knowles, Hyde, & White, 2012; Masser, Bednall, White, & Terry, 2012; Oreg & Katz-Gerro, 2006; J. R. Smith & McSweeney, 2007). Research has also demonstrated that the TPB effectively explains doctors' intentions to refer patients to local mental health services (Conner & Heywood-Everett, 1998). In a South African sample, Sorsdahl, Stein and Flisher (2013) found that the TPB significantly predicted traditional healers' referrals of patients to Western mental health practitioners. Moreover, the TPB has recently (and pertinently) been used to explain 'informal' individuals' intentions to seek professional help for another individual experiencing mental health problems (Aldrich, 2015; Aldrich, Harrington, & Cerel, 2014; S. H. Lee et al., 2015; Rivis & Sheeran, 2003). It is yet to be applied to other responses offered by 'informal' helpers.

Past behaviour was initially included in the TRA (1972) and scholars have argued that the inclusion of past behaviour as a predictor would benefit the explanatory quality of the TPB (Conner & Armitage, 1998; Ouellette & Wood, 1998; Sommer, 2011), see Figure 4.

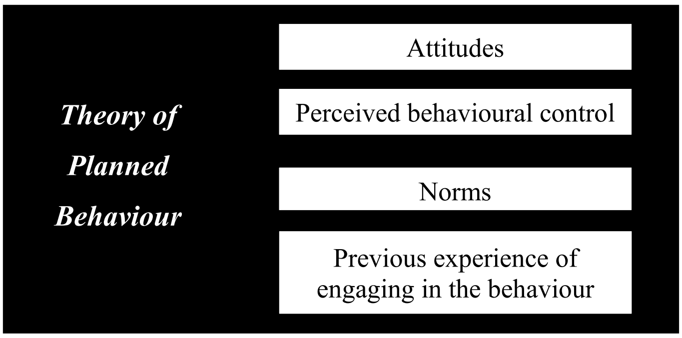

Figure 4: Theory of Planned Behaviour with past behaviour included as a fourth variable

However, others suggest that the effect of past behaviour is dependent upon whether the behaviour became habitual (Danner, Aarts, & De Vries, 2008; Forward, 2009; Trafimow, 2000). Indeed, Ouellette and Wood (1998) conducted a meta-analysis which found that intention is a stronger predictor of infrequently-performed behaviours and past behaviour is a stronger predictor of frequently-performed behaviours. It is unclear whether the development of habit would pertain to the informal provision of support to an individual experiencing depression. However, given the strong evidence arising from this meta-analysis, this factor, together with the three 'classic' factors of the TPB, warrant inclusion in the conceptual framework of the current study.

3.7 Mental health literacy

While mental health literacy (MHL) was not initially proposed as a formal theory, it has been extensively used as an organising framework (Kutcher, Wei, & Coniglio, 2016), and a recent paper submits that MHL would most appropriately be considered a theory (Spiker & Hammer, 2018). MHL was first introduced as a concept in 1997 and defined as the "knowledge and beliefs about mental disorders which aid their recognition, management or prevention… the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes; of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking" (Jorm et al., 1997, p. 182). More recently, MHL has been defined as a range of cognitive and social skills and capacities that support mental health promotion, including understanding mental health disorders and their treatment, having decreased stigma related to mental disorders, and having help-seeking efficacy (knowing when and where to seek help) (Kutcher, Bagnell, & Wei, 2015; Kutcher et al., 2016).

One of the key elements of both definitions of MHL is the ability to recognise disorders, see Figure 5. This is typically assessed by asking participants to label a set of symptoms described in a vignette (Reavley & Jorm, 2011).

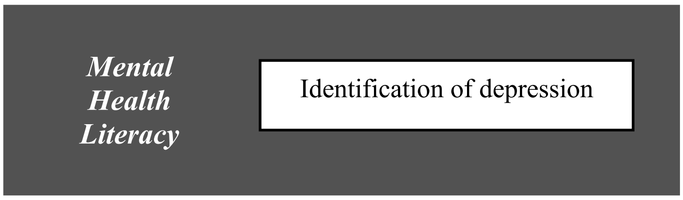

Figure 5: Identification of depression as a core concept of mental health literacy

The impact of this act of classification is central to labelling theory, which states that "the label rather than the behaviour *per se* shapes the fate of mentally ill persons, by creating chronic mental illness or by compromising the life chances of those so labelled… [setting] into action cultural stereotypes and negative images about mental illness that are applied to the person by others and by the person to himself or herself" (Rosenfield, 1997, p. 660). This is debated; other theorists have suggested that labelling plays an important and positive role (Biddle, Donovan, Sharp, & Gunnell, 2007; Vogel, Wester, Larson, & Wade, 2006), by facilitating the identification of a need for support: "If the mental health problem is seen as an illness, the privileges of the patient role will be granted" (Angermeyer & Matschinger, 2003, p. 304). Intentions to provide help to a mentally ill person are generally increased among individuals who recognise the presence of mental health problem (Jorm, Blewitt, et al., 2005; D. P. Olsson & Kennedy, 2010). As stated by Mueller and Waas, "A prerequisite for the delivery of such support efforts is the recognition that a peer is exhibiting behaviours that are associated with potentially serious health risks" (2002, p. 326).

Previous studies have primarily focused on the relationship between MHL and participants' personal help-seeking behaviour, by assessing what they might do if they personally were to experience problems similar to those displayed by a character described in a vignette (Calear, Batterham, & Christensen, 2014; Goldney, Fisher, & Wilson, 2001; Taylor-Rodgers & Batterham, 2014). However, as highlighted by Cruwys, An, Chang and Lee (2018, p. 96), "a theme throughout the research on MHL is that one of its most important potential benefits is that people will (a) provide more appropriate social support to their friends and family who experience symptoms of mental illness, and (b) facilitate entry into formal professional care for friends and family when this is indicated". Promisingly, a meta-analysis has suggested that receipt of training in MHL is associated with increased willingness to assist individuals experiencing mental illness (Hadlaczky, Hökby, Mkrtchian, Carli, & Wasserman, 2014). Additionally, greater MHL has been shown to be associated with increased confidence in providing support to others experiencing mental health problems (Bond, Jorm, Kitchener, & Reavley, 2015; Mason et al., 2015; Ojio et al., 2015; D. P. Olsson & Kennedy, 2010), and thus may corroborate the proposed importance of PBC in determining behavioural intentions in the TPB. As noted in Kutcher's definition of MHL above, 'help-seeking efficacy' refers to the knowledge of when and where to seek help, and is thus likely to relate closely to the concept of PBC. All in all, it is clear that MHL is a necessary addition to the conceptual framework of the current study.

3.8 Theories of exposure to mental illness

Gordon Allport's seminal chapter, '*The Effect of Contact*', in his book '*The Nature of Prejudice*' (Allport, 1979) lead to a proliferation of research and theory regarding what became termed the 'contact hypothesis' (and, relatedly, the Intergroup Contact Theory). The contact hypothesis rests on the fundamental assumption that prejudice stems from a lack of knowledge about a stigmatised group, that negative stereotypes are activated by this lack of knowledge, and that prejudice would be reduced following contact with that group (Pescosolido & Manago, 2018; Pettigrew & Tropp, 2005). Level of contact is therefore the mechanism of action or driver of behavioural change, see Figure 6.

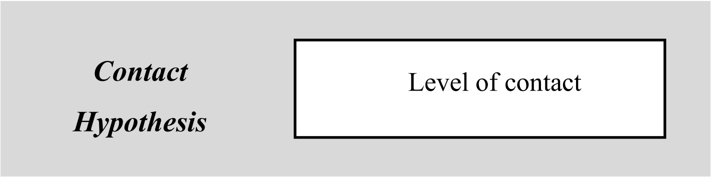

Figure 6: Contact hypothesis

Indeed, contact with individuals experiencing mental health issues is known to reduce stigma (Angermeyer, Matschinger, & Corrigan, 2004; Corrigan, Green, Lundin, Kubiak, & Penn, 2001; Spagnolo, Murphy, & Librera, 2008). Greater familiarity with individuals experiencing mental illness is associated with significantly more positive attitudes about mental illness (Couture & Penn, 2003), and previous contact with a person who had a mental illness has also been found to be associated with correctly identifying depression (Lauber, Nordt, Falcato, & Rössler, 2003). Furthermore, lifetime experience with mental illness predicted MHL in a study of parents of young people diagnosed with mood disorders (Mendenhall & Frauenholtz, 2013). Importantly, though, the effects of contact may differ according to whether this exposure is actual or perceived (Cooley-Strickland et al., 2016). Knowing that low MHL decreases the likelihood of identifying depression, it seems probable that some individuals will not recognise the true level of their exposure to mental illness. Thus, participants' self-reported exposure to mental illness is potentially *in itself* a measure of their ability to recognise signs of mental health issues in others.

Contact or exposure to mental illness has, up to now, primarily been explored with regards to its association with *discriminatory* attitudes and behaviours; the relationship between level of contact and *support-giving* behaviour has yet to be investigated. However, contact has been linked to prosocial behaviour in other contexts. Direct and imagined contact with members of an experimentally-allocated ‘outgroup’ has been found to be associated with more positive helping intentions towards the outgroup among 8- to 10-year-old children (Vezzali, Stathi, Crisp, & Capozza, 2015). Among adult work colleagues, personal contact with employees in another workgroup predicted prosocial behaviour towards an individual within that workgroup (Koschate, Oethinger, Kuchenbrandt, & van Dick, 2012). Exposure to mental illness is therefore included in the conceptual framework of support-giving behaviour for the current study.

3.9 Resulting conceptual framework

The review of theory described above has helped to ascertain that the Attribution-Empathy Model of Helping Behaviour, Theory of Planned Behaviour, the concept of mental health literacy, and the Contact Hypothesis each contribute useful concepts that may impact an individual’s intentions to provide support to a young person showing signs of depression. As discussed in section 3.2 of this chapter, a framework to guide the focus and consequent design of the current study is achieved by bringing these concepts together, see Figure 7. This ‘toolbox’ identifies key variables to be investigated with regards to their association with caregivers’ and peers’ support-giving behaviour, and therefore provides a structure for the Method of the study.

3.10 Conclusion

This chapter presented a review of theories that may be relevant to understanding caregivers’ and peers’ support-giving responses to a young person showing signs of depression. This review identified several variables as being potentially associated with intentions to provide support. These were: attitudes towards support-giving, norms regarding support-giving, PBC regarding support-giving, trait empathy, perceived controllability of symptoms, anger, sympathy, previous experience of support-giving, MHL (specifically, the ability to identify depression), and exposure to mental illness. These factors were brought together in a conceptual framework, used to determine the specific theoretically-grounded variables of interest in the current study. The research evidence for each factor and how it may be associated with caregivers' and peers' support-giving responses will thus be reviewed in the next chapter.

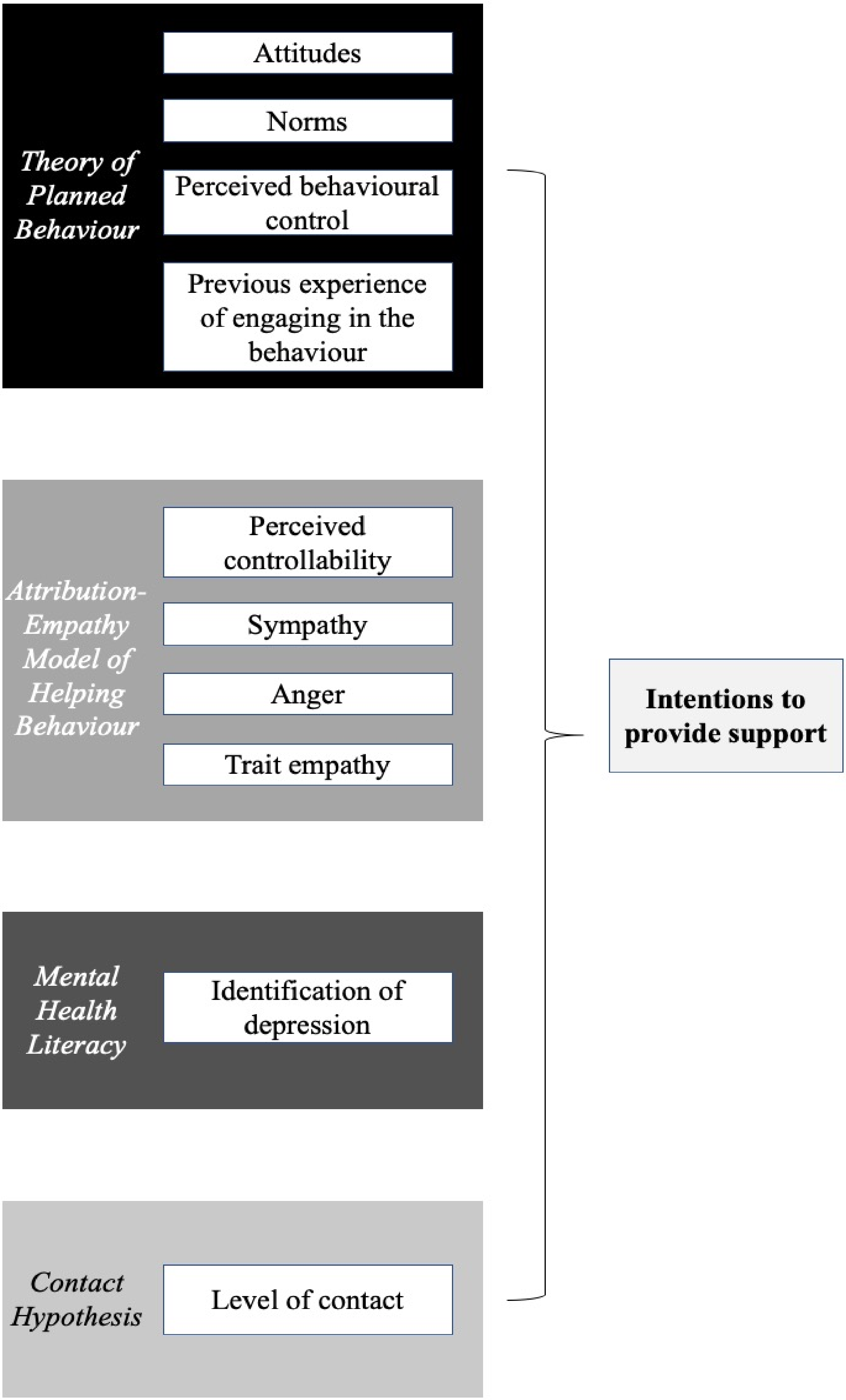

Figure 7: Conceptual framework

Chapter 4 Review of literature supporting the conceptual framework of factors associated with support-giving responses

4.1 Introduction

The previous chapter established a conceptual framework for the current study, grounded by theory. As a next step, it is important to establish the empirical support for the relationship between each concept contained within the framework, and the specific outcome of interest, caregivers' and peers' support-giving behaviour. As such, the current chapter aims to comprehensively investigate the extant literature with regards to these factors among caregivers and adolescents. It is important to note here that the available literature on many of these factors is sparse; the research reviewed here represents the extent to which the topic has been explored empirically thus far, to the best of the author's knowledge. The chapter is structured by addressing each factor contained with the conceptual framework in turn.

4.2 Attitudes toward support-giving

As specified by the Theory of Planned Behaviour (TPB), attitudes towards performing a behaviour are thought to influence intentions to engage in said action. The literature on caregivers' and peers' attitudes towards providing support to a young person with depression is reviewed below.

4.2.1 Caregivers

The affective experience of providing care for an individual with mental illness is well-established in the literature, and is consistently reported as negative in valence, such that the label 'the burden of caregiving' has resulted (Angold et al., 1998; Brannan, Heflinger, & Bickman, 1997; Chiang, Lu, Lin, Lin, & Sun, 2015; Hastrup, Van Den Berg, & Gyrd-Hansen, 2011; Mak & Cheung, 2012; McCann et al., 2011; Perlick et al., 2016; Schulze & Rössler, 2005). Beyond affect, the literature is also clear that caregivers experience high levels of stress when providing support to children and adolescents with mental illnesses (Chesla, 1991; Harden, 2005; Highet, McNair, Davenport, & Hickie, 2004; Karp, 2001; Karp & Tanarugsachock, 2000; McCann et al., 2011; Oruche, Gerkensmeyer, Stephan, Wheeler, & Hanna, 2012; Wade, 2006). Notwithstanding this, caregivers in one study reported feeling accomplishment, connection and happiness through the act of caring (Suiter & Heflinger, 2011).

In addition, caregivers' attitudes towards mental health professionals and services, as well as the consequences of seeking and receiving professional mental health support for children, have been explored by multiple studies. These attitudes again appear to typically be negative in nature, and this is thought to be reflective of parents' self-stigma (Dempster, Davis, Faye Jones, Keating, & Wildman, 2015; Dempster, Wildman, & Keating, 2013; K. Eaton, Ohan, Stritzke, & Corrigan, 2016; Morawska & Sultan, 2015; O'Dea et al., 2018; Reardon et al., 2017; Turner, 2012; Vogel, Wade, & Haake, 2006). For example, participants in one study outlined worries about not being 'good enough' parents if they 'resorted' to seeking help for their child (Sayal et al., 2010), and in another study, "one of the parents questioned how things could have got to this point, where she and her partner had been so unable to deal with their daughter's behaviour that they had had to seek professional help for her" (Stapley et al., 2016, p. 623). Richardson (2001) reported that 12% of participants expected that bringing their child to see a mental health professional would make them feel embarrassed. However, one study found that, in comparison to other evidence, parents experienced primarily positive attitudes towards their child's engagement with therapy (Nevas & Farber, 2001), and another found that counselling was perceived as beneficial for children and having few risks (J. Stevens et al., 2009). Positive attitudes towards treatment among parents are associated with greater likelihood of seeking treatment for their child (Gustafson, McNamara, & Jensen, 1994).

4.2.2 Adolescents

There has been limited research on adolescents' attitudes towards providing support to a peer showing signs of mental illness. A study with university resident assistants revealed that participants had positive attitudes towards referring peers with substance use or other mental health issues to services (Reingle, Thombs, Osborn, Saffian, & Oltersdorf, 2010). Some studies suggest that young people experience positive outcomes if perceived as 'good' support-providers, such as popularity among peers (Burleson & Kunkel, 1996), which may result in the development of positive attitudes towards support-giving. In contrast to this, however, supporting a friend engaging in self-harm has been reported to be associated with feelings of sadness and guilt by adolescent girls (Fisher et al., 2017). It has been suggested that attitudes towards support provision may be influenced by adolescents' MHL; Morelli et al. (2015, p. 485) proposed "it may feel taxing to help a friend fix a problem when you do not understand why he or she feels stressed". The results of one study appeared to suggest that attitudes may determine whether support is offered at all; in an experimental study of female university students' comforting skills, highly apprehensive participants tended to avoid interacting with a distressed confederate (Samter & Burleson, 1984).

4.3 Perceived behavioural control

Alongside attitudes, perceived behavioural control (PBC) comprises another component of the TPB. Self-efficacy beliefs have been found to relate to prosociality more generally (Alessandri, Caprara, Eisenberg, & Steca, 2009; Caprara, Alessandri, & Eisenberg, 2012; Caprara & Steca, 2005). However, in a recurrent trend, there is a significant paucity of research on the impact of PBC or self-efficacy on caregivers' and peers' support-giving behaviour in the mental health context. The literature is reviewed below.

4.3.1 Caregivers

Parental self-efficacy (PSE) has been defined as “parents’ feelings of competence in their parenting role, including beliefs about being able to handle developmentally specific issues and being able to influence their child in a way that fosters the child’s positive development and adjustment” (Glatz & Buchanan, 2015, p. 1367). PSE has been examined among caregivers of children and adolescents experiencing various mental health issues, such as eating disorders (A. L. Robinson, Strahan, Girz, Wilson, & Boachie, 2013) and autism spectrum disorders (Giallo, Wood, Jellett, & Porter, 2013). Research suggests that higher PSE is associated with greater child adjustment, as well as increased social and academic functioning (T. L. Jones & Prinz, 2005; Junttila, Vauras, & Laakkonen, 2007; Steca, Bassi, Caprara, & Fave, 2011). However, it is important to note that PSE typically refers to caregivers’ perceptions of their overall parenting competence, rather than specifically referring to their beliefs about their ability to support their child through a mental illness.

Another concept that may be somewhat analogous to parental PBC is parental locus of control (PLOC), which refers to parental perceptions of their power and efficacy in the parent-child relationship (Campis, Lyman, Prentice-Dunn, & Prentice-Dunn, 1986). The attribution of children’s behaviour to parenting techniques and strategies is thought to reflect an internal PLOC (Freed & Tompson, 2011). The literature suggests that some parents attribute their child’s mental illness to their own ineptitude as a parent, with a participant in one study stating, “I thought I was not a good mother because I did not take good care of her… If I had discovered her problem earlier, she might not have become mentally ill” (Yen et al., 2010, p. 262). Similarly, one study found that most parents did believe that specific types of parenting behaviours have a role to play in preventing depression in young people (Yap & Jorm, 2011a). It is unclear whether this necessarily reflects a belief among parents that they have the capacity to support their child, if depression has already developed.

One qualitative study found that parents clearly identified PBC as influencing their responses to their child’s mental illness, citing time, finances, and other resources as well as skills and self-confidence as components of their feeling that “they could do it” (Honey et al., 2015). Some research suggests that caregivers’ self-efficacy may impact on their beliefs about their ability, or potentially their responsibility, to manage their child’s mental health problems on their own. For example, parents in one qualitative study shared their beliefs that they did not possess the skills to help their child, and that mental health professionals would be “the only ones” who could provide support (Hassett et al., 2018). In an unpublished PhD thesis, Singer (2009) found a negative association between parental self-efficacy and seeking professional help for their child’s mental health problems. In comparison, however, Pavuluri, Luk, and McGee (1996), in a study of parents of preschool children, found a relationship between high parental self-efficacy and the belief that parents should be able to manage their child’s problems on their own, without professional or other help.

The literature on parental PBC in relation to supporting their adolescent children is, in summary, mixed. Parents in one study generally endorsed the belief that they could assist a friend of their adolescent child who was experiencing suicidal ideation (Schwartz, Pyle, Dowd, & Sheehan, 2010). Another study found that parents, on average, reported moderate-to-high self-efficacy for a range of suicide prevention activities, such as asking their child about their mood or suicidal thoughts (Czyz, Horwitz, Yeguez, Ewell Foster, & King, 2017). However, Jorm et al. (2007) found that only a minority of parents of 12- to 17-year-old adolescents were ‘very confident’ that they could help an adolescent displaying depressive symptoms, and one of the major themes that emerged from a qualitative account of parents’ experiences was ‘helplessness’ (Stapley et al., 2016). Research demonstrates that parents have a tendency to underestimate their importance as supporters for their children; for example, Jorm and Wright (2007) found that parents were less likely than young people to rate family as source of support for adolescents. These discrepancies establish parents’ responses to mental health problems in their children as worthy of further investigation.

4.3.2 Adolescents

Adolescent self-efficacy has been assessed with regards to prosocial behaviours of other forms. For example, the literature is clear that self-efficacy in adolescents is positively associated with defending the victims of bullying (Gini, Albiero, Benelli, & Altoè, 2008; Pöyhönen, Juvonen, & Salmivalli, 2010; Thornberg & Jungert, 2013). It appears likely that self-efficacy would have a similar association with adolescents' intentions to provide support to a peer experiencing mental health difficulties. Indeed, the direction of the effect between university students' self-efficacy and willingness to provide emotional support to a friend has been demonstrated to be positive in nature (Egbert, Miraldi, & Murniadi, 2014; K. R. Rossetto et al., 2014). However, the literature is mixed in relation to the actual level of self-efficacy among adolescents in this domain. Some studies have found that the majority of adolescents report that they have a good understanding of how to help a friend going through a tough time (Chambers & Murphy, 2011) and are confident in their abilities to help (Yap et al., 2012). In contrast, another study found that just one-third of adolescents felt 'quite a bit' confident in their ability to help a hypothetical peer represented in a vignette (L. M. Hart et al., 2016). Nevertheless, adolescents appear to be more confident than young adults in their ability to provide help to peers (Jorm et al., 2007a). Just one-fifth of university students in one study strongly believed that they could help a friend at risk to see a mental health professional, effectively offer support, or talk with others to determine if the friend was at suicide risk (King et al., 2008). However, one would be remiss to draw any firm conclusions based on the current literature, as adolescents' self-efficacy or PBC in this domain is critically under-researched, and further robust assessment is required.

4.4 Subjective norms about support-giving

Subjective norms form the final component of the TPB. Ajzen (1991, p. 188) initially defined subjective norms as "the perceived social pressure to perform or not to perform the behaviour". Other academics consider norms to include both what other people in our social groups *are* doing – referred to as 'descriptive norms' – and what we believe one *ought to* do – referred to as 'injunctive norms' (House, 2018). It is well-established that helping behaviour is subject to normative influence (e.g., House, 2018; Nook, Ong, Morelli, Mitchell, & Zaki, 2016), and norms are also commonly discussed in relation to mental health stigma (Abdullah & Brown, 2011; Norman, Sorrentino, Windell, & Manchanda, 2008; Silke et al., 2017). Research with university students has demonstrated that awareness of close others' (i.e., family members and friends) help-seeking for mental health related issues has been shown to associated with increased help-seeking for oneself (Disabato, Short, Lameira, Bagley, & Wong, 2018). However, there is limited research available regarding the impact of norms on caregivers' and peers' help-giving responses to other individuals, in a mental health related context. The potential relationship between norms and support-giving behaviour among caregivers and peers is explored below.

4.4.1 Caregivers

One of the most pervasive norms across human societies is that a parent is responsible for providing care to their child(ren) (Bainham, 1999; Blustein, 1997; Millum, 2008; Mowder, 2005). As such, one could expect that this would be the primary norm to which caregivers would subscribe, with regards to their response to their child's symptoms of mental health difficulties. However, stigma towards children experiencing mental illness has been observed among adults (Martin, Pescosolido, Olafsdottir, & McLeod, 2007). Stigma is known to be governed by norms (Crandall, Eshleman, & O'Brien, 2002; Silke et al., 2017; Walker, Sinclair, & MacArthur, 2015), and research suggests that some parents' responses to their child's mental illness are determined by the fear of this stigma (Boulter & Rickwood, 2013; Michael A. Lindsey, Chambers, Pohle, Beall, & Lucksted, 2013; Logan & King, 2001). For example, Richardson (2001) reported that almost a third of participants said they would be worried if someone else learned that their child was attending a mental health professional. This suggests that the predominant norm adhered to by parents does not prescribe mental health service use.

Additionally, it has been noted that “the public perception of the threshold for initiating a professional mental health consult is set at a much higher level of severity than for primary medical care” (E. J. Costello et al., 1998, p. 170). This public perception is likely to influence perceived norms about caregivers’ support; indeed, research suggests that caregivers’ beliefs that they should be able to ‘fix’ their child’s problem on their own is a primary reason why caregivers do not seek professional treatment for their child (Pavuluri et al., 1996). Different norms may be associated with parents’ group memberships; for example, members of certain cultural groups may share a belief that parents should deal with their children’s mental health problems on their own (Gopalan et al., 2010). It appears that, in many cases, family norms may dictate judgements of the efficacy of formal or informal supports for children and adolescents with mental health difficulties (Srebnik et al., 1996). Furthermore, societal norms regarding mental health more generally, for example regarding what constitutes abnormal or problematic behaviour, may influence how parents respond to a child’s presentation of symptoms (Cauce et al., 2002).

4.4.2 Adolescents

Adolescence is a life stage during which peer influence is particularly prominent, such that the expectation of conformity to social norms may be even greater than at other ages (Brechwald & Prinstein, 2011; Clasen & Brown, 1985; Lashbrook, 2000). The desire for social distance from those with mental illnesses is expressed by individuals of all ages (Angermeyer et al., 2004; Corrigan, Edwards, Green, Diwan, & Penn, 2001; Corrigan, Green, et al., 2001). Correspondingly, adolescents who experience mental health issues are frequently ostracised by classmates and peers (Manfro et al., 2017; Moses, 2010; O’Driscoll, Heary, Hennessy, & McKeague, 2015a, 2015b; Platt, Kadosh, & Lau, 2013; Silke et al., 2017; Swords, Heary, et al., 2011). Given that the establishment of relationships and a sense of belonging within the peer group is an important developmental goal of adolescence (Baumeister & Leary, 1995; Buhrmester, 1998; Buhrmester & Furman, 1987), interaction with stigmatised peers may be perceived to carry significant ‘social risk’ in terms of reputation management (Engelmann & Rapp, 2018). For example, social risk may accompany the act of defending the victim of bullying, as bullies are often perceived as popular in the peer group (Dijkstra, Lindenberg, & Veenstra, 2008; Peets, Pöyhönen, Juvonen, & Salmivalli, 2015). This hypothesis is supported by Wright’s person-group dissimilarity model (J. C. Wright, Giammarino, & Parad, 1986), such that a peer with mental illness is seen as a member of an out-group (P. Byrne, 2000; Cruwys & Gunaseelan, 2016). Thus, it seems plausible that offering support to a peer experiencing mental health difficulties may carry a social risk, similar to that associated with intervening in a bullying scenario.

However, another powerful norm governing prosocial and helping behaviour among young people is reciprocity (Berkowitz, 1968; Knoll, Burkert, & Schwarzer, 2006; B. Simpson & Willer, 2008; Uehara, 1995). From childhood onwards, friendship is associated with certain expectations (Bigelow, 1977; MacEvoy & Asher, 2012; MacEvoy, Papadakis, Fedigan, & Ash, 2016; Zarbatany, Ghesquiere, & Mohr, 1992), and one consistent expectation across the lifespan is to “‘be there’ for one another, especially during times of emotional turmoil and upset” (Burleson & Kunkel, 1996, p. 108). Indeed, one reason adolescents give to explain why they would support a friend experiencing mental health difficulties is that it is the ‘duty of a friend’ (S. Byrne et al., 2015). As such, neglecting to provide support may be seen as a transgression of the norms of friendship (MacEvoy & Asher, 2012).

4.5 Previous experience of support-giving

Two studies have investigated the relationship between past support-giving behaviour and help-giving in the mental health context. Aldrich found that previous suicide intervention experience predicted college students’ intentions to intervene (Aldrich, 2018), and a longitudinal study of Australian adults found that having experience of helping someone with mental illness at baseline predicted having engaged in helping behaviour at six-month follow up (A. Rossetto, Jorm, & Reavley, 2016). These two studies represent the extent to which the relationship between past behaviour and future intentions have been investigated in the context of the provision of informal support to someone experiencing mental illness.

4.6 Mental health literacy

The body of MHL research is proliferating rapidly, furthering our understanding of public knowledge of mental health and illness. However, the study of MHL (and its various constituent components) is frequently focused on its relationship to help-*seeking* behaviour (e.g., Stolzenburg et al., 2018); the association of MHL with the provision of support to another individual experiencing symptoms of mental health problems has not been thoroughly assessed. Nevertheless, the following section details the current picture with regards to caregivers' and adolescents' MHL, including any studies that have reviewed the links between MHL and support-giving behaviour.

4.6.1 Caregivers

Research suggests that caregivers' understanding of adolescent mental health is limited (Frauenholtz, Conrad-Hiebner, & Mendenhall, 2015; Mendenhall & Frauenholtz, 2013). The majority of parents of children with mental health problems do not identify that their child has a problem (Logan & King, 2002; Sayal, Taylor, & Beecham, 2003). For example, Teagle (2002) reported an identification rate as low as 13% among parents of 9- to 13-year-old children; more recently, a study with parents of 10- to 12-year-old preadolescents found a recognition rate of 29.1% (Villatoro, DuPont-Reyes, Phelan, Painter, & Link, 2018). Identification of depression and other internalising disorders may be impeded by parents' misattribution of the cause of symptoms. It appears that many caregivers do not have a good understanding of how symptoms of mental health problems are expressed in children or adolescents, particularly the symptomatology of internalising disorders (Mesman & Koot, 2000; Sourander et al., 1999; van de Looij-Jansen et al., 2010). It appears that parents may perceive 'disruptive' externalising disorders, such as ADHD, as more severe and more in need of treatment (Wu et al., 1999).

Additionally, many studies have reported significant discrepancies between parents' reports of their child's mental health and the child's self-report (E. K. Hughes & Gullone, 2010; Mojtabai & Olfson, 2008; Ohannessian, 2012; Ohannessian, Laird, & De Los Reyes, 2016; Oltean & Ferro, 2018; Orchard, Pass, Marshall, & Reynolds, 2017; Roberts, Alegria, et al., 2005; Salbach-Andrae, Klinkowski, Lenz, & Lehmkuhl, 2009; Treutler & Epkins, 2003; van de Looij-Jansen et al., 2010; Wahlin & Deane, 2012). A meta-analysis conducted in the 1980s found a mean correlation of .25 (Achenbach, McConaughy, & Howell, 1987). This was replicated by a subsequent meta-analysis of 341 studies published between 1989 and 2014, with regards to the correspondence between multiple individuals' accounts of a child or adolescent's internalising symptoms (De Los Reyes et al., 2015). Indeed, Ferdinand, van der Ende, and Verhulst (2004, p. 198) state "low agreement between different informants regarding psychopathology in children and adolescents is the rule, rather than the exception", and Kuhn et al (2017, p. 386) state "discrepancies between youth and adult information on mental health symptoms are one of the most robust findings in child and adolescent psychiatry". Furthermore, the relationship between parent-child concordance and the child's actual symptomatology has been reported to be negative, such that concordance is lower when symptoms of depression are elevated (C. D. Williams, Lindsey, & Joe, 2011). This is extremely concerning when one considers the fact that it has been consistently demonstrated that mental health service use is not predicted by the severity of the child's problems (Zwaanswijk, Verhaak, Bensing, van der Ende, & Verhulst, 2003), but rather is mediated by parental perception of need for services (Alegría et al., 2004; L. A. Barker & Adelman, 1994; Broderick et al., 2016; Farmer, Burns, Phillips, Angold, & Costello, 2003; G. E. Miller & Prinz, 2003;

Sourander et al., 2005). In addition, once services have been obtained, parents are often depended upon to provide diagnostically-relevant information (Seiffge-Krenke & Kollmar, 1998).

Parents' recognition of their child's mental health problems may be impacted by their beliefs about mental illness more globally. Moses (2011, p. 67) states: "Mostly anecdotal and retrospective accounts suggest parents' conceptualization of their child's problems can be found on a continuum between lack of acknowledgement of problems, rejection of psychiatric/medical labels, and some level of acknowledgement or acceptance of problems as an illness or disorder." It has been established that stigma influences parents' responses, such that recent study found that increased desire for social distance between their child and individuals with mental illness was associated with decreased likelihood that parents believed their preadolescent child had a mental health problem, even when parents reported their child experiencing a high level of symptoms (Villatoro et al., 2018). In tandem, research has demonstrated that young people's likelihood of mental health service use increases as caregivers' intended stigmatising behaviour decreases (Gronholm et al., 2015). Studies have also shown that parents are unlikely to seek help from formal mental health services if they perceive their child's needs as unrelated to mental health (Arcia & Fernandez, 2003; Stiffman et al., 2004). For example, research on anxiety disorders has revealed that parents may perceive symptoms as being related to their child's traits and dispositions, rather than an indicator of psychopathology, and that such perceptions are associated with parents being less likely to support attempts to change the child's behaviour (Bögels & Brechman-Toussaint, 2006). Other research has shown that parents who believed that the cause of their child's mental health difficulties was their relationships with friends were 25% less likely to bring their child to mental health services (Yeh, McCabe, Hough, Dupuis, & Hazen, 2003).

The impact of caregivers' confusion may extend to engagement with mental health professionals: primary care providers have reported interactions with parents "who disagreed with a positive depression screen and felt that the depressive symptoms were consistent with normal adolescent development” (Radovic et al., 2015, p. 913). Mothers have been shown to accept the child’s ‘choice’ of withdrawal and even support it (Hastings & Rubin, 1999).

Parents’ perceptions of the helpfulness of treatments, another component of MHL, also appears to play a role in their actions. Some parents in Sayal et al. (2010)’s study did not think mental health care formed part of a general practitioner (GP)’s role if their child’s emotional or behavioural problems were not due to a ‘health condition’, as they saw GPs’ surgeries as strictly ‘medical’ places. This is perhaps reflective of inconsistencies in what parents consider as ‘professional mental health services’. For example, although 65% of parents in one study recommended getting ‘professional help’, only 3% encouraged seeking the help of a psychologist or psychiatrist (Jorm et al., 2007a). Half of the parents in one study ‘somewhat’ to ‘strongly’ believed that use of antidepressants could result in their child engaging in self-harm, and perception of higher risk was associated with a lower chance of their child visiting a community mental health centre for medication (J. Stevens et al., 2009). Richardson (2001) found that approximately one-quarter of parents did not understand the benefit of mental health interventions for their children, however, only one-fifth believed that their child would recover from behavioural or emotional problems without intervention; this inconsistency is problematic, as utilisation of professional mental health services is reduced when the effectiveness of the service is not well understood (L. A. Richardson, 2001). If parents feel that their child’s problem is likely to get better by itself, they are unlikely to seek help (Pavuluri et al., 1996).

MHL may also affect the provision of ‘informal’ support: if parents are not aware of the problem (‘problem’ meaning that they perceive that the child’s symptoms negatively impact the child’s life), it is unlikely that they will recognise the need to provide emotional support (Alegría et al., 2004; Sayal et al., 2003). A recent study found that low levels of depression literacy in parents was associated with increased emotional withdrawal from their child (Johnco & Rapee, 2018). In addition, parents may hold certain positive beliefs regarding the helpfulness of support responses that are not deemed beneficial by mental health professionals. For example, ‘keep busy to keep mind off problems’ was seen to be a helpful measure by half (49.8%) of parents in one study, in stark contrast to less than ten percent of GPs and psychologists (6.9% and 9.4% respectively; Jorm et al., 2008). Parents have also self-reported a link between their knowledge of mental illness and ability to help their child (Honey et al., 2015), with a parent in one study stating, “The less you know, the harder it is to manage” (Andershed et al., 2017, p. 1057).

4.6.2 Adolescents

Adolescent MHL has been assessed with respect to several different mental illnesses – primarily depression (e.g., Townsend et al., 2017), but also schizophrenia (Loureiro et al., 2014; Melas et al., 2013), obsessive compulsive disorder (García-Soriano & Roncero, 2016), social anxiety disorder (Coles et al., 2016), and bulimia nervosa (Mond et al., 2007). Furthermore, studies of adolescent MHL have been conducted in a variety of cultural contexts beyond Australia, the US, the UK, and Ireland, including Nigeria (Adeosun, 2016; Aluh, Anyachebelu, Anosike, & Anizoba, 2018), Kenya (Mbuthia, Kumar, Falkenström, Kuria, & Othieno, 2018), South Africa (Aggarwal, Berk, Taljard, & Wilson, 2016), Norway (Bjørnsen, Eilertsen, Ringdal, Espnes, & Moksnes, 2017), Sweden (Melas et al., 2013), Spain (García-Soriano & Roncero, 2016), Portugal (Loureiro et al., 2013, 2014), Iran (Essau, Olaya, Pasha, Pauli, & Bray, 2013), China (Lam, 2014), and Japan (Yoshioka, Reavley, Hart, & Jorm, 2015). This body of literature suggests that adolescents have generally poor MHL; a systematic review found that correct recognition of depression among young people varied from 23.4% to 73%, with an average of 40.8% (Georgakakou-Koutsonikou & Williams, 2017). Research has consistently shown that adolescents’ accounts of their knowledge of mental health and mental illness demonstrate both confusion and underlying stigma (Armstrong, Hill, & Secker, 2000; Leighton, 2005; Teng, Crabb, Winefield, & Venning, 2017). For example, in one study adolescent participants expressed concerns about the ‘authenticity’ of others’ mental illnesses, due to a perceived ambiguity of symptoms and lack of visible 'proof' (Teng et al., 2017). Adolescents' typically low levels of actual MHL contrast with their perceptions of their own knowledge, which tend to be very positive – in a Scottish study, the overwhelming majority of adolescents stated that they felt they had a good understanding of depression (92% of boys and 96% of girls; Williams & Pow, 2007).

Research suggests that adolescents' ability to identify disorders may impact on the types of help-giving responses offered; Jorm et al. (2006) found that correct identification and labelling of a disorder is associated with the recommendation of 'appropriate' (as ascertained by the authors) help. This finding has since been corroborated by other studies (Coles et al., 2016; A. Wright, Jorm, Harris, & McGorry, 2007; Yap, Reavley, & Jorm, 2013). For example, in a study of Sri Lankan university students, recognition of depression was associated with greater intentions to seek professional assistance (Amarasuriya, Jorm, & Reavley, 2018). Adolescents in one US study who correctly selected '*He/she has a mental health problem or illness*' from a list of explanations for a vignette character's behaviour were three to four times more likely to state that they would contact their school counsellor or another adult for help, than adolescents who did not (D. P. Olsson & Kennedy, 2010). Recognition of distress and beliefs about controllability were also found to influence 13- to 15-year-old girls' supportive responses to a peer engaging in non-suicidal self-injury (Fisher et al., 2017). In line with this, research has demonstrated that adolescents are more likely to engage the help of an adult if suicidal intent is unambiguous through the target peer's words and actions (Dunham, 2004; Kalafat, Elias, & Gara, 1993); in other words, when identification of symptoms is relatively easy. On the other hand, if the individual's symptoms present ambiguously, most adolescents stated that they would talk to the peer on their own (Dunham, 2004). Additionally, evidence suggests that adolescents' responses may differ depending on the disorder identified. In one study, adolescents were more than twice as likely to suggest peer support for depression than for ADHD (Swords, Hennessy, et al., 2011a). Adolescents also have been found to perceive less controllability of internalising symptoms in comparison to those associated with externalising disorders such as ADHD (O'Driscoll et al., 2012).

Linked to the literature discussed in section 2.3 in Chapter 2, research examining adolescents' help-seeking for their own mental health issues indicates that they are often fearful of professional mental health services, and view these as a 'last resort' (Jorm, Wright, & Morgan, 2007b; Yap, Wright, & Jorm, 2011b). This appears to extend to beliefs about mental health treatments and supports for other individuals. Less than half (47.4%) of adolescents believed that a GP would be helpful for a hypothetical vignette character demonstrating suicidal ideation (L. M. Hart et al., 2016). Indeed, a large longitudinal survey of 12- to 25-year-old Australians found that just 15% of those who had attempted to provide support to someone with mental health issues in the past 12 months had encouraged that person to seek professional help (Yap et al., 2011a). As noted by Coles and colleagues (2016, p. 58), "more data are needed documenting adolescent knowledge and beliefs regarding mental health interventions".

4.7 Empathy (both trait and state)

Empathy comes from the German *Einfühlung*, meaning 'feeling into', and incorporates affective experiences (e.g., pity, anger) as well as the cognitive adoption of another's perspective (Davis, 1983b, 1983a). The link between empathy and prosocial behaviour is well-established (Eisenberg & Fabes, 1990; Paciello, Fida, Cerniglia, Tramontano, & Cole, 2013; Telle & Pfister, 2012). Furthermore, empirical evidence supports a relationship between empathy and support-giving behaviour in the mental health context (Egbert et al., 2014; Trobst, Collins, & Embree, 1994): a recent cross-sectional study demonstrated that individuals with greater MHL had greater empathy (Furnham & Sjokvist, 2017), and the empathic emotions of pity and anger have demonstrated a mediating role between beliefs about controllability and willingness to support an individual experiencing mental illness (Obonsawin et al., 2013). Additionally, lower 'trait empathy' has been reported to be associated with greater prejudice against people experiencing depression and ‘nondescript mental illness’ (Foster, Elischberger, & Hill, 2017), and mental health professionals have been shown to exhibit higher empathic concern toward others in comparison to general physicians and non-medical workers (Santamaría-García et al., 2017). Literature on caregivers’ and peers’ empathy, and its relation to responses to a young person’s symptoms of depression, is reviewed below.

4.7.1 Caregivers

While adults’ empathy has been assessed in abundant studies (e.g., Ze, Thoma, & Suchan, 2014), empathy research has less often specifically targeted parents. Moreover, the study of parental empathy has typically focused on parents of infants and young children (e.g., Barnett, King, Howard, & Dino, 1980), and is rarely directed toward parents of adolescents. It is unclear whether, or to what degree, information about the impact of empathy on parents’ responses to children can be extrapolated to the parent-adolescent context. Nevertheless, it seems some findings may be relevant to our understanding of the impact of empathy on parents’ responses to an adolescent child experiencing mental health problems.

Parental empathy is thought to have developed in parallel with the attachment system, and is considered a core facilitator of the parental drive to care for offspring (Mikulincer et al., 2001; Mikulincer, Shaver, Gillath, & Nitzberg, 2005; Stern, Borelli, & Smiley, 2015). Neuroimaging research has revealed that the brain regions associated with empathy are dramatically reconfigured following pregnancy (Hoekzema et al., 2017). Evidence demonstrates that parents’ self-reported empathy and neural engagement of empathy networks are intensified when witnessing their own child’s physical pain, in comparison to an unknown child’s pain (L. Goubert, Craig, & Buysse, 2009; L. Goubert et al., 2005; Liesbet Goubert, Vervoort, Sullivan, Verhoeven, & Crombez, 2008; Leibenluft, Gobbini, Harrison, & Haxby, 2004). A recent study found that mothers of adolescents demonstrated highly similar neural representations of their own distress and their child's distress; in other words, mothers mentalise their child's distress as if it were their own (T. H. Lee, Qu, & Telzer, 2017). Anger, one of the empathic emotions described in the Attribution-Empathy Model of Helping Behaviour, has been reported qualitatively by parents of children who have experienced mental and physical illnesses (Bonner et al., 2006; Shpigner, Possick, & Buchbinder, 2013; Svensson, Nilsson, Levi, Suarez, & Suarez Carballeira, 2013). Parents of children experiencing eating disorders and post-traumatic stress disorders have also reported feeling sympathy for their child (Honey & Halse, 2005; Williamson, Creswell, Butler, Christie, & Halligan, 2019); like anger, sympathy is thought to reflect 'state' empathy.

As such, it seems plausible that parental empathy may affect responses to children's behaviour, and by extension, signs of mental health problems that children may display. Empirical evidence indicates that parental empathy is associated with greater attentiveness and responsiveness, thus suggesting that empathy helps to calibrate parents' responses to their young child's needs (Dix, 1992; Kochanska, 2002). In addition, traits adjacent to empathy have also been shown to impact parents' behaviour during interactions with their children, including general 'trait-like' orientation towards social interactions (S. Wilson & Durbin, 2012). It appears important to note here that *low* parental empathy has been associated with greater levels of psychopathology in children (Feshbach, 1987), including depression (Werner, der Graaff, Meeus, & Branje, 2016), as well as poorer emotional regulation (Manczak, DeLongis, & Chen, 2016) and stress reactivity (Abraham, Raz, Zagoory-Sharon, & Feldman, 2017). Indeed, burgeoning research suggests that there may be a link between parental empathy and children's physical illnesses, such as asthma (Manczak et al., 2017). However, the relationship between parental empathy and responses to adolescents' depressive symptoms requires further exploration.

4.7.2 Adolescents

Empathy has been widely studied in children and adolescents (Findlay, Girardi, & Coplan, 2006; Hein, Röder, & Fingerle, 2016), and adolescence in particular is thought to mark a key period in the development of empathy (Eisenberg, Spinrad, & Morris, 2013), in line with the acquisition of cognitive competencies, increased emotion regulation, and relevant social experiences (Burleson, 1984; Krettenauer, Colasante, Buchmann, & Malti, 2014; Steinberg & Morris, 2001; Van der Graaff et al., 2014). Research has demonstrated a link between empathy and prosocial behaviour among children and adolescents (S. S. Clark & Giacomantonio, 2015; Eisenberg et al., 2009; McMahon, Wernsman, & Parnes, 2006; Sierksma, Thijs, & Verkuyten, 2014; Spinrad & Eisenberg, 2017; Yoo, Feng, & Day, 2013). For example, empathy is linked to young children's comforting of a crying baby (Eisenberg, Fabes, Karbon, et al., 1996) and adolescents' supportive responses towards victims of bullying (Machackova & Pfetsch, 2016; Rieffe & Camodeca, 2016) and aggression (Barchia & Bussey, 2011). Adolescents who have greater empathy have friendships characterised by caring and companionship (Chow et al., 2013; R. L. Smith & Rose, 2011; Soenens, Duriez, Vansteenkiste, & Goossens, 2007).

Together, this evidence suggests that empathy is likely to play a role in determining whether or to what extent a young person may be likely to provide support, should their friend experience mental health problems. Indeed, a study of college students found that participants with higher empathy rated both emotional and behavioural signs of suicide as being more serious, and were more likely to provide assistance to a hypothetical peer (Mueller & Waas, 2002). In addition, the empathic emotions of anger, sympathy and pity were all named by participants in a qualitative study of adolescent supporters of peers engaging in self-harm (Fisher et al., 2017), suggesting that empathy was invoked by the support-giving act. In contrast with these findings, a recent Irish study with adolescents found mixed results regarding the relationship between empathy and stigma towards a peer showing signs of depression (Silke et al., 2017), which the researchers attributed to the moderate nature of the symptoms displayed. It has been hypothesised that the salience of the target individual’s need influences empathic arousal, such that an ambiguous presentation of symptoms may be less likely to result in an empathic response from a peer; this hypothesis was supported by Mueller and Waas (2002). On the whole, it is clear that the role of empathy in adolescents’ support-giving behaviour is under-researched, but that the literature has established that it is deserving of further investigation.

4.8 Perceived controllability

Classification of the cause of an individual’s symptoms is also likely to incorporate a judgement of both the controllability of these symptoms, and the individual’s responsibility for their situation, aligning with the AEMHB as described in section 3.4 of Chapter 3, as well as in attribution theory (Corrigan, 2000; Dolphin & Hennessy, 2014, 2017; Steins & Weiner, 1999; Weiner, 1980, 1995). For example, if symptoms are perceived to be caused by a biologically-driven mental illness, this may be accompanied by different controllability beliefs than if symptoms are perceived to be caused by lifestyle choices (Coleman, Walker, Lee, Friesen, & Squire, 2009; Pilkington, Reavley, & Jorm, 2013; Schomerus, Matschinger, & Angermeyer, 2014; Speerforck, Schomerus, Pruess, & Angermeyer, 2014; Yoshioka, Reavley, Rossetto, & Nakane, 2016). In turn, perceived controllability of symptoms is linked to the determination of the individual’s responsibility for their circumstances – as well as potentially the helper’s responsibility or obligation to provide support (Badahdah & Alkhder, 2006; Schmidt & Weiner, 1988; Virtanen, Isotalus, & Keaton, 2014; Weiner, 1995). Research has shown that highly sensitive forms of emotional support are less likely to be provided to individuals who are perceived as responsible for their own problems (S. M. Jones & Burleson, 1997; MacGeorge, 2001). The association between perceived controllability and support-giving from caregivers and peers has not yet been studied in this context, however.

4.9 Exposure to mental illness

Given the prevalence of depression in the general population (Ferrari et al., 2014; World Health Organization, 2017) and among young people in particular (Mojtabai, Olfson, & Han, 2016), it is likely that most individuals have had contact with a young person experiencing symptoms of depression. It is unclear whether this high prevalence rate may thus result in ceiling effects, impacting the statistical capacity to ascertain the effects of exposure on individuals' responses. In addition, it is difficult to objectively and accurately measure an individual's level of exposure to mental illness. Perhaps for these reasons, the impact of exposure to mental illness on caregivers' and adolescents' help-giving responses to a young person showing signs of depression has not yet been assessed through a research study. As such, there is no literature specifically on this topic that can be reviewed and discussed. Research investigating the association between empathy and support-giving in related contexts, or with other groups of participants, is reviewed below.

One study has demonstrated an association between exposure to suicide and subsequent support-giving intentions. One-third (33%) of university students who had known someone who died by suicide stated that they would deal with a suicidal peer on their own, compared to three-quarters (73%) of those with no social exposure to suicide (Kalafat & Elias, 1992). Although 'another person' could refer to a same-age peer or a mental health professional, this response is interpreted to reflect a more advanced understanding of appropriate support-giving behaviour in this context. Standing in contrast to this interpretation, however, is the fact that almost one-third (29%) of those who had previously experienced someone dying by suicide said that they would do *nothing* to help a hypothetical suicidal peer, in contrast with just 6% of those with no experience (Kalafat & Elias, 1992). These seemingly-discrepant findings indicate that the impact of exposure on support-giving intentions requires further examination.

Beyond mere exposure to mental illness in others, personal experience of mental illness may also affect responses. As stated by

Batson et al. (1996, p. 474), “it is often said that one’s own prior experience with a need facilitates, if not creates, empathy for others experiencing that need”. Indeed, those with personal experience of mental illness and seeking help for mental health problems have been found to report ‘better’ intentions to provide help (Davies et al., 2016; Jorm, Blewitt, et al., 2005; King et al., 2008; Yap et al., 2012). However, Rossetto, Jorm, and Reavley (2014a) did not find a significant association between participants’ personal experience with mental illness and their help-giving responses. Undergraduate students with personal experience of depression were more likely to recommend self-help strategies and provide informal support, but less likely to encourage professional support (Amarasuriya et al., 2017). Dunham (2004) found that adolescents who had attempted suicide were more likely to try to talk to a suicidal peer on their own than those who had expressed suicidal ideation but had not attempted suicide. Jorm et al. (2008c) found that young people who had recently experienced mental health problems, but had not received professional help, were more likely to endorse the use of alcohol as self-medication than those without such personal experience, while participants who had received professional support were more likely to endorse assessing for suicide risk. It is important to recognise that the phenomenology of depression itself may result in the development of negative expectations regarding the future (Beck, 2002; Korn, Sharot, Walter, Heekeren, & Dolan, 2014), including the efficacy of depression treatments.

4.10 Conclusion

This chapter provided an assessment of the literature supporting the factors comprising the conceptual framework presented at the end of Chapter 3. Very few studies have investigated the relationship between any of these factors and support-giving behaviour in the specific context of adolescent depression, or with caregivers and adolescents. It is thus clear that this area is critically under-researched and is lacking in both exploratory or confirmatory studies. The identification of this gap has informed the fifth research question of this study:

5. *What is the relationship between each of the theoretically-grounded factors included in the conceptual framework of this study (namely: attitudes, norms, perceived behavioural control, previous experience engaging in the behaviour, perceived controllability, sympathy, anger, trait empathy, identification of depression, and level of contact) and the types of support-giving responses offered by caregivers and peers towards the character depicted in the vignette?*

The next chapter of this thesis will present the methods employed to address the five research questions of the current study, and document the characteristics of the participant sample as well as the procedures followed in data collection.

Chapter 5 Method

5.1 Introduction

This chapter outlines the method applied to the current study. The chapter first provides information on the design of the study. Next, the participant recruitment process is detailed. The chapter then continues by providing information on the study participants. The materials used, and the procedure followed in carrying out the study, are then reported, followed by a description of the preliminary analyses of the study variables.

5.2 Study design

The current study aims to explore 'informal' support provided by caregivers and peers to a young person experiencing depression. Little is currently understood about the caregivers' and peers' support-giving in this context. Furthermore, the review of relevant theories and supporting literature detailed in Chapter 3 resulted in the identification of a range of variables that may be associated with caregivers' and peers' support-giving responses to a young person experiencing depression. These variables are: attitudes towards help-giving; perceived behavioural control toward help-giving; subjective norms toward help-giving; previous experience of support-giving; mental health literacy; empathy; age; sex; and exposure to mental illness. As such, the study aims to understand the factors that shape the type, or mode, of support an individual may offer. Thus, the research questions are:

1. *How do caregivers and peers respond to the expression of depressive symptoms in an adolescent character portrayed in a vignette?*
2. *Are there significant differences between caregivers' and peers' responses?*
3. *Do caregivers' and peers' responses differ according to sex?*

4. *Do adolescents' responses differ according to age?*
5. *What is the relationship between each of the theoretically-grounded factors included in the conceptual framework of this study (namely: attitudes, norms, perceived behavioural control, previous experience engaging in the behaviour, perceived controllability, sympathy, anger, trait empathy, identification of depression, and level of contact) and the types of support-giving responses offered by caregivers and peers towards the character depicted in the vignette?*

In order to address the central research questions of the study, a mixed within-between groups design was developed. Responses of caregiver participants were compared within-groups, as were responses of adolescent participants. Responses of these two groups were also compared. Furthermore, groups were disaggregated by sex, and, for adolescent participants, age. Data were collected through a cross-sectional quantitative questionnaire. Ethical approval for the study was sought and granted from School of Psychology Research Ethics Committee, Trinity College Dublin (see Appendix A).

5.3 Participants

5.3.1 Sample size requirements

Sample size requirements were calculated using G*Power (Faul, Erdfelder, Buchner, & Lang, 2009; Faul, Erdfelder, Lang, & Buchner, 2007; Mayr, Buchner, Erdfelder, & Faul, 2007). For a two-tailed *t*-test between independent groups, a sample size of 172 participants is required to achieve a medium effect size (i.e., $d = .5$), with $\alpha = .05$, power $(1-\beta) = .9$, and equal allocation to groups (e.g., equal numbers of male and female participants). Under the same parameters, but in the instance where $\alpha = .001$, a sample of 340 participants would be required. This sample size would therefore facilitate analyses of differences between male and female participants. However, based on the literature, one can anticipate that a greater number of adolescents will be recruited than caregivers, which must therefore be taken into account in these calculations. A recruitment ratio of 2:1 (adolescents:caregivers) would mean a total sample size of 192 would be required to detect a medium effect size (i.e., $d = .5$), with $\alpha = .05$, power ($1-\beta$) = .9. If $\alpha = .001$, a total sample size of 382 is required.

For analyses using categorical variables, χ^2 tests will be employed. Calculations suggest that a sample of 117 is required to achieve a medium effect size (i.e., $w = .3$) with $\alpha = .05$, power ($1-\beta$) = .9, and 1 degree of freedom.

In cases where there is an imbalance of characteristics across groups (specifically, when comparing adolescents' and caregivers' responses, where the gender breakdown is different in each group), ANCOVA tests may be conducted. In order to achieve a medium effect size ($\eta p^2 = 0.5$), with $\alpha = .05$, power ($1-\beta$) = .9, numerator $df = 1$, two groups, and one covariate, the total sample size required is 171.

5.3.2 Participant recruitment

The study involved two groups of participants: young people aged 12-18 years attending post-primary school in the Leinster region of the Republic of Ireland, and adults who are primary caregivers of young people aged 12-18 years and reside in the Republic of Ireland. Adolescents and caregivers were not required to participate as a dyad; an adolescent could still participate even if their caregiver declined to participate, and *vice versa*. Instances where both a caregiver and their adolescent child participated was captured by requesting the caregiver to provide their child's name and date of birth[6]. Thus, the ability to link data collected from both individual in the dyad could be facilitated, should this be required in future studies examining this dataset. However, analyses of the relationship between adolescents' and their caregivers' responses were not required to answer the research questions of the current study. Participants were recruited through two streams: through post-primary schools, and online. Each recruitment stream is detailed below.

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[6] Note that this was only possible among school-recruited caregivers, as all adolescent participants were recruited through schools.

5.3.2.1 School-based recruitment (adolescents and caregivers)

A list of all post-primary schools in the Republic of Ireland was obtained from the website of the Government of Ireland Department of Education and Skills ("Data on individual schools," 2016). School recruitment was restricted to the Leinster region of Ireland, solely because of practicalities relating to the length of the school day and the researcher's base in Dublin city. A total of 373 post-primary schools in the Leinster region are listed by the Department of Education and Skills. Of this total, 55 (15%) are all-boys schools, 75 (20%) are all-girls schools, and 243 (65%) are mixed-sex schools.

To manage efficient communication with schools during the recruitment process, twenty schools were contacted at a time. In order to maintain correspondence between the sample and the breakdown of single-sex and mixed-sex schools in the region, three (15%) of these 20 schools were all-boys schools, four (20%) were all-girls schools, and thirteen (65%) were mixed-sex schools. Within each category (all-boys, all-girls, mixed-sex), schools were randomly selected. Random numbers were generated using the RAND function on Microsoft Excel; for example, three random numbers between 1 and 55 were generated for the selection of three all-boys schools. The schools listed in the correspondingly-numbered rows of the spreadsheet were thus selected for recruitment. A letter was posted to the school principal of each school selected for recruitment (see Appendix B). The letter first gave information on the study. The letter then asked if the school would facilitate students and caregivers being contacted regarding their participation, after which the researcher would visit the school to collect consent forms and caregiver questionnaires, and oversee the completion of questionnaires by participating students. This letter was accompanied by a sample of the information sheets (see Appendix C and Appendix D) and consent forms (see Appendix E and Appendix F) that would be provided to caregivers and students. Approximately four days after posting the letter, the researcher made a telephone call to the school principal to follow up on the letter, and to provide more information on the study, if requested. Further phone calls and e-mails were then made as required.

In total, 200 schools were contacted in this manner, and 14 schools (7% recruitment rate) agreed to facilitate the study. Two (14.3%) of these were all-boys schools, four (28.6%) were all-girls schools, and eight (57.1%) were mixed-sex schools. Some of these schools facilitated recruitment from students across all school years. However, other schools conditionally agreed to facilitation based on recruitment from specific year groups only. Typically, in this instance, the school requested that third year and sixth year students were not recruited for participation[7].

A total of 1,561 study packs were distributed across the fourteen schools. Each pack included an information sheet and consent form for the adolescent, an information sheet and consent form for his/her caregiver, and a caregiver questionnaire. The caregiver's information sheet detailed their child's potential participation, and their own potential participation. Similarly, the caregiver was asked to consent to their child's participation and their own participation. Should they wish, the caregiver could consent for their child's participation without participating themselves, or could consent to their own participation without giving consent for their child to participate. In total, 535 adolescent participants (34% response rate) and 257 caregivers (16% response rate) fully completed[8] questionnaires.

5.3.2.2 Online recruitment (caregivers only)

As the response rate for caregivers was considerably lower than for adolescent participants, it was decided to explore the potential recruitment of caregivers through alternative channels. Online recruitment of participants is often used in studies with populations that prove to be 'hard-to-reach' (Thornton et al., 2016; Tustin et al., 2017). A systematic review found that samples recruited online tended to be representative of the population to a degree similar to samples recruited through traditional

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[7] State examinations in Irish post-primary schools take place at the end of third and sixth years.

[8] A questionnaire was considered fully completed if at least one question from each section was answered.

means (Thornton et al., 2016). Furthermore, the results of one study specifically assessing online recruitment of parents as research participants found that “the Internet can be a useful way to recruit parents for research in a relatively short time with limited resources” (Quach et al., 2013, p. 11). Thus, it was decided that an additional and concurrent recruitment drive for caregiver participants would be conducted online.

The information sheet, consent form, and questionnaire for the current study was uploaded to an online survey host. An individual who clicked into the link would be presented with information about the study, and then asked to check boxes to indicate their consent to participate. If the individual consented, they would then be presented with the questionnaire section-by-section, with sections and constituent items presented in the same order as in the pen-and-paper questionnaire. ‘Question display logic’ was implemented so that caregivers of boys would read a vignette describing a character called Michael, and caregivers of girls would read a vignette describing a character called Michelle, to replicate the protocol for caregivers recruited through schools. ‘Display logic’ rules were set so that 50% of caregivers who indicated that their child did not identify as male or female would read the Michael vignette, and 50% would read the Michelle vignette.

Individuals were eligible to participate online if they resided anywhere in the Republic of Ireland. There was no evidence to suggest that systematic differences would be expected between caregivers residing in Leinster and those residing in any other region of the Republic of Ireland. However, as the National Health Service in the United Kingdom operates different public mental health care services to the Health Service Executive in the Republic of Ireland, it was decided that residence in Northern Ireland would be a criterion for exclusion.

The link to this survey was then circulated through a range of online media. The link was sent to Facebook pages and Twitter accounts related to parenting (e.g., “Family Friendly HQ”). The link was also sent by email to groups such as the National Parents’ Council, who shared it among their members as well as posting on their social media accounts. Snowball recruitment was also used, inviting the researcher’s personal

Facebook friends and Twitter contacts to participate in the study if they were eligible, and to in turn forward the invitation on to their own Facebook friends. This snowball method of online recruitment has been successful in other studies (Boyce, Schanding, Burridge, & Keller-Margulis, 2013; Mannix, Wilkes, & Daly, 2014; Thornton et al., 2016).

In total, 155 individuals started the online questionnaire. Eleven individuals decided that they did not consent to participate, and six were not based in the Republic of Ireland. The questionnaire was abandoned by a further 76 individuals. The number of participants who fully completed the questionnaire was 64 (19.9% of caregiver sample).

5.3.3 Adolescent participants

The final adolescent sample (*n* = 535) comprised 277 (51.8%) individuals who identified as male, 256 (47.9%) individuals who identified as female, and 2 (0.4%) individuals who did not identify as male or female[9]. Participants ranged in age from 12 to 18 years (*M* = 14.90 years, *SD* = 1.58). Three (0.5%) participants did not give their date of birth. For the purpose of analysis, participants' ages were aggregated into two categories: younger adolescents (aged 12-14 years, *n* = 199) and older adolescents (aged 15-18 years, *n* = 336). Participants were enrolled across all six years in the Irish post-primary school system; 14.5% of participants were in first year, 19.3% were in second year, 2.2% were in third year, 25.6% were in Transition Year, 23.5% were in fifth year, and 4.3% were in sixth year. Fifty-six participants did not specify their school year.

Participants' primary caregivers were asked to give some information on their families' ethnic, cultural and socioeconomic background when giving consent to their child's participation in the study. The majority (74.6%) of caregivers of adolescent participants stated that they were born in Ireland, with 14% stating that they were not born in

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[9] As this variable was to be used to categorise participants in analyses, it was decided that these two participants would be removed from the dataset given that statistical significance tests would be negatively impacted by the inclusion of a third category that included less than 1% of the sample.

Ireland and 11.4% not specifying their country of birth. Those who stated that they were not born in Ireland were asked to specify their country of birth. Of the caregivers who responded to this question, 34.66% stated that they were born in the United Kingdom (28% England, 4% Scotland, 2% Wales, and 8% stating United Kingdom without specifying which constituent country). The next most frequently mentioned countries were Poland (10.66% of caregivers not born in Ireland), Nigeria (9.33%), and United States of America (9.33%).

The majority of caregivers of adolescent participants identified as White Irish (77.6%), with 0.2% identifying their ethnicity as Irish Traveller, 1.7% as Black Irish, 0.9% as African, 0% as Chinese, 0% as 'Any other Black background', 5.2% as 'Any other White background', 1.7% as 'Any other Asian background', and 0.4% as 'Other, including mixed background'. Sixty-six (12.3%) did not state their ethnic or cultural background. The most recent Irish census data reports that 82% of individuals residing in Leinster identify themselves as White Irish, 0.6% identify as Irish Traveller, 1.9% as 'Black or Black Irish', 2.5% as 'Asian or Asian Irish', 9.5% as 'Any other White background', and 1.0% as 'Other'; 1.8% of Leinster residents did not state their ethnic or cultural background in the 2011 census (Central Statistics Office Ireland, 2011). Thus, the ethnic and cultural background of adolescent participants' caregivers in this study appears to approximate the ethnic and cultural background of Leinster residents.

Adolescent participants' caregivers were also asked about the highest level of education completed by the child's mother or female guardian, which has been shown to be a valid proxy measure of socioeconomic status (Hupkens, Knibbe, & Drop, 2000; Hupkens, Knibbe, Van Otterloo, & Drop, 1998; Sirin, 2005; Vereecken, Keukelier, & Maes, 2004). A small minority (2.6%) had completed primary school or less, 10.8% had completed the Junior Certificate, 23% had completed the Leaving Certificate, 29.3% had completed a diploma or certificate, 10.3% had completed a primary (Bachelor's) degree, 10.3% had completed a postgraduate or higher degree, and 13.6% did not provide any information. It is not possible to compare to the most recent Irish census data, as the data available to the public on the Central Statistics Office website does not specify whether women are mothers when giving details of education completed.

5.3.4 Caregiver participants

Caregiver participants (*n* = 321) ranged in age from 20[10] to 63 years (*M* = 46.2 years, *SD* = 6.2 years); 73 participants (22.7%) did not give their date of birth. Of note, only two of the online-recruited participants provided their date of birth. The majority (73.8%) of caregiver participants stated that they were the mother of an adolescent child, with 15.9% stating that they were a father of an adolescent child. A small proportion (2.2%) stated that they were another type of caregiver; these participants were asked to provide details of their relationship to the child. Two participants indicated that they were foster mothers, two identified themselves as being a 'host mother', and two indicated that they were a sister of the adolescent child. A small proportion of participants (8.1%) did not indicate their relationship to the adolescent. For the purposes of analyses, it was decided that the caregiver group would be disaggregated based on the gender typically associated with the caregiving role each participant stated, such that participants who stated that they were a foster mother, host mother, or sister were collapsed into a 'Female caregiver' category. Participants who stated that they were the father of an adolescent were categorised as 'Male caregiver'.

Participants were asked the gender of their adolescent child; 45.8% stated that their adolescent child identified as male, and 54.2% stated that their child identified as female. Participants' children ranged in age from 12 to 18 years (*M* = 15.4 years, *SD* = 1.6); 12.1% were in first year of post-primary school, 15.0% in second year, 3.1% in third year, 15.3% in Transition Year, 35.5% in fifth year, and 8.4% in sixth year. Most caregiver participants were recruited through their child's school, but, as detailed above, recruitment was also conducted online. Therefore, a small

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[10] This participant was an older sister and legal guardian of an adolescent.

proportion (1.6%) of participants' children were not in school. Four of these participants stated that their child was in their first year of university, three stated that their child was working, and one stated that their child "finished [post-primary] school in September". Additionally, 9% of participants did not indicate their child's school year.

The majority (75.4%) of caregiver participants were born in Ireland, with 15.9% stating that they were born in another country, and 8.7% not stating their country of birth. The majority of participants not born in Ireland were born in the United Kingdom (54%). The majority of caregiver participants identified themselves as White Irish (82.2%), with 0.3% identifying as Irish Traveller, 5.6% identifying as 'Any other White background', 0.3% identifying as Black Irish, 0.6% identifying as African, 0% as Chinese, 1.6% as 'Any other Asian background', and 0.6% identifying as 'Other ethnic or cultural background, including mixed'. Twenty-eight (8.7%) of participants did not provide information on their ethnic or cultural background.

Participants were asked about the highest level of education completed to date by the primary female caregiver of their adolescent child; 1.9% had completed primary school or less, 10.9% had completed the Junior Certificate, 21.2% had completed the Leaving Certificate, 27.7% had completed a diploma or certificate, 15.6% had completed a primary (Bachelor's) degree, and 14% had completed a postgraduate or higher degree. Twenty-eight (8.7%) did not provide any information on educational attainment.

5.3.5 Balance of characteristics across subsamples

As planned analyses involve comparison between the adolescent and caregiver samples, as well as comparisons within each sample (according to gender and, for the adolescent sample, age), the balance of characteristics across subsamples was explored, see Table 1and Table 2.

There was a larger proportion of female participants in the caregiver sample (82.7% of caregivers) than in the adolescent sample (47.9% of adolescents). This is not unexpected, given that previous studies have reported significant difficulties recruiting fathers/male parents to research studies (e.g., Phares, Lopez, Fields, Kamboukos, & Duhig, 2005). However, as it has been theorised (see Chapter 2, section 2.7) that gender may play an important role in determining responses to young people with depression, this imbalance will be addressed in analyses comparing adolescents' and caregivers' responses.

Analyses between school and online recruited caregiver participants are not planned, however the balance of characteristics across these groups was investigated to ensure that recruitment source was not a potential confounding variable. Caregiver participants were disaggregated into groups according to the channel through which they were recruited to the study: through schools, or online. Differences between these groups were then assessed. In sum, online-recruited participants were significantly older than school-recruited caregiver participants, as well as being significantly more likely to have children who were students in the Senior cycle of secondary school, significantly more likely to identify as White, and significantly more likely to have completed education past the Leaving Certificate. Online- and school-recruited caregivers did not differ in the proportions of each group that were mothers, fathers, or other caregivers, nor in the proportion of each group that cared for a male or female adolescent, the mean age of the children of each group, or the proportion of each group that was born in Ireland.

Table 1 Characteristics of adolescent participants

	TOTAL SAMPLE	**Male**	**Female**	**Younger**	**Older**
Gender					
Male	51.8%	-	-	58.8%	47.6%
Female	47.9%	-	-	41.2%	51.8%
Other	.4%	-	-	-	.6%
Age - M (*SD*)	14.9 (*1.58*)	14.7 (*1.49*)	15.1 (*1.66*)	13.1 (.71)	15.9 (.83)
School year					
First year	16.3%	19.5%	13.3%	42.6%	-
Second year	21.5%	26.7%	16.6%	54.6%	1.0%
Third year	2.5%	1.3%	3.7%	2.7%	2.4%
Transition year	28.6%	34.7%	22.0%	-	46.3%
Fifth year	26.3%	14.0%	38.6%	-	42.6%
Sixth year	4.8%	3.8%	5.8%	-	7.8%
Parent born in Ireland	84.2%	87.1%	81.2%	79.8%	86.9%
Ethnic background					
White Irish	77.6%	73.6%	81.6%	74.4%	79.5%
Irish Traveller	.2%	0%	.4%	.5%	0%
Any other white background	5.2%	4.0%	6.6%	8.0%	3.6%
Black Irish	1.7%	1.8%	1.6%	3.0%	.9%
African	.9%	1.1%	.8%	1.5%	.6%
Chinese	-	-	-	-	-
Any other Asian background	1.7%	2.5%	.8%	2.5%	1.2%
Other	.4%	.7%	-	-	.6%

	TOTAL SAMPLE	Male	Female	Younger	Older
Mothers' highest education achieved to date					
Primary or less	3.0%	2.7%	3.0%	3.4%	2.8%
Junior Certificate	12.6%	14.3%	11.0%	13.5%	12.0%
Leaving Certificate	26.6%	23.7%	29.7%	29.8%	24.6%
Diploma/Certificate	34.0%	36.2%	31.8%	33.1%	34.5%
Primary Degree	11.9%	8.9%	14.8%	9.6%	13.4%
Postgraduate or Higher Degree	11.9%	14.3%	9.7%	10.7%	12.7%

Table 2 Characteristics of caregiver participants

	TOTAL SAMPLE	**Male**	**Female**	**School**	**Online**	
Recruitment source						
School	80.1%	78.4%	78.3%	100%	-	
Online	19.9%	21.6%	21.7%	-	100%	
Relationship to child						χ^2 (2) = .200, p >.05
Mother	73.8%	-	97.1%	80.5%	79.7%	
Father	15.9%	100%	-	17.3%	17.2%	
Other	2.2%	-	2.9%	2.2%	3.1%	
Gender						
Female	82.7%	-	100%	82.7%	82.8%	
Male	17.3%	100%	-	17.3%	17.2%	
Age – M (*SD*)	46.2 (*6.19*)	46.2 (*5.36*)	46.2 (*6.17*)	46.1 (*6.15*)	56.5 (*2.12*)	t (246) = -2.385, p <.05
Born in Ireland	82.6%	83.7%	82.2%	82.1%	84.4%	χ^2 (1) = .181, p >.05
Ethnic background[11]						χ^2 (7) = 18.33, p <.05
White Irish	82.2%	86.3%	89.3%	79.8%	92.2%	
Irish Traveller	.3%	-	.4%	.4%	-	
Any other white background	5.6%	3.9%	6.6%	5.8%	4.7%	
Black Irish	.3%	-	.4%	.4%	-	
African	.6%	2.0%	.4%	.8%	-	

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[11] The proportion of Leinster residents who identified as ‘White Irish’ or ‘Any other White background’ in the 2011 census was 92.2%, compared to 95.3% of Munster residents, 94.5% of Connacht residents, and 96.3% of Ulster residents. Therefore, a greater proportion of Leinster residents (the population from which school-recruited parents were drawn) identify as non-White than any other province in Ireland.

	TOTAL SAMPLE	Male	Female	School	Online	
Chinese	-	-	-	-	-	
Any other Asian background	1.6%	2.0%	1.6%	1.9%	-	
Other	.6%	2.0%	.4%	-	3.1%	
Mothers' highest education achieved to date						χ^2 (5) = 23.89, p <.001
Primary or less	2.0%	2.0%	2.1%	2.6%	-	
Junior Certificate	11.9%	18.4%	10.8%	14.0%	4.7%	
Leaving Certificate	23.2%	16.3%	24.5%	25.3%	15.6%	
Diploma/Certificate	30.4%	24.5%	31.5%	32.3%	23.4%	
Primary Degree	17.1%	22.4%	15.8%	14.4%	26.6%	
Postgraduate or Higher Degree	15.4%	16.3%	15.4%	11.4%	29.7%	
Child's gender						χ^2 (1) = .354, p >.05
Male	45.8%	47.1%	44.3%	47.1%	40.6%	
Female	54.2%	52.9%	55.7%	52.9%	59.4%	
Other	-	-	-	-	-	
Child's age - M (*SD*)	15.4 (*1.60*)	15.1 (*1.84*)	15.4 (*1.56*)	15.4 (*1.60*)	15.3 (*1.63*)	t (292) = .037, p >.05
Child's school year						χ^2 (6) = 59.718, p <.001
First year	13.4%	14.3%	13.3%	14.5%	9.4%	
Second year	16.4%	24.5%	14.9%	14.9%	21.9%	
Third year	3.4%	2.0%	3.7%	.4%	14.1%	
Transition year	16.8%	10.2%	17.8%	15.8%	20.3%	
Fifth year	39.0%	32.7%	40.2%	45.6%	15.6%	
Sixth year	9.2%	14.3%	8.3%	8.8%	10.9%	
Child is not in school	1.7%	2.0%	1.7%	-	7.8%	

5.4 Materials

5.4.1 Participant recruitment materials

All potential participants were provided with an information sheet (see Appendix C and Appendix D), which detailed what participation in the study would involve, the right to withdraw participation at any stage, the bounds of confidentiality, and the right to access any personal information provided. Adolescent participants completed and signed a consent form (see Appendix F) which required each individual to tick a series of boxes to indicatae that they understood the details of the information sheet. Adolescents' caregivers also completed and signed a consent form to confirm that they too had read and understood the information about their child's participation in the study, and agreed for their child to participate in the study (see Appendix E). Caregivers who participated in the study completed an additional section of the form, confirming that they understood the details of the information sheet, and their consent to personally participate in the study. On the back of this consent form, caregivers were asked to provide details of their ethnic or cultural background. The ethnic and cultural background categories replicated those used in the Irish census ("Census Forms," 2016). Caregivers were also asked to indicate the highest level of education obtained by the child's mother/female caregiver. Research supports asking caregivers to provide family background information, instead of asking the child participant to provide this information (Entwisle & Astone, 1994; Sirin, 2005).

5.4.2 Questionnaire

Data were collected through the use of a questionnaire instrument constructed for the current study. The instrument incorporated a set of scales and measures which each addressed one of the variables under investigation. Adolescents' and caregivers' questionnaires were identical in all aspects except that adolescents' questionnaires made reference to a peer, while caregivers' questionnaires made reference to an adolescent child. In this section, the components of the questionnaire instrument are detailed. Both the adolescent and caregiver versions of the questionnaire can be viewed in Appendix G and Appendix H, respectively.

5.4.2.3 Empathy

The first section of the questionnaire instrument comprised an assessment of empathy. Dispositional empathy was measured using The Basic Empathy Scale (Jolliffe & Farrington, 2006). This 20-item scale has been validated in both adult (Carré, Stefaniak, D'Ambrosio, Bensalah, & Besche-Richard, 2013; Schwenck, Schneider, & Reichert, 2015) and adolescent (Albiero, Matricardi, Speltri, & Toso, 2009; D'Ambrosio, Olivier, Didon, & Besche, 2009; Geng, Xia, & Qin, 2012; Jolliffe & Farrington, 2006) samples. Items are rated on a five-point scale from 'Strongly disagree' to 'Strongly agree'. A sample item is "*I get caught up in other people's feelings easily*". Four items are worded negatively and are thus reverse-scored. Cronbach's α was .709 for caregiver sample and .827 for adolescent sample.

Research indicates that empathy is "a result of the interaction between state and trait influences" (Cuff, Brown, Taylor, & Howat, 2016, p. 149), and that the 'empathic emotions', anger and sympathy, are related to help-giving behaviour (Greitemeyer & Rudolph, 2003; Rudolph et al., 2004). Thus, the anger and sympathy subscales of the Indicator Questions for Perceived Controllability scale (Reisenzein, 1986) were also included in the questionnaire in order to measure participants' situationally-generated or 'state' empathic response. Cronbach's α for the anger subscale was .832 in the adolescent sample and .787 in the caregiver sample. Cronbach's α for the sympathy subscale was .748 in the adolescent sample and .524 in the caregiver sample[12].

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[12] It is noted that this α value is lower than what would be desired; issues regarding the psychometric properties of the selected instruments are discussed in Chapter 9, section 9.6.

5.4.2.4 Vignette stimulus

The questionnaire then presented each participant with a vignette stimulus, which described a young person's recent behaviour. Vignettes are "short stories about a fictional character or fictional scenario appropriate to a particular study. The story places the behaviour of the character in a concrete context and allows the researcher to explore participants' views on the issues arising from the situation" (O'Dell, Crafter, de Abreu, & Cline, 2012, p.703). The use of vignettes has been effective for the exploration of sensitive topics and adolescents' subjective definitions (Barter & Renold, 2000; Burns & Rapee, 2006). Finch (1987, p. 105-106) notes that vignettes "allow for features of the context to be specified, so that the respondent is being invited to make normative statements about a set of social circumstances, rather than to express his or her 'beliefs' or 'values' in a vacuum". Carefully developed vignette stimuli allow for systematic and controlled assessment of the factors that may influence participants' responses; indeed, as O'Dell and colleagues state, "the method is useful precisely because of the schematic nature of the material" (O'Dell et al., 2012, p. 704). Although it is likely that most participants in this study will have had contact with a young person experiencing symptoms of depression, due to the prevalence of depression in adolescence (Schubert et al., 2017), it is possible that some may not have had this experience. In these cases, the use of vignettes is beneficial as it permits participants to imagine situations beyond the realm of personal experience (Barter & Renold, 2000; R. Hughes & Huby, 2002; Schoenberg & Ravdal, 2000).

Asking about a hypothetical situation may appear potentially problematic, due to the possibility that social desirability may prompt participants to respond how they would 'ideally' act in such a situation (Henderson, Evans-Lacko, Flach, & Thornicroft, 2012). Relatedly, there exists a continuing debate regarding whether responses to vignettes reflect how individuals act in reality, with little consensus and much contradiction, in itself illustrating the complexity of this issue (Carlson, 1996; Collett & Childs, 2011; Faia, 1980; R. Hughes, 1998; Rahman, 1996). It has also been queried whether the hypothetical nature of vignette methodology encourages “subjects to process vignette information less carefully and effectively than they would under ideal or real conditions” (Stolte, 1994, p. 727). Proponents of vignette methodologies argue, however, that there is no one research instrument that can directly encompass the complexity of individuals’ beliefs and social existence (Barter & Renold, 2000; Leighton, 2010; Prior, Chun, See, & Huat, 2000). Therefore, while “there can be little doubt that vignette-based experiences are different from real-life… whether this in itself makes it as unsuitable research tool depends on the rationale for using it” (Hughes, 1998, p.384). Vignettes are not designed to simulate complete reality (R. Hughes & Huby, 2004), and researchers acknowledge that responses to vignettes cannot be taken as equivalent to real-life action (Dixon et al., 2013). It would however be difficult, if not impossible, to directly observe natural, spontaneous support-giving interactions between a young person and their depressed peer, or a caregiver and their depressed child. Moreover, the generalisability of direct observation of behaviour cannot be assumed, as it is necessarily limited by situational specificity (Barter & Renold, 2000). Analogue methodologies such as vignette stimuli are thus appropriate when ‘*in vivo*’ research is “impossible, impractical, and/or unethical” (Cook & Rumrill, 2005, p. 94). Furthermore, it is important to remain cognisant that behavioural *intentions* are the dependent variable of interest in the Theory of Planned Behaviour. Studies also suggest that social desirability is reduced in vignette responses, in comparison to direct questioning (Alexander & Becker, 1978; Finch, 1987; Ganong & Coleman, 2006; R. Hughes & Huby, 2004).

The vignette stimulus used in the present study was adapted from vignettes originally developed and validated by O’Driscoll (2013), see O’Driscoll, Heary, Hennessy and McKeague (2012, 2015b, 2015a), and further validated by Silke (2016), see Silke, Swords and Heary (2016; 2017). O’Driscoll (2013) modelled the vignette on a previously-validated vignette developed by Swords et al. (2011; 2011b; 2011a) and Hennessy and Heary (2009). The development of this original vignette included review by clinical psychologists, however O’Driscoll noted that the DSM-IV diagnostic criteria for depression (American Psychiatric Association, 2013; Carr, 2008) were not sufficiently represented. Consequently, O'Driscoll amended the vignette to more comprehensively reflect these diagnostic criteria. Internal validity of this new vignette (following O'Driscoll's amendments) was assessed through a review by an expert panel of twelve trainee and qualified clinical psychologists. Each panellist was asked to evaluate the accuracy of the vignette in describing a child with a clinical diagnosis of depression, using a six-point Likert scale ranging from 'very inaccurate description' to 'very accurate description', with higher scores representing greater accuracy. Panellists were also asked to provide specific feedback and comments. The mean accuracy score for the expert panel was 5.25, with 83.4% of the panel rating the vignette as 'accurate' or 'very accurate'. An example of specific feedback received was "*I would consider depression as being my first hypothesis in going in to conduct an assessment with this child*".

Silke (2016) noted that the vignette did not make reference to the time in which the character depicted in the vignette has been experiencing symptoms of depression. As such, Silke modified the vignette to specify that the symptoms had been present for a period of time that aligned with the DSM-IV criteria for depression (American Psychiatric Association, 2013; Carr, 2008). In addition, Silke expanded the vignette to include information that was not explicitly diagnostically-relevant, to give additional details about the character. This was done in order to increase ecological validity, as the most useful vignettes have been evidenced to be realistic, context-sensitive and meaningfully tailored to target participants (O'Dell et al., 2012; Schoenberg & Ravdal, 2000). Internal validity of Silke's modified vignette was assessed by an expert panel of eleven trainee and qualified clinical psychologists, who rated the accuracy of the description on a seven-point Likert scale ranging from 1 'very inaccurate description' to 7 'very accurate description'. The mean accuracy rating was 4.82. Panellists provided some qualitative feedback which suggested that the vignette "appeared to have been written from a clinical perspective, and as such may be too clear to be true", and that it may be beneficial to include symptoms of depression that are 'less well known', such as irritability. Accordingly, Silke refined the vignette further based on this feedback; the vignette employed by Silke (and thus the vignette used in the current study) was as follows:

Michael is in the same year as you. He used to enjoy lots of hobbies, such as hanging out with his friends and playing football for his local team. Although Michael sometimes complained about how much time the team had to spend training, he was usually quite good at turning up for practice. A few months ago, Michael started missing a lot of training sessions and has since stopped coming altogether. Over this time, Michael's friends have noticed a change in him, in that he doesn't seem to be interested in doing things with them anymore as he no longer makes an effort to hang out with them or talk to them online. Some of Michael's close friends have also noticed that he seems more irritable lately and doesn't smile, or laugh, or appear to find as much enjoyment in things as he used to. Michael has also started to experience some problems at school. Over the past six weeks or so, Michael has been constantly late for school and has started to fall behind on his school work. When the head teacher asked Michael about this, he said that he has been finding it extremely difficult to get to sleep at night and feels tired all the time. Michael explained that although he would like to do better in school, he just couldn't concentrate on things or think as well as he used to. Michael said that he just feels 'down' all the time now and doesn't think that he is good at anything anymore.

It is important to note here that no diagnostic labels accompanied the vignette, therefore facilitating assessment of participants' ability to spontaneously identify or label the symptoms depicted. While it is recognised that mental illness can be a sensitive topic, it is clear that the ethical principle of beneficence was applied to the development of the vignette (R. A. Thompson, 1990); although it may be impossible to fully predict what will cause a participant to become distressed, the vignette was not graphic in its representation of mental ill health.

In the current study, the vignette character was age-matched (same age as adolescent participant; same age as adolescent child of caregiver participant) and sex-matched (same sex as adolescent participant; same sex as adolescent child of caregiver participant) to participants. This study design was selected for several reasons. Firstly, investigation of the relationship between the age and sex of the vignette character and the age and sex of the adolescent participant or caregiver participant's child was beyond the scope of the current study. Secondly, assessment of the interaction between age and sex of the target and age and sex of the participant on each variable of interest would have required a considerably increased sample size in order to detect an effect (Tabachnik & Fidell, 2007; VanVoorhis & Morgan, 2007). Given that addressing this interaction was not the goal of the study, as per the first point above, increasing the required sample to this extent was deemed unwarranted. Finally, as it is known that adolescents' friendships are typically characterised by homophily (Kandel, 1978; McPherson, Smith-Lovin, & Cook, 2002; Selfhout et al., 2007), it was thought that matching the age and sex of the vignette character to the adolescent participant would enhance the realistic quality of the situation. Similarly, as caregiver participants may not have experienced parenting a child of any other age or sex (i.e., if their adolescent child was an only child), it was thought that matching the vignette character to their own child in these characteristics would assist participants in responding to the scenario in a naturalistic manner. Future studies, however, may benefit from counterbalancing the characteristics of the vignette among participants, to facilitate exploration of any differences in responses when the vignette character is a different age or sex to an adolescent participant, or caregiver participant's child.

In the initial stage of questionnaire design, a second vignette was included in the study as a control. This vignette, also originally developed by O'Driscoll et al. (2012), described a young person who was experiencing a transient life crisis. The behaviours described in the vignette were not associated with any clinical diagnosis. The function of the inclusion of a control vignette was to determine whether participants could distinguish between behaviours that reflected an underlying mental health problem, and behaviours associated with a 'normal' adolescent experience. Control vignettes have been implemented in other studies for similar reasons (S. Byrne et al., 2015; E. Doyle et al., 2017).

The vignettes were pilot tested for use in the current study with a group of young people and a group of caregivers of young people (see section 5.5 in this chapter for a detailed description of the pilot study). Following feedback from pilot study participants, it was decided to remove the control vignette from the questionnaire instrument (see section 5.5.4 for details).

5.4.2.5 Mental health literacy

The questionnaire also included an assessment of participants' MHL. The original definition of MHL by Jorm et al. (1997, p. 182) was "the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes; of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking". This definition has proved difficult to operationalise; the literature reveals that MHL has been measured in many different ways. For example, Furnham and Sjokvist (2017) state that they address MHL by reporting whether participants correctly identified the disorder presented in a vignette, whereas in Doyle, O'Sullivan, Nearchou and Hennessy's (2017) conceptualisation of MHL, participants' identification of specific symptoms and knowledge of prevalence were additionally included. The discrepancies between different tools that purport to measure mental health knowledge has since been addressed in a series of reviews, which call attention to the need for the development of a strongly validated tool (Wei, McGrath, Hayden, & Kutcher, 2015, 2016). Without such a tool, replication of research is difficult (S. R. Hart et al., 2014) [13].The current study thus operationalised MHL by using 'identification of depression' as a proxy for this concept, suitable for use in regression analyses. However, in order to more broadly characterise and describe participants' MHL, a combination of measurement strategies was additionally included.

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[13] It is important to note here that in the time that has passed since the current study was designed, a number of instruments have been developed to measure MHL and depression literacy in an attempt to address the issues discussed in this paragraph.

One widely-employed technique is presenting participants with a series of questions following a vignette; one such example is the Friend in Need questionnaire (Burns & Rapee, 2006). This tool was selected for use in the current study, and encompasses assessment of severity of symptoms, identification of disorder, recognition of symptoms, and assessment of prognosis. Participants are first asked, "*How worried are you about X's overall wellbeing?*" and can respond on a four-point scale ranging from 'not at all worried' to 'extremely worried'. The next question is open-ended; participants are asked, "*In five words or less, what do you think is the matter with X?*". This item served as the measure of identification of depression in the current study. Next, participants responded to another open-ended question: "*Please quote all the words/phrases from X's story that suggest to you that he/she might be experiencing difficulties*". Participants are then asked, "*How long do you think it will take for X to feel better again?*" and respond on a four-point scale ranging from 'one or two days' to 'longer than a few months'. The last question in the Friend in Need questionnaire asks, "*Do you think X needs help from another person to cope with his/her problems?*"; participants can select 'Yes', 'No', or 'Don't Know'.

An individual's attributional response to a situation also reveals information about an individual's level of MHL, as attributional responses have been shown to be influenced by stigma (Corrigan, 2000; Corrigan et al., 2003). Furthermore, the nature of the attributional responses can help to predict help-giving and prosocial behaviour (MacGeorge, 2001; Regan & Totten, 1975; Reisenzein, 1986; Weiner, 2004). In the context of the current study, attributional response refers to the participant's assessment of whether the situation was within personal control of the help-recipient, or whether it was determined by external factors outside of the help-recipient's control. Thus, the controllability subscale of the Indicator Questions for Perceived Controllability scale (Reisenzein, 1986) was also included, in order to measure participants' perceptions of the controllability of the vignette characters' symptoms. This subscale comprises three questions, each answered on a nine-point scale: "*How controllable, do you think, is the cause of X's present condition?*"

(response options range from ‘Not at all under personal control’ to ‘Completely under personal control’), “*How responsible, do you think, is X for his/her present condition?*” (response options range from ‘Not at all responsible’ to ‘Very much responsible’), and “*I would think that it is X’s own fault that he/she is in the present situation*” (response options ranging from ‘No, not at all’ to ‘Yes, absolutely so’). Cronbach’s α was .564 for caregiver participants and .625 for adolescent participants.

Finally, beliefs about the helpfulness or harmfulness of various potential responses were assessed by asking participants to mark whether they believe each of ten potential ‘treatments’ would be ‘helpful’, ‘harmful’ or would ‘make no difference’ to the vignette character. Example items rated by participants are ‘*Listen to X’s problems in an understanding way’* and ‘*Encourage X to become more physically active*’. This method of assessment has been used in multiple studies (Cotton et al., 2006; Jorm & Wright, 2008; Jorm et al., 2007a; A. Wright et al., 2005, 2007). These questions do not form a scale, and as such reliability is not reported here. For the same reason, participants’ responses were analysed at an item level. In order to control for multiple comparisons, the critical alpha level was reduced to .001.

5.4.2.6 Support-giving intentions

A range of tools that measure responses to individuals with mental illness were reviewed for selection to use in the current study. One such tool is the Social Distance Scale (Link, Cullen, Frank, & Wozniak, 1987), which assesses participants’ self-reported behavioural intentions to interact with an individual with mental health issues. The relationship between reported previous behaviour and future intended behaviour was addressed in the development of the Reported and Intended Behaviour Scale (Evans-Lacko et al., 2011). However, these scales do not address support behaviours, and were primarily designed as measures of discriminatory behaviour. Other tools exist that measure intentions to engage in supportive (Kunkel & Burleson, 1999), helping (Gottlieb, 1978), and prosocial behaviours (Carlo & Randall, 2002); yet, these tools are not relevant or appropriate for assessing supportive behaviours in a mental health context. Aldrich, Harrington, and Cerel (2014) developed a questionnaire assessing intentions to intervene when an individual expresses suicidal intent. A similar questionnaire was developed in an unpublished doctoral thesis (Tarquini, 2010). While situated in a mental health context, these tools target behaviours relevant in a crisis situation, and do not include support behaviours relevant to earlier signs of mental distress. A review of the literature hence suggests that no standardised tool exists to assess support responses to an individual showing signs of depression. Therefore, the Modes of Intended Mental Health Support (MIMHS) scale was developed for the purposes of the current study.

The scale development process and initial factor analysis is fully detailed in Chapter 6. Each item took the form of a statement of intent to engage in a certain behaviour in response to the vignette, which participants rated based on how likely it was that they would engage in said behaviour. Items were rated on a scale from 1 '*Extremely unlikely*' to 4 '*Extremely likely*'. The subscales that emerged among adolescent participants were titled 'Generic Support' (GS; sample item: "*I would listen to X in an understanding way*", 'Seeking Expertise' (SE; sample item: "*I would ring a professional for help and advice about the situation*"), and 'Informing Adults' (IA; sample item: "*I would tell X's parent or key caregiver about the situation*"). The subscales that emerged among caregiver participants were 'Facilitating Professional Support' (FPS; sample item: "*I would offer to accompany X to an appointment with a mental health professional*"), 'Problem Minimisation' (PM; sample item: "*I would try to distract X from his/her problems*"), and 'Support Resource Utilisation' (SRU; sample item: "*I would seek help from a website or online support forum*").

5.4.2.7 Attitudes, perceived behavioural control, and subjective norms

The questionnaire incorporated an assessment of the primary components of the Theory of Planned Behaviour (TPB), which are attitudes, subjective norms, and perceived behavioural control (PBC) (Ajzen, 1991). Ajzen (2006) emphasised the importance of contextual specificity when measuring these three components, and gives guidelines for the construction of a tool to measure attitudes, norms, and perceived behavioural control within the specific context under study by other researchers. These guidelines were followed by Aldrich, Harrington and Cerel (2014) when constructing their Willingness to Intervene Against Suicide questionnaire, which applied the TPB to support-giving behavioural intentions in a suicide intervention context. Some support behaviours addressed in Aldrich et al.'s study were specific to the emergency nature of suicide intervention, and thus the tool required adaptation in order to be applicable to the current study. Thus, the current study used adapted versions of the attitudes and perceived behavioural control subscales of the Willingness to Intervene Against Suicide scale.

Items on the attitudes subscale took the form of a sentence stem, "Helping X would be…", rated on a seven-point semantic differential scale. Sample scale poles are "*Negative – Positive*", "*Useful – Useless*", "*Not scary – Scary*". Participants answered 11 subscale items in total. For six of the items, a rating of 1 was associated with the most negatively-valenced response, while 7 was associated with the most positively-valenced response. For the other five items, the valences of the scales' poles were reversed. In analysis, responses were re-coded so that a higher rating on each item reflected a more positive attitude. Participants' mean across all items was calculated such that potential mean scores ranged from 1 to 7. Cronbach's α was .701 for the adolescent sample and .698 for the caregiver sample.

The PBC subscale presented participants with a series of ten statements, which were rated on a 5-point scale from 'Strongly disagree' to 'Strongly agree'. Sample items are "*I am confident in my ability to discuss X's situation with him/her*" and "*It would be difficult for me to discuss my concern for X*". One item was negatively worded ('*I am NOT confident I could talk to a teacher about my concern*'); this was reverse-coded in analysis so that a higher score across all items indicated a greater perception of behavioural control over giving support to a young person with depression. Participants' mean across all items was calculated such that potential mean scores ranged from 1 to 5. Cronbach's α was .782 for the adolescent sample and .803 for the caregiver sample.

The subjective norms subscale of the Willingness to Intervene Against Suicide questionnaire was deemed inappropriate for use in the current study, as the constituent items asked participants to respond about perceived norms within their family, school, community, and friend groups for each support behaviour investigated. For the current study, which incorporated 36 items in its measure of behavioural intentions, this approach would have resulted in 144 subjective norms items. This was considered an imprudent use of participants' volunteered time. Instead, it was decided to construct items to assess subjective norms according to the guidelines set out by Ajzen (2006). Four items were constructed: "*Other people like me would involve a professional (e.g. GP, psychologist) in X's situation*", "*Other people like me would involve another person who isn't a professional (e.g. friend, family member, teacher) in X's situation*", "*Other people like me would talk with X one-on-one about his/her situation*" and "*Other people like me would not get involved in X's situation*". Cronbach's α was .651 for the caregiver sample and .493 for the adolescent sample.

5.4.2.8 Previous support-giving experience

Participants' previous experience providing help to someone experiencing depression was assessed by a series of questions used by Yap and Jorm (2011, 2012). First, participants were asked, "*In the past year, has anyone in your family or close circle of friends had a problem similar to X's?*", and responded by ticking 'Yes', 'No', or 'Don't Know'. Participants who answered 'No' were directed to section J of the questionnaire (which contained items measuring exposure to mental illness - see section 5.4.2.9 below). Participants who answered 'Yes' were asked, "*Did just one person have the problem, or more than one?*", and answered by selecting 'Just one' or 'More than one'. Participants who selected 'More than one' were directed to a call-out box that contained the following instruction: "*Because you know more than one person who had* *a problem similar to X's, for the next few questions, I want you to think about the person you know best.*" Participants were next asked, "*How old was that person at the time?*" and answered by selecting one of the following options: '0-9 years', '10-19 years', '20-29 years', '30-39 years', '40-49 years', '50-59 years', '60 years or over', 'Don't Know'. The next question was "*What was this person's gender?*"; participants selected 'Male', 'Female' or 'Other'. Following this, participants were asked "*Was this person a family member or a friend?*" and selected 'Family member' or 'Friend'. Previous support-giving behaviour was then assessed by asking "*In the past year, have you done anything to help this person?*". Participants selected 'Yes' or 'No', after which they were finally asked "*What did you do?*", which was open-ended and allowed participants to write their response.

5.4.2.9 Exposure to mental illness

The final section of the questionnaire consists of an amended version (Tsang, Tam, Chan, & Cheung, 2003) of the original Level of Contact Report (LCR; Holmes, Corrigan, Williams, Canar, & Kubiak, 1999), which measures exposure to mental illness. The amended version of this tool consists of nine items; items original to the Holmes et al. (1999) version were eliminated due to perceived repetition across items, and lack of clarity regarding the frequency of contact with individuals with mental illness (Tsang et al., 2003). Participants are asked to mark each item that applies to their own personal situation. Each item is given an ordinal score from 0 to 9, which represents the level of contact with mental illness, with 9 representing the highest level of contact. Participants are then assigned a score that corresponds with the highest level of contact they indicated. For example, one participant may tick, "*I have seen realistic portrayals of people with mental illness in newspapers, magazines, films, or TV programmes*" (ranked 1 out of 9) and "*I have frequent contact with a friend or relative who has a mental illness*" (ranked 8 out of 9) – in this instance, the participant's assigned score would be 8, as 8 is the highest ranked item that was ticked.

5.4.3 Participant debriefing materials

Following completion of the questionnaire, participants were provided with a debriefing form (see Appendix I), which explained that the behaviours described in the vignette were indicative of depression, and gave contact information for an online resource where participants could learn more about depression in young people. The form also provided information about support services that participants could contact if they were negatively affected by what they read and thought about. The final section of the form provided contact information for the researcher and the supervisors of the research study, should the participant have any questions or wish to learn more about the study.

5.5 Pilot study

The questionnaire instrument was pilot tested in April 2015 in a post-primary school in County Carlow, in the Leinster region of Ireland. The aim of this pilot study was to obtain feedback on the acceptability and feasibility of data collection methods.

5.5.1 Participants

Sixty-six adolescents (32 male) and twenty-eight caregivers participated in the pilot study. Adolescent participants ranged in age from 12 to 18 years (*M* = 15.09 years, *SD* = 1.9) and came from five school years (19.7% of the sample were first year students, 22.7% second year, 21.2% third year, 25.2% fifth year and 21.2% sixth year). No Transition Year (fourth year) students participated. The majority (78.3%) of caregiver participants stated that they were a mother to an adolescent child; the remaining 8.7% stated that they were a father to an adolescent child. The majority of caregiver participants had a female child (60.9%). Caregivers' adolescent children ranged in age from 12 to 17 years (*M* =14.9 years, *SD* = 1.71) and came from five school years (13% were in first year, 21.7% in second year, 8.7% in third year, 34.8% in fifth year and 4.3% in sixth year). Four participants did not indicate their child's school year. No caregiver participants had an adolescent child in Transition Year.

5.5.2 Materials

The pilot study questionnaire for adolescents can be found in Appendix J, while the pilot study questionnaire for caregivers can be found in Appendix K[14]. Two vignettes were presented in each questionnaire. One vignette described a young person displaying symptoms of depression as classified by the DSM-IV (American Psychiatric Association, 2013; Carr, 2008). The other vignette described a young person experiencing a transient life crisis; this vignette functioned as a control. Male adolescent participants and caregiver participants who cared for male adolescents completed questionnaires that described a male vignette character. Similarly, female adolescent participants and caregivers of female adolescents completed a questionnaire that described a female vignette character.

The first section of the questionnaire comprised the Basic Empathy Scale, as detailed in section 5.4.2.3 of this chapter. The questionnaire then presented one of the vignettes. The proceeding sections, assessing MHL, behavioural intentions, attitudes, subjective norms, PBC, and previous support-giving experience (assessed through the measures detailed in section 5.4.2.7 of this chapter), were all completed in response to this vignette. Then, the second (control) vignette was presented. This was followed by questionnaire sections which assessed MHL, behavioural intentions, attitudes, subjective norms, PBC, and previous support-giving experience (using the measures detailed in section 5.4.2.7 of this chapter), this time in relation to the second vignette. The final section of the questionnaire was the LCR, measuring participants' exposure to mental illness.

The school recruited for the pilot study held Green-Schools status ("Green-Schools Ireland," n.d.) and requested that paper usage was

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[14] Note that these questionnaires were completed online in the pilot study, and as such the formatting seen in the appendices is not representative.

minimised. To meet this requirement, the adolescent version of the questionnaire was uploaded to an online survey host. ‘Question logic’ was implemented so that half of the adolescent participants would read and respond to the vignette describing the depressed character first, and the control vignette second. The order in which vignettes and associated questions were presented was reversed for the other 50% of participants. The caregiver version of the questionnaire took a pen-and-paper form. Half of the caregiver questionnaires were printed with the vignette describing the young person with depression first, with the control vignette presented afterwards. The other half of the caregiver questionnaires presented the vignettes in the reverse order.

All potential participants were provided with information sheets detailing what their participation would involve. Adolescent participants’ caregivers were required to consent to their child’s participation, and adolescents also personally consented.

5.5.3 Procedure

Caregiver participants completed the questionnaire at home in their own time. Caregivers were invited to submit any feedback in written form at the end of the questionnaire. Caregivers then returned the completed questionnaire to school. The researcher collected the completed caregiver questionnaires, together with signed consent forms, when visiting the school to facilitate the adolescent participants’ completion of the questionnaire.

The link to the questionnaire was loaded onto each computer in a computer lab in the school. Participating students were brought to the computer lab in groups, according to school year. Participants were reminded verbally that they could withdraw from the study at any time, without any negative consequences. Participants then progressed through the questionnaire at their own pace; on average, completion of the questionnaire took approximately 45 minutes. Following completion of the questionnaire, the group were asked verbally for feedback. The feedback session lasted approximately 15 minutes for each group.

5.5.4 Feedback from pilot study participants

The wording of all questions was deemed easy to understand by adolescent participants. Participants stated that they thought the descriptions of the vignette characters appeared realistic. The questionnaire was perceived as excessively long by the majority of both adolescent and caregiver participants; for example, one participant stated, "*By the end, I didn't care what happened to* [vignette character]*, I just wanted it to end!*" (Caregiver participant, mother of male child). Participants stated that the length of the questionnaire induced boredom, and that it encouraged satisficing in responding, "*I was just ticking random ones near the end*" (Adolescent participant, male). Participants also shared that some of the questions did not appear to make sense when applied to the control vignette, "*When it asked if I would ask her if she was suicidal, I was like, why would I be asking her about that?*" (Adolescent participant, female).

5.5.5 Resulting questionnaire refinements

The questionnaire instruments for use in the main stage of the current study were refined in consideration of the feedback received from the pilot study. Specifically, in light of participants' feedback about the length of the questionnaire, it was decided that the control vignette, and the associated sections of the questionnaire in which participants responded in relation to that vignette, should be removed. This decision was based on two main factors: school recruitment, and feedback from participants about their experience of completing the questionnaire. It was thought that the benefits brought by addressing these two factors outweighed the costs of certain analyses not being facilitated, particularly as the analyses were not crucial to the research questions of the current study.

5.5.5.10 School recruitment

When recruiting schools to facilitate a study, disruption of the regular school timetable is a reason frequently cited by stakeholders when access to the school is denied (Harrell, Bradley, Dennis, Frauman, & Criswell, 2000). Therefore, given that adolescent participants would complete the questionnaire in school, during school hours, it was considered important to minimise potential disruption to classes. By removing the control vignette and the related sections of the questionnaire, the length of time required to complete the questionnaire should be significantly reduced, thus decreasing the time students would be removed from their regular classes, and, it was hoped, increasing the likelihood that school stakeholders would grant access.

5.5.5.11 Participation experience

When designing a research study, it is imperative to remain cognisant of the ethical principal of beneficence; the cost of participation should be minimised wherever possible. Completion of a questionnaire is associated with cognitive burden (Krosnick, Narayan, & Smith, 1996) and it is likely that this burden is greater for young people (Borgers, de Leeuw, & Hox, 2000; Borgers, Hox, & Sikkel, 2003). Additionally, "when participants are interested in the research, [and] feel it to be relevant and real, then the quality of the data is likely to increase" (Hughes & Huby, 2004, p. 41). Reduction in data quality is primarily attributed to the fact that participants in questionnaire-based research can resort to satisficing when uninterested or cognitively-overburdened (Krosnick, 1999). Reducing the length of the questionnaire by removing the control vignette was thus an attempt to (a) reduce the cognitive load experienced by participants, and (b) reduce the likelihood of participant satisficing.

5.5.5.12 Final version of questionnaire instruments

The questionnaire instruments for adolescent and caregiver participants were thus refined following the removal of the control vignette and the sections relating to this vignette. The first section of the final instrument comprised the Basic Empathy Scale. Following this, the remaining (depressed) vignette was presented, followed by the sections of the questionnaire that required participants to respond in relation to the vignette (i.e., the sections that assess MHL, behavioural intentions, attitudes, subjective norms, and PBC). The last section of the questionnaire contained the LCR, which measured participants’ exposure to mental illness. The final version of the adolescent questionnaire can be viewed in Appendix G and the final caregiver questionnaire can be viewed in Appendix H. All questionnaires in the main stage of data collection were in pen-and-paper form; questionnaires were printed in A4-size booklets.

5.6 Procedure followed for main stage of data collection

5.6.1 Adolescent participants

Participation took place in an empty classroom on the premises of each participating school, during school hours. Participants were brought into the classroom in groups according to their school year. Where possible, participants were seated at separate desks to minimise distraction and maximise privacy in completing the questionnaire. The researcher verbally introduced the participation session, starting by thanking participants for their interest in the study. The researcher detailed again what participation would involve, and reminded participants that they could decide to withdraw their participation at any time. Participants were informed that there were no ‘right’ or ‘wrong’ answers to any of the questions, and were asked to answer as honestly as possible. The researcher asked that the questionnaire be completed in silence. In the case that participants shared desks, the researcher asked that each individual’s privacy was respected. At this point, the researcher asked if anyone had any questions, and answered any questions that arose. Participants were then informed that if they had a question while they completed the questionnaire, or if they did not understand any aspect of the questionnaire, they could ask the researcher at that time. Finally, participants were told that they could complete the questionnaire at their own pace.

Participants then proceeded to complete the questionnaire. Whenever a participant was finished, the researcher thanked them, collected the questionnaire from their desk, provided the participant with a debriefing form, and invited the participant to read the debriefing form. When all participants in the group had completed the questionnaire, and received a debriefing form, the researcher thanked them again for their participation as a group. Participants were then asked to return to their regularly-scheduled classroom.

5.6.2 Caregiver participants

5.6.2.13 School-recruited participants

Caregiver questionnaires were provided to the school in individual envelopes, which also included the study information sheets and consent forms. The envelopes were bundled according to the sex of the vignette character in the enclosed questionnaires. The researcher requested that male students were given an envelope from the male vignette character bundle, and female students were given an envelope from the female vignette character bundle. The researcher requested that students were asked to bring these envelopes home to their caregivers.

The caregiver information sheet, enclosed in the envelope asked participants to complete the questionnaire in their own time, at home, and to place the completed questionnaire together with the signed consent forms, back in the envelope. Participants were then asked to return this envelope to their child’s school.

The researcher collected these envelopes from the school on the day of her visit to facilitate the adolescent participants’ completion of the questionnaire. Debriefing forms for caregiver participants were provided, and the researcher requested that these were disseminated to participating caregivers.

5.6.2.14 Online-recruited participants

When participants clicked on the link to the study, a webpage was loaded onto their screen that contained the information included in the information sheet provided to school-recruited participants, amended to reflect the fact that participants were asked to progress through the questionnaire by completing each page and then clicking the button labelled ‘Next’. Participants were asked to tick boxes on-screen that confirmed that they understood this information and consented to participate in the study, and to click the button labelled ‘Next’ to commence the questionnaire.

Participants progressed through the questionnaire at their own pace. When participants completed the final section of the questionnaire, a webpage loaded that contained the information included in the debriefing sheet provided to school-recruited participants.

5.7 Preliminary interrogation of data

Prior to formal analysis, data were reviewed using IBM Statistical Package for Social Sciences (SPSS) (IBM Corp., 2017).

5.7.1 Missing data

Missing data are a common feature in survey research (Scheffer, 2002). Missing data can be categorised as follows: (a) Data can be missing completely at random (MCAR), where the missingness mechanism does not depend on the variable of interest, or on any other variable, observed in the data set (Scheffer, 2002); (b) missing at random (MAR), or conditionally missing at random (Graham, 2009), where missing data values do not occur as a consequence of the variable of interest but are related to some other variable in the data set (R. J. A. Little & Rubin, 1989); or (c) not missing at random (NMAR), which occurs when the missingness mechanism depends on the actual value of the missing data (Scheffer, 2002) and is considered a more serious problem for researchers than data that are MCAR or MAR.

Selection of a method for addressing missing data is of critical importance in order to minimise bias and maximise the use of available information (Allison, 2001). One such method is the Expectation Maximisation (EM) procedure for multiple imputation (Graham, 2009).

The EM technique imputes missing data by using an iterative estimation procedure to converge at a maximum-likelihood estimate that averages over the distribution of missing values (Schafer, 1997). It is considered a more advantageous choice of technique than single imputation methods such as listwise and pairwise deletion (Allison, 2001). EM is suitable when data are MCAR or MAR, or when the percentage of missing data is small to minimal. The nature of missingness is determined by Little's (1988) MCAR test, where a significant chi-square value indicates that data are not missing completely at random.

Firstly, it was observed during data entry that a number of participants appeared to miss the middle two pages of the questionnaire booklet, on which the Affective Attitudes and Perceived Controllability, Anger, and Sympathy scales were printed. Therefore, they had no data for these two scales. This was confirmed by preliminary analyses, which showed that there were 13 participants who had missing values for all items on these scales. These participants were removed from the dataset, and their descriptive information was analysed to confirm whether there was a systematic reason underpinning their omission of the middle two pages. This did not appear to be the case.

Missing values analysis revealed that there were five participants with >10% missing data; this is considered a large amount of missing data, which may bias the results of subsequent statistical analyses (Bennett, 2001). Tabachnik and Fidell advise that if very few cases have large amounts of missing data, and the pattern of missingness among these casese appears random, deletion of these cases is a reasonable choice (Tabachnik & Fidell, 2007). These participants' responses were thus deleted from the dataset. Little's MCAR test was then conducted, and was found to be significant, χ^2 (9999) = 10459.394, $p < .001$, indicating that the data were not MCAR. There were no variables with 5% or more missing values, so the data were deemed suitable for EM. Missing data were thus imputed using the EM algorithm.

5.7.2 Normality of distribution

Descriptive statistics were generated for all study variables, in order to assess the normality of distributions (specifically, by calculating skewness and kurtosis). Skewness and kurtosis values of +/- 1.0 are considered excellent (George & Mallery, 2016). Acceptable skewness and kurtosis values are +/- 3.0 and +/- 7.0, respectively (Finney & DiStefano, 2013). It is important to remain cognisant that formal inference tests (i.e., the Kolmogorov-Smirnov and Shapiro-Wilk tests of normality) are likely to reject the null hypothesis of normality in samples with a larger *N*, even when there are only minor deviations from normality (Field, 2018; Tabachnik & Fidell, 2007). Additionally, the impact of departure from zero kurtosis diminishes with samples of 200 or more participants (Tabachnik & Fidell, 2007; Waternaux, 1976). Although Kolmogorov-Smirnov and Shapiro-Wilk tests were significant for all variables in the current study, skewness and kurtosis values for all variables fell within these acceptable ranges and as such, data were considered normally distributed.

5.8 Analytic plan

Chi-square (χ^2) tests were used to compare categorical outcome variables (e.g., level of concern for the vignette character) across participant groups (e.g., sex, age once discretised). Analysis of the adjusted standard residuals indicated where the differences lay (an adjusted standard residual > 2.0 indicates that this is significant). For continuous outcome variables, where a mean was calculated for each participant group, *t*-tests were conducted in order to determine whether significant differences existed between these means. In cases where there is an imbalance of characteristics across groups (specifically, when comparing adolescents' and caregivers' responses, where the gender breakdown is different in each group), ANCOVA tests are conducted. Mann-Whitney U tests were run to investigate differences between groups on ordinal (ranked) categories (e.g., recovery time measured categorically). In order to explore the influence of these variables on participants' intentions to engage in different types of support-giving (as assessed by the subscales of the MIMHS), hierarchical multiple regression (HMR) was employed.

Critical significance levels of $p = .05$ and $p = .001$ are reported throughout. It is noted that a large number of tests are conducted in this thesis and, as such, caution is warranted when results are significant at $p < .05$ but $> .001$, due to the likelihood of Type 1 error. In order to aid interpretation of significance, effect sizes are reported, with interpretation of effect sizes conducted by following Cohen's (1988) suggested benchmarks of small ($d = .2$), medium ($d = .5$) and large ($d = .8$).

5.9 Conclusion

The primary aim of this chapter was to describe the methods employed to address the research questions of the current study, including the specific instruments selected to measure study variables. In reviewing the methods and instruments currently available, it became evident that no standardised means of assessing support-giving intentions existed (or could be identified at the time of study design). To ensure that the key outcome variable of this study could be measured in a systematic and well-defined manner, it was decided that a scale measuring different types of support-giving intentions would be developed. As such, the development of the Modes of Intended Mental Health Support scale is detailed in Chapter 6.

Chapter 6 Development of the Modes of Intended Mental Health Support Scale

6.1 Introduction

This chapter will describe the development of the Modes of Intended Mental Health Support (MIMHS) scale. Although a number of authors have provided scale development strategies (e.g., Dawis, 1992), there tends to be little variation in the steps and processes described (Worthington & Whittaker, 2006). DeVellis' (2017) recommendations are the most current resource, and as such, functioned as a guide for the current study. The process of establishing the scale's remit and generating an item pool is detailed. Following this, pre-testing of the scale with pilot samples is described. Finally, the process and results of exploratory factor analysis of the scale, with larger samples, are reported.

6.2 Determining what is to be measured

DeVellis (2017, p. 267) recommends that researchers start by setting out "a well-formulated definition of the phenomenon they seek to measure… a description of how the new construct relates to existing phenomena and their operationalisations." This definition should be guided by theory and existing research (DeVellis, 2017; Strauss & Smith, 2008). The current study aims to explore the 'informal' support provided by caregivers and peers to a young person experiencing depression, and, more specifically, the type, or mode, of support an individual may offer. As such, it is necessary to operationally define informal mental health support.

6.2.1 Measuring informal mental health support

The purpose of this scale is to establish the behavioural response of an individual to the exhibition of signs of mental health issues by another individual (henceforth, the ‘target’). As such, the working definition of ‘informal mental health support’ in the current thesis is “Behaviour of an individual without professional training or expertise, which is intended to support a target, who is showing signs of mental ill health.”[15]

6.2.1.15 How this construct relates to existing phenomena and their operationalisation

This definition of informal mental health support draws upon literature relating to cognate concepts, such as intervening against suicide, and ‘Mental Health First Aid’ (MHFA). For example, in reference to the development of the Willingness to Intervene against Suicide (WIS) scale, Aldrich (2015, p. 335) discusses the notion of “intervening on behalf of another person’s welfare”, which highlights that this behaviour aims to benefit another person’s wellbeing. This suggests that the support-giver has identified or perceives a problem that the target individual is experiencing. Another related concept is that of MHFA, which is defined as “the help provided to a person developing a mental health problem or in a mental health crisis” (Kitchener & Jorm, 2008, p. 55). More recently, the definition has been expanded upon to include the help provided to “a person experiencing the worsening of a mental health problem” (Kitchener, Jorm, & Kelly, 2015). While this definition of MHFA appears quite broad and inclusive, the concept itself is typically deployed in studies that aim to evaluate the *quality* of individuals’ responses, by measuring against a standard of MHFA best practice, derived from a series of expert consensus studies that created a set of guidelines for the public on how to appropriately engage in MHFA (e.g., Langlands, Jorm, Kelly, & Kitchener, 2008). For example, one study scored participants’ responses to vignettes by awarding one point for each component of the MHFA ‘action plan’ that they mention (A. Rossetto et al., 2014a). In contrast to

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[15] Note that “behaviour” here can refer to both taking action and refraining from action, as studies have demonstrated that some individuals may perceive that “not getting involved” is most helpful for the target (S. Byrne et al., 2015).

the broader concept of ‘informal mental health support’ under investigation in the current study, which is taken to refer to all behaviours *perceived by the support-giver to be supportive* (which may not necessarily align with expert opinion, nor be perceived as supportive by other laypeople (Cutrona, Cohen, & Igram, 1990)), MHFA appears to be more appropriately considered the actions to be *ideally* undertaken, as per expert advice.

6.2.1.16 Guidance from theory and existing research

The review of theory and research on informal mental health support (see Chapter 3 and 0), suggests that individuals may respond in a way they perceive as helpful, but that would not be recommended by mental health professionals (e.g., encouraging the use of alcohol; Byrne, Swords, & Nixon, 2015; Kelly, Jorm, & Rodgers, 2006). Studies have found that “participants perceived or defined helping in various ways” (A. Rossetto, Jorm, & Reavley, 2018, p. 58). Furthermore, while most social support theory implies that there are objectively supportive things to say depending upon the circumstances (Hobfoll, 2009), relational regulation theory states that what is supportive is primarily a matter of each perceiver’s idiosyncratic tastes (Lakey & Orehek, 2011). Additionally, it appears that provision of support is not necessarily predicated upon recognition that the target’s problem is related to mental health, but rather, simply that a need for help exists. The purpose of the current study is not to make a judgement about the quality of individuals’ responses or to measure whether the response is actually helpful.

Instead, the conceptual definition of informal mental health support in this context aims to capture the full range of responses that individuals may offer, whether or not these would meet best practice standards. Also important to capture in this definition is the informal nature of this support. The term ‘informal’ is seen as analogous to ‘non-professional’, and is applied here to the provider of help. The term ‘informal’ has been selected in light of criticism directed towards other usage of the term ‘expert’ (Baker, Lovell, & Harris, 2006), which does not clearly distinguish between professionals and non-professionals (Jorm, 2015); for example, it is not intrinsically clear whether ‘experts by experience’ are included or excluded.

6.2.2 Measuring *modes* of informal mental health support

The reason for assessing the *mode* of support is because empirical evidence, and theory, indicates that ‘informal mental health support’ may be seen as an overarching category that describes a wide range of behaviours. For example, Rossetto and colleagues have developed a model of help-giving towards people with a mental health problem, which suggests that actions taken by the helper fall on a helping spectrum, from ‘not helping’ to ‘adopting a carer role’ (A. Rossetto et al., 2018). In a qualitative study of helping intentions towards peers with depression, Amarasuriya et al. (2017) reported that participants’ responses fell into seven categories: Consider approach to person; assess risk of harm; explore problem; provide support; encourage/help to seek professional help; encourage/help to seek informal help; encourage/help in self-help strategies. Categorisation of behaviours is also seen in the social support literature; one recent paper suggested that “supportive individuals make available or provide what can be termed emotional support (e.g., expressions of caring), informational support (e.g., information that might be used to deal with stress), tangible support (e.g., direct material aid, also referred to as instrumental, practical, or financial support), and belonging support (e.g., having others to engage with in social activities)” (Holt-Lunstad & Uchino, 2015, p. 185). Drawing on this information from the literature, it appears that informal mental health support is best considered a multidimensional construct, with different forms (or modes) of behaviour captured within this overarching concept.

6.2.3 Measuring *intentions* to provide informal mental health support

Unfortunately, the direct observation of natural family and/or peer interactions featuring the provision of this support would be difficult, if not impossible. However, the theory of planned behaviour (TPB; Ajzen, 1991), which remains the dominant model for understanding health-related behaviours, suggests that an individual's behaviour is proximally determined by the formation of a behavioural intention. Therefore, by assessing individuals' intentions to give support, the researcher can obtain a measurement that approaches the individuals' responses to a real-life situation. Thus, theory supports that the current scale should measure *intentions* to engage in different modes of support-giving. This is also support by existing research in the area. Rossetto et al. (2016) found that participants' help-giving intentions towards a hypothetical person experiencing mental illness were associated with their real-life behaviours. Correlations between support-giving intentions and actions were also reported in a previous study by the same research group (A. Rossetto et al., 2014a). Moreover, as described by Jorm, Blewitt, et al. (2005), participants' reported support-giving intentions could be considered to place an upper limit on their actual responses, where if they fail to state their intentions relating to a particular action, it is unlikely that they would exhibit this in real-life.

6.3 Item pool generation

The next stage of scale development involves generating a large pool of candidate items for inclusion in the scale (DeVellis, 2017). Given the focus of the current study, a criterion for item choice was that the associated behaviour could be performed by both caregivers and peers. Some items required minor adjustments to meet this criterion (for example, young people responded to 'I would tell X's parent or key caregiver about the situation', while parents responded to 'I would tell X's other parent or key caregiver about the situation'). At this stage of scale development, it is recommended to include multiple items that appear to assess the same or similar behaviours in order to maximise face validity; redundancy is not problematic at this stage, whereas nuanced differences between items may prove important in assessing the target construct (DeVellis, 2017; Matsunaga, 2011).

Initial generation of candidate items drew from related tools, such as the Willingness to Intervene Against Suicide Scale (Aldrich et al., 2014) and the intentions subscale of a similar suicide intervention questionnaire (Tarquini, 2010). Other studies asked participants about a small number of specific behaviours (Jorm et al., 2008b); these responses were reviewed as potential candidate items also. Where necessary, items were amended to be appropriate for the context of the current study. Previous research with Irish adolescents has also shown that some young people state that they would not support a peer showing signs of depression (Byrne et al., 2015). It was thus decided that items describing a 'non-response' (e.g., ignoring the young person) should also be included. Original items were also written specifically for the purposes of the current study, and reviewed using DeVellis' recommendations on item length and valence. Candidate items were reviewed for clarity, taking particular consideration of the fact that the youngest participants in this study would be 12-years-old (Borgers et al., 2000). The final item pool consisted of 36 items, see Table 3.

Table 3: Item pool for inclusion in the developed scale

Item	**Drawn from**	**Original item wording, if amended**
1. I would suggest X seek professional help	Jorm, Morgan, & Wright (2008)	
2. I would make an appointment for X to see a professional*	Jorm et al., (2008)	Was "I would make an appointment for X to see a general practitioner (GP)"
3. I would talk to a friend about my concern for X*	Tarquini (2010)	Was "I would talk to a friend about the situation"
4. I would encourage X to go to a teacher or another member of school staff (e.g., school	Original to current study	
5. I would wait to gather more information before saying or doing anything	Tarquini (2010)	
6. I would tell X that his/her new pattern of behaviour is unacceptable	Tarquini (2010)	
7. I would talk X out of his/her negative feelings*	Tarquini (2010)	Was "I would cheer her up by talking her out of her negative feelings"
8. I would try to distract X from his/her problems	Tarquini (2010)	
9. I would encourage X to look on the bright side of things	Tarquini (2010)	
10. I would ask a friend for advice about what do to	Original to current study	
11. I would offer to accompany X to an appointment with a mental	Original to current study	
12. I would tell X's parent or key caregiver about the situation*	Tarquini (2010)	Was "I would tell one of her parents about the situation"
13. I would tell one of my family members about the situation	Original to current study	
14. I would not say or do anything	Tarquini (2010)	

Item	Drawn from	Original item wording, if amended
15. I would tell a teacher or another member of school staff (e.g. school counsellor) about	Original to current study	
16. I would give X information on how to make appointment to see a mental health	Original to current study	
17. I would call a crisis hotline (e.g. Samaritans, Childline) for help and advice*	Aldrich, Harrington, & Cerel (2014)	Was "I would call a crisis hotline for help and advice"
18. I would tell X to stop being so dramatic*	Aldrich et al. (2014)	Was "I would tell the suicidal person to stop being so dramatic"
19. I would give X space*	Aldrich, et al. (2014)	Was "Give the suicidal person space he or she is sad and needs time to
20. I would express my concern about X to others	Aldrich et al. (2014)	
21. I would talk to one of X's friends about my concern for X*	Aldrich et al. (2014)	Was "I would talk to a mutual friend about my concern for her"
22. I would encourage X to seek advice from a website or online support forum*	Aldrich et al. (2014)	Was "Tell the suicidal person to seek advice from a suicidal webpage"
23. I would encourage X to seek help from a crisis hotline*	Aldrich et al. (2014)	Was "Encourage the suicidal person to seek help from a suicide crisis hotline"
24. I would seek help from a website or online support forum*	Aldrich et al. (2014)	Was "Seek help from a webpage about suicide prevention"
25. I would ignore the subject unless X brought it up first	Aldrich et al. (2014)	Was "Ignore the subject of suicide unless the suicidal person brings it
26. I would tell X that I am concerned about him/her*	Aldrich et al. (2014)	Was "Tell the suicidal person I am concerned about her or him"
27. I would encourage X to talk to his/her family*	Aldrich et al. (2014)	Was "Encourage the suicidal person to talk to his or her family"
28. I would ask X if anything is wrong	Aldrich et al. (2014)	

Item	Drawn from	Original item wording, if amended
29. I would ring a professional for help and advice about the situation*	Aldrich et al. (2014)	Was "Talk to a professional for help and advice about the suicidal person's situation"
30. I would contact X's family about my concern	Aldrich et al. (2014)	
31. I would listen to X's problems in an understanding way	Jorm et al. (2008)	
32. I would talk to X firmly about getting his/her act together	Jorm et al. (2008)	
33. I would ask X if he/she is feeling suicidal	Jorm et al. (2008)	
34. I would suggest X has a few drinks to forget about his/her troubles	Jorm et al. (2008)	
35. I would encourage X to become more physically active	Jorm et al. (2008)	
36. I would wait to see if X's symptoms continued before saying or doing anything	Original to current study	

* denotes that the item was amended from its original version

6.4 Determine format for measurement

DeVellis (2017) suggests that the choice of question format should occur simultaneously with item pool generation. Numerous question formats exist, but composite measures such as Likert-type scales are frequently used "due to the unambiguous ordinality of response categories" (Babbie, 2014, p. 185). Participants' ability to discriminate meaningfully between response options on a Likert-type scale is an important consideration (DeVellis, 2017); it is essential that items "produce responses that can be scored in a meaningful way in relation to the construct definition" (Worthington & Whittaker, 2006, p. 813). There exists disagreement, however, regarding the inclusion of a 'neutral' middle response option. Some proponents contend that a midpoint provides a legitimate option for participants who genuinely do not have an opinion (Courtenay & Weidemann, 1985; Weems & Onwuegbuzie, 2001). However, other methodologists have suggested that the middle response option is "at least occasionally utilised as a 'dumping group' for not applicable, uncertain, indifferent or ambivalent response orientations" (Kulas & Stachowski, 2009, p. 489). Bearing the nature of the current study in mind, it is also possible that participants may prefer to choose a neutral option out of reluctance to reveal a stigma-associated response (Henderson et al., 2012). Further, others argue that a neutral response option stems from researchers' satisficing, and furthermore encourages participant satisficing (Krosnick, 1999; Krosnick et al., 2012, 1996; Krosnick & Presser, 2010). What is more, the ambiguity associated with neutral response options has been identified as particularly problematic for child and adolescent participants in research (Carson, 2007). Therefore, an even number of response options was specified for the current scale. Scale reliability and validity has been shown to be compromised when there are fewer than three and more than eleven response options (Krosnick & Presser, 2010). Four or six response options are typically utilised (L. A. Clark & Watson, 1995); four response options has been deemed optimal for research involving children and young people (Borgers, Hox, & Sikkel, 2004). The quality of young people's responses has also been shown to improve when all points on the response scale are clearly labelled (Borgers et al., 2003). A four-point response scale was thus chosen, and the points on the scale were labelled '*Extremely unlikely*' (1), '*Unlikely*' (2), '*Likely*' (3), and '*Extremely likely*' (4). Response options were presented in a matrix format (Babbie, 2014). The scale and response options can be viewed in Appendix L.

6.5 Pre-test of scale with pilot sample

The scale was piloted as part of the overall questionnaire instrument, in April 2015. A full description of this pilot study is included in section 5.5 of Chapter 5. This pre-test of the scale allowed participants to give feedback on the comprehensibility of items and response options, which has been deemed an important but often neglected stage of scale (and questionnaire) development (de Leeuw, Borgers, & Smits, 2004). A post-primary school in the Leinster region was recruited to facilitate this pilot study. Sixty-six adolescents (32 male, age range 12 to 18 years, *M* =15.09 years) and twenty-three caregivers (18 mothers, 2 fathers, 3 did not indicate type of caregiver[16]) agreed to participate in the study. The questionnaire instrument piloted included two age-matched (same age as adolescent participant; same age as adolescent child of caregiver participant) and sex-matched (same sex as adolescent participant; same sex as adolescent child of caregiver participant) vignettes. One vignette described a young person displaying signs of depression, according to DSM-IV diagnostic criteria (Carr, 2008). The other vignette described a young person experiencing a transient life crisis; this vignette functioned as a control. Further information about these vignettes and their development can be viewed in section 5.4.2.4 of Chapter 5. After reading each vignette, participants completed the MIMHS scale, along with the other sections of the questionnaire. Caregiver participants completed the questionnaires in their own homes, and were invited to provide written feedback at the end of the questionnaire. Adolescent participants completed the questionnaires in school, during school hours, and were invited to give feedback verbally following completion of the questionnaire.

No caregiver participant indicated any issues with the MIMHS scale. Adolescent participants were asked about the wording of MIMHS items and the language used across the items. Participants indicated that all items in the MIMHS scale were clearly worded and easy to understand. The use of clarifications/examples in parentheses was reported as useful; for example, in the items that addressed crisis hotlines, Samaritans and Childline were provided as examples.

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[16] Caregivers' dates of birth were not collected in the pilot study. This was an oversight and was amended for the main stage of data collection.

6.6 Administration of scale to larger sample

A new sample of 535 adolescent participants (277 male, age ranging from 12 to 18 years, *M* = 14.87 years) and 321 caregiver participants (237 mothers, 51 fathers, 7 other types of caregivers, ranging in age from 20 to 63 years, *M* = 46.2 years, with 73 participants not providing their date of birth) was recruited through 14 post-primary schools across the Leinster region of Ireland. These participants completed the MIMHS scale as part of the questionnaire instrument. Participants read one vignette, describing a young person showing signs and symptoms of depression, and completed the scale in response. The control vignette was removed from the questionnaire instrument based on feedback from the pilot study (see section 5.5 of Chapter 5 for more information). Exploratory factor analysis (EFA) of the scale was carried out using these participants' responses. EFA is a statistical technique used to explore the links between the observed items of the MIMHS scale, and their underlying factors (Hansenne, Delhez, & Cloninger, 2010), and is particularly relevant in the scale development process, as it allows researchers to identify the number of factors that underlie the set of items, as well as the defining features of these factors (Tabachnik & Fidell, 2007; Worthington & Whittaker, 2006).

6.7 Methodological considerations underpinning EFA

EFA has been deemed “a complex procedure with few absolute guidelines and many options” (Costello & Osborne, 2005, p. 1), however “any thoughtful analytic choices that yield clear factors are justified” (Thompson, 2004, p. 48). Conducting EFA requires prior consideration of various methodological issues, which are detailed in the sections below.

6.7.1 Sample size

Sample size is one of the main methodological considerations associated with conducting an EFA; however, recommendations of the optimal size vary widely (MacCallum, Widaman, Zhang, & Hong, 1999). A sample size of at least 300 has been deemed necessary to comfortably run EFA, and a sample of 500 participants is ‘very good’ (Comrey & Lee, 1992; Tabachnik & Fidell, 2007). Thus, the size of the samples in the current study ($N = 535$ for adolescent participants, $N = 321$ for caregiver participants) was considered appropriate for EFA.

6.7.2 Factorability of the data

The factorability of the data was assessed using the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy and Bartlett’s test of sphericity. In the adolescent sample, the KMO value was .832, and in the caregiver sample, the KMO value was .783; values above .6 are required for EFA (Tabachnik & Fidell, 2007). Bartlett’s test was significant in both samples, $\chi^2(630) = 5973.027$, $p < .001$ for the adolescent sample and $\chi^2(630) = 3575.472$, $p < .001$ for the caregiver sample. If Bartlett’s test is significant, it indicates that the correlation matrix is an identity matrix (i.e. that the variables being analysed are related to each other) and that factors can sensibly be extracted from the matrix (Tabachnik & Fidell, 2007; B. Thompson, 2004).

6.7.3 Distribution of responses

Before conducting EFA, it is recommended that tests of distributional normality are conducted (L. A. Clark & Watson, 1995), as normality enhances the solution, although assumptions regarding the distributions of variables are not in force (Tabachnik & Fidell, 2007). The Shapiro-Wilk test should be used for datasets smaller than 2000 participants and is therefore the appropriate test for the current study. The Shapiro-Wilk test was significant for all 36 of the scale items in both the adolescent sample (see Table 4) and the caregiver sample (see Table 5), indicating that the data significantly deviate from a normal distribution. Thus, a factor extraction method that is robust to deviation from normality is advised.

Table 4: Shapiro-Wilk test of distributional normality for MIMHS items in the adolescent sample

	Shapiro-Wilk		
Item	**Statistic**	***df***	**Sig.**
MIMHS1	.833	535	.000
MIMHS2	.856	535	.000
MIMHS3	.708	535	.000
MIMHS4	.863	535	.000
MIMHS5	.809	535	.000
MIMHS6	.781	535	.000
MIMHS7	.850	535	.000
MIMHS8	.813	535	.000
MIMHS9	.756	535	.000
MIMHS10	.817	535	.000
MIMHS11	.864	535	.000
MIMHS12	.864	535	.000
MIMHS13	.534	535	.000
MIMHS14	.876	535	.000
MIMHS15	.859	535	.000
MIMHS16	.826	535	.000
MIMHS17	.590	535	.000
MIMHS18	.846	535	.000
MIMHS19	.865	535	.000
MIMHS20	.872	535	.000
MIMHS21	.818	535	.000
MIMHS22	.855	535	.000
MIMHS23	.853	535	.000
MIMHS24	.859	535	.000
MIMHS25	.804	535	.000
MIMHS26	.772	535	.000
MIMHS27	.733	535	.000
MIMHS28	.691	535	.000
MIMHS29	.853	535	.000
MIMHS30	.877	535	.000
MIMHS31	.633	535	.000
MIMHS32	.819	535	.000
MIMHS33	.881	535	.000
MIMHS34	.643	535	.000
MIMHS35	.828	535	.000
MIMHS36	.853	535	.000

Table 5: Shapiro-Wilk test of distributional normality for MIMHS items in the caregiver sample

Item	Shapiro-Wilk		
	Statistic	***df***	**Sig.**
MIMHS1	.779	321	.000
MIMHS2	.794	321	.000
MIMHS3	.492	321	.000
MIMHS4	.877	321	.000
MIMHS5	.791	321	.000
MIMHS6	.775	321	.000
MIMHS7	.870	321	.000
MIMHS8	.875	321	.000
MIMHS9	.822	321	.000
MIMHS10	.798	321	.000
MIMHS11	.697	321	.000
MIMHS12	.773	321	.000
MIMHS13	.282	321	.000
MIMHS14	.764	321	.000
MIMHS15	.875	321	.000
MIMHS16	.864	321	.000
MIMHS17	.515	321	.000
MIMHS18	.848	321	.000
MIMHS19	.602	321	.000
MIMHS20	.862	321	.000
MIMHS21	.862	321	.000
MIMHS22	.861	321	.000
MIMHS23	.857	321	.000
MIMHS24	.863	321	.000
MIMHS25	.618	321	.000
MIMHS26	.647	321	.000
MIMHS27	.621	321	.000
MIMHS28	.577	321	.000
MIMHS29	.795	321	.000
MIMHS30	.875	321	.000
MIMHS31	.491	321	.000
MIMHS32	.788	321	.000
MIMHS33	.867	321	.000
MIMHS34	.277	321	.000
MIMHS35	.747	321	.000
MIMHS36	.767	321	.000

6.7.4 Number of factors

Upon confirmation of the suitability of the data for EFA, the number of reliable and interpretable factors in the data set must be assessed (Tabachnik & Fidell, 2007). Deciding how many factors to retain has been described as “one of the thorniest problems a researcher faces” in EFA (Hubbard & Allen, 1989, p. 155). Many methodologists have argued that, in most circumstances, there is no true operating model that has the potential to perfectly describe the population factor structure, and that the task of the researcher is instead to find the optimal (rather than the ‘correct’ or ‘true’) number of factors (e.g., MacCallum, 2003). Using multiple strategies to determine factor retention is recommended in Thompson’s (2004) decision sequence for EFA.

6.7.4.17 Parallel analysis

Parallel analysis (PA), developed by Horn (1965), is one method for determining the optimal number of factors that has been demonstrated to perform well (Crawford et al., 2010; Green, Thompson, Levy, & Lo, 2015; Piccone, 2009). Syntax developed by O’Connor (2000) was used to obtain the necessary real-data eigenvalues for parallel analysis. A set of eigenvalues are then extracted from random datasets that parallel the actual dataset in terms of the number of cases and variables.

Two ways of conducting parallel analysis were trialled. First, random datasets were generated through additional syntax written by O’Connor (2000). The eigenvalues derived from the real data were then compared to the eigenvalues that corresponded to the 95th percentile of the distribution of random data eigenvalues. In the adolescent sample, each of the first eleven eigenvalues from the real data (6.019330, 2.542140, 1.792782, 1.319451, 1.154705, .784779, .754471, .480673, .387917, .285221, .261174) were each greater than the eigenvalue at the corresponding rank from the random data (.663931, .584962, .528959, .480554, .437172, .402170, .370178, .337349, .306820, .277348, .249564). The twelfth random-data eigenvalue (.221820) was larger than the twelfth real-data eigenvalue (.217577). As “researchers would not be interested in a factor that does not account for more variance than the parallel factor obtained from random numbers" (Hayton, Allen, & Scarpello, 2004, p. 194), this indicates that eleven factors should optimally be extracted. In the caregiver sample, the first ten eigenvalues from the real data (5.147250, 3.144820, 2.095529, 1.279462, 1.097757, .826902, .626521, .526774, .444197, .437962) were each greater than the eigenvalue at the corresponding rank from the random data (.907047, .795937, .715890, .655488, .600019, .550432, .503984, 457661, .417294, .380475). The eleventh random-data eigenvalue (.341888) was larger than the eleventh real-data eigenvalue (.286706), indicating that ten factors should optimally be extracted. An eleven-factor or ten-factor structure of thirty-six items suggests the presence of minor factors, and contends with the overarching goal of simplicity (Fabrigar, MacCallum, Wegener, & Strahan, 1999).

A second parallel analysis was conducted using the Monte Carlo PCA for Parallel Analysis software developed by Watkins (2006). The mean value of eigenvalues generated through 1,000 replications of random datasets with 36 variables and 535 participants was calculated, for the adolescent sample. This process was then repeated with 1,000 replications of random datasets with 36 variables and 321 participants, for the caregiver sample. For the adolescent sample, the first three eigenvalues from the real data (6.019330, 2.542140, 1.792782) were larger than the first three mean eigenvalues generated using this method (1.5245, 1.4619, 1.4138). However, the fourth random-data mean eigenvalue (1.3732) was greater than the fourth real-data eigenvalue (1.319451), indicating that three factors should be extracted. For the caregiver sample, the first three eigenvalues from the real data (5.147250, 3.144820, 2.095529) were greater than the first three mean eigenvalues generated (1.6985, 1.6095, 1.5454), but the fourth mean eigenvalue (1.4879) was larger than the fourth real-data eigenvalue (1.279462), again indicating the presence of three factors.

6.7.4.18 Eigenvalues-greater-than-one rule

The eigenvalues-greater-than-one rule, developed by Guttman (1954) but often incorrectly attributed to Kaiser, is the default decision-making strategy for determining the optimal number of factors (B. Thompson, 2004). While the validity of this rule has been questioned, it has been observed that if following the eigenvalues-greater-than-one rule results in error, typically this error relates to *over*-estimating the number of factors (Fabrigar et al., 1999). In both samples, the first five real-data eigenvalues have values greater than one. In this case, the rule specifies six *fewer* factors than does the PA conducted using O'Connor's syntax for the adolescent sample, and five fewer for the caregiver sample. Specifying too few factors has traditionally been considered a more severe error than specifying too many (Hayton et al., 2004). However, DeVellis (2017, p.404) states that "in the course of scale development, we often want to know about the few, most influential sources of variation underlying a set of items, not every possible source we can ferret out". In addition, it is important to note that in the case that PA is inaccurate, it tends to over-factor (Zwick & Velicer, 1986).

6.7.4.19 Velicer's Minimum Average Partial test

Velicer's Minimum Average Partial (MAP) test (Velicer, Eaton, & Fava, 2000) calculates the average of squared partial correlations after each factor is partialled out. The number of factors that produces the minimum mean squared partial correlation is the number of factors suggested to retain (Tabachnik & Fidell, 2007). The MAP test, run through SPSS using syntax developed by O'Connor (2000), suggested that five factors should be extracted for both samples.

6.7.4.20 Scree plot

Although the scree plot has been critiqued due to the subjective nature of its interpretation, studies have indicated that it provides a reasonably accurate indication of the number of factors (Fabrigar et al., 1999). An inspection of the scree plot (Cattell, 1966) also appeared to support the extraction of five factors for the adolescent sample (see Figure

8 below). The scree plot generated from the caregiver sample appeared to support the presence of four factors (see Figure 9).

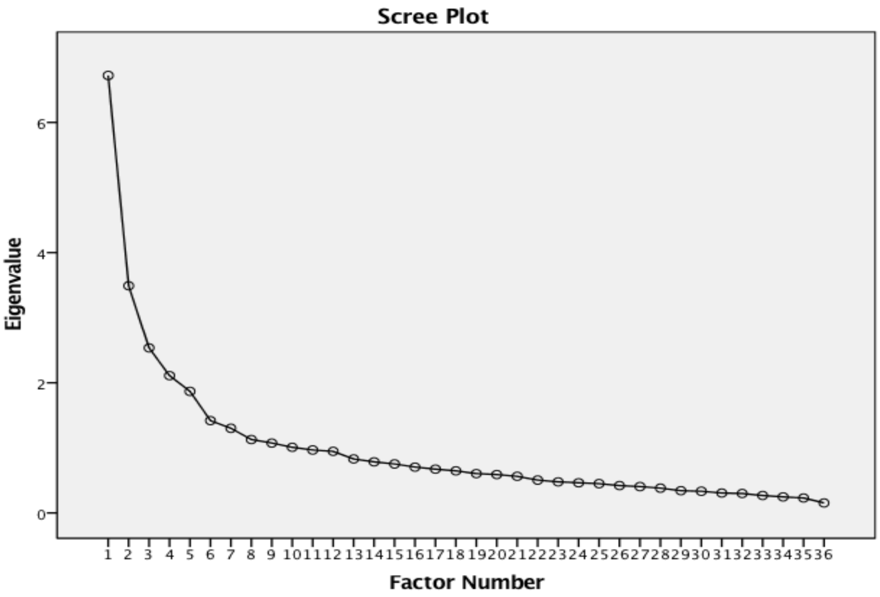

Figure 8: Scree plot of eigenvalues derived from iterative principal axis factoring of the real data from the adolescent sample

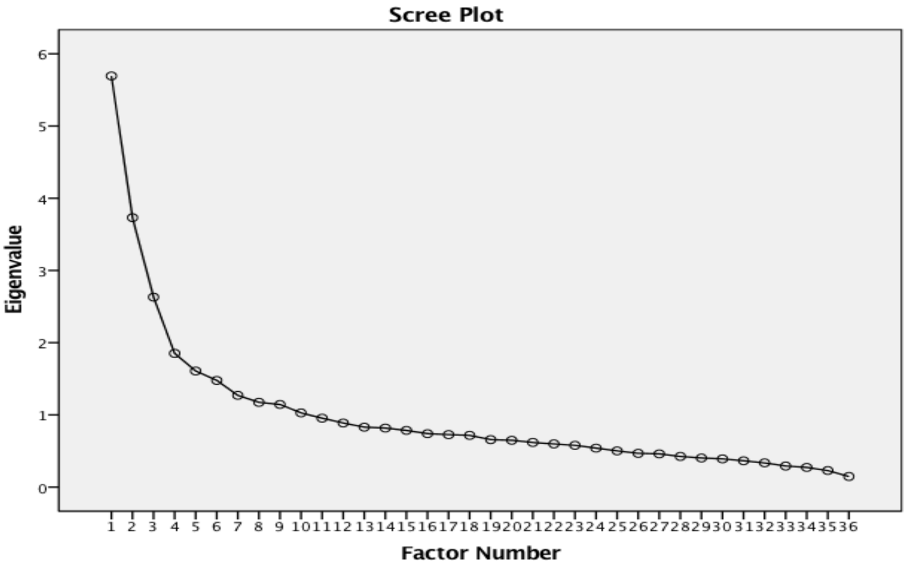

Figure 9: Scree plot of eigenvalues derived from iterative principal axis factoring of the real data from the caregiver sample

Given the results of the PA conducted through Watkin's software (indicating the presence of three factors in both samples), and the convergence between the eigenvalues-greater-than-one rule (five factors in both samples), Velicer's MAP test (five factors in both samples), and the scree plot (five factors for the adolescent sample, four factors for the caregiver sample), it was decided that both a three-factor, a four-factor, and a five-factor solution would be tested in both samples in order to find the "cleanest" factor structure (A. B. Costello & Osborne, 2005). The process will be detailed first in relation to data from the adolescent sample, after which the process used in analysing the data from the caregiver sample will be reported.

6.8 Testing factor solutions with data from the adolescent sample

Principal-axis factoring (PAF) was chosen as the factor extraction method, because it fits common models to data without distributional assumptions (A. B. Costello & Osborne, 2005; Fabrigar et al., 1999). PAF has also been shown to provide more accurate results in terms of population factor loadings than principal components analysis (Widaman, 1993), and is not affected by problems that occasionally occur with maximum-likelihood extraction (Gorsuch, 1997). Oblique rotation was employed as some degree of inter-relatedness among the factors is expected across most psychological factors (DeVellis, 2017). As such little literature exists on the relationship between different types of support-giving behaviours, promax rotation was chosen as the specific type of oblique rotation. This decision was based on the fact that, if it happens to be the case that factors are uncorrelated (or nearly so), promax rotation will account for lack of correlation by permitting rotation that is close to orthogonal, thus improving the fit to simple structure (Fabrigar et al., 1999).

6.8.1 Three-factor solution

The three factors that were extracted explained 33.5% of the variance, with factor one explaining 18.3%, factor two explaining 8.7%, and factor three explaining 6.6%. When there are three or more factors, the pattern matrix should be used for interpretation instead of the factor plot (Gie Yong, Pearce, Yong, & Pearce, 2013). This matrix represents the variance in an item accounted for by the factors (Matsunaga, 2011). The pattern matrix showing each item's loading on the three factors is shown in Table 6.

The criteria for determining the acceptable magnitude of loadings and cross-loadings has been described as a matter of researcher preference (Tabachnik & Fidell, 2007). Setting the minimal loading cut-off at .4 has been described as the lowest acceptable threshold, and .6 the most conservative threshold (Matsunaga, 2011). In terms of cross-loadings, .32 has been deemed a reasonable cut-off point for the highest loading acceptable on a second factor (Worthington & Whittaker, 2006). As can be seen in Table 6, item number 32 loaded on factor one with a coefficient of .570, and had a cross-loading of .340 on factor three. For ease of interpretation, the pattern matrix was re-generated, suppressing factor loadings < .5 (see Table 7).

The factor correlation matrix was also consulted to ensure that no two factors were very highly correlated, indicating redundancy. The highest correlation between any two factors was .490, indicating that the factors were sufficiently independent.

Item communalities can also be a useful guide for the adequacy of the factor solution (Worthington & Whittaker, 2006). The communality represents the extent to which the common factors explain variance in responses to that item (Fabrigar et al., 1999). Just nine of the items had communalities above the recommended cut-off of .4 (A. B. Costello & Osborne, 2005; Worthington & Whittaker, 2006), see Table 8.

Table 6: Pattern matrix for three-factor solution with adolescent sample

	Factor		
Items	**1**	**2**	**3**
MIMHS1	-.173	.573	-.128
MIMHS2	.050	.573	.000
MIMHS3	-.463	.086	.187
MIMHS4	.131	-.171	.131
MIMHS5	-.124	.109	.298
MIMHS6	.566	.081	.288
MIMHS7	.107	-.088	.452
MIMHS8	.038	.010	.196
MIMHS9	.034	-.165	.506
MIMHS10	-.019	.119	.200
MIMHS11	-.335	.500	-.042
MIMHS12	-.121	-.027	.435
MIMHS13	.513	.160	-.160
MIMHS14	.017	.101	.468
MIMHS15	-.195	.611	-.012
MIMHS16	.177	.720	.034
MIMHS17	.737	.055	.106
MIMHS18	.460	-.068	.211
MIMHS19	.041	.046	.685
MIMHS20	.090	-.037	.300
MIMHS21	.027	-.072	.473
MIMHS22	-.013	.528	-.125
MIMHS23	.132	.728	-.023
MIMHS24	.034	.511	-.024
MIMHS25	.559	-.009	-.045
MIMHS26	-.406	.063	.256
MIMHS27	-.423	.009	.392
MIMHS28	-.296	-.067	.229
MIMHS29	.086	.598	.205
MIMHS30	-.020	.087	.654
MIMHS31	-.546	-.059	.185
MIMHS32	.570	.025	.340
MIMHS33	.049	.362	.034
MIMHS34	.371	.013	-.135
MIMHS35	.192	.085	.194
MIMHS36	.404	-.094	.157

Table 7: Pattern matrix for three-factor solution for adolescent sample, with coefficients <.5 suppressed, and coefficients sorted by size of loading on each factor

Items	**Factor** **1**	**2**	**3**
MIMHS17	.737		
MIMHS32*	.570		
MIMHS6	.566		
MIMHS25	.559		
MIMHS31	-.546		
MIMHS13	.513		
MIMHS3			
MIMHS18			
MIMHS27			
MIMHS26			
MIMHS36			
MIMHS34			
MIMHS28			
MIMHS23		.728	
MIMHS16		.720	
MIMHS15		.611	
MIMHS29		.598	
MIMHS2		.573	
MIMHS1		.573	
MIMHS22		.528	
MIMHS24		.511	
MIMHS11			
MIMHS33			
MIMHS4			
MIMHS19			.685
MIMHS30			.654
MIMHS9			.506
MIMHS21			
MIMHS14			
MIMHS7			
MIMHS12			
MIMHS20			
MIMHS5			
MIMHS10			
MIMHS8			
MIMHS35			

*denotes that this item has a cross-loading on another factor >.32

Table 8: Item communalities for three-factor solution

Items	Communalities
MIMHS1	.362
MIMHS2	.310
MIMHS3	.357
MIMHS4	.048
MIMHS5	.182
MIMHS6	.295
MIMHS7	.161
MIMHS8	.037
MIMHS9	.196
MIMHS10	.082
MIMHS11	.459
MIMHS12	.223
MIMHS13	.280
MIMHS14	.269
MIMHS15	.493
MIMHS16	.476
MIMHS17	.484
MIMHS18	.209
MIMHS19	.485
MIMHS20	.074
MIMHS21	.190
MIMHS22	.234
MIMHS23	.462
MIMHS24	.238
MIMHS25	.335
MIMHS26	.334
MIMHS27	.444
MIMHS28	.158
MIMHS29	.477
MIMHS30	.501
MIMHS31	.365
MIMHS32	.316
MIMHS33	.133
MIMHS34	.183
MIMHS35	.062
MIMHS36	.170

6.8.2 Four-factor solution

The four-factor solution accounted for 38.8% of the variance as the addition of the fourth factor addressed 5.3% of variance. The pattern matrix indicated that the only item that loaded >.5 on the fourth factor was item 7, see Table 9.

A one-item factor is not appropriate, as the factor is inherently poorly defined (Tabachnik & Fidell, 2007). Therefore, factor four should not be retained. An examination of the communalities indicated that only two items (17 and 31) on factor one and four items (23, 16, 15, and 29) on factor two had communalities >.4. Overall, the four-factor solution did not appear to be ideal.

6.8.3 Five-factor solution

The fifth factor accounted for an additional 4.98% of the variance in the data. The loadings of items across the five factors can be seen in Table 10. Item 7 is the sole item loading on factor four again; however, items 21 and 20 are now loading on an additional factor. Generally, it is recommended that factors with fewer than three items should not be retained; however, if the two items are highly correlated (i.e., r >.7) and are relatively uncorrelated with other items, it is possible to retain a two-item factor (Gie Yong et al., 2013; Tabachnik & Fidell, 2007). Items 21 and 20 are significantly correlated, $p < .01$ (two-tailed), but each item is also significantly correlated with several other items. A two-item factor is therefore not supported.

Item communalities were also examined, see Table 11. Items with low communalities (i.e. <.4) after rotation should be considered for deletion, as low communalities indicate that the items are not highly correlated with one or more of the factors in the solution (A. B. Costello & Osborne, 2005; Worthington & Whittaker, 2006).

Deleting items with communalities <.4 results in the following factor structure: items 17, 31, 3, and 26 on factor one; items 23, 16, 15, 22, 29, 2, and 1 on factor two; and items 19, 30, and 14 on factor three. Item 17 has a negative loading coefficient on factor one, indicating that it should be reverse scored. DeVellis (2017) states that the reliability coefficient, alpha, is one of the most important indicators of a scale's quality. Cronbach's α was .704, .803, and .787 for factors 1, 2 and 3, respectively, indicating good internal consistency (DeVellis, 2017; Ponterotto & Ruckdeschel, 2007).

Table 9: Pattern matrix for four-factor solution with coefficients >.5 suppressed, and coefficients sorted by size of loading on each factor

Items	**Factor**			
	1	**2**	**3**	**4**
MIMHS17	.749			
MIMHS32	.608			
MIMHS6	.603			
MIMHS25	.544			
MIMHS31	-.507			
MIMHS13				
MIMHS18				
MIMHS3				
MIMHS36				
MIMHS27				
MIMHS34				
MIMHS35				
MIMHS4				
MIMHS23		.733		
MIMHS16		.672		
MIMHS22		.618		
MIMHS15		.577		
MIMHS24		.562		
MIMHS29		.522		
MIMHS1		.513		
MIMHS2		.507		
MIMHS11				
MIMHS33				
MIMHS19			.810	
MIMHS30			.741	
MIMHS14			.635	
MIMHS12				
MIMHS5				
MIMHS7				.506
MIMHS9				
MIMHS26				
MIMHS21				
MIMHS28				
MIMHS8				
MIMHS20				
MIMHS10				

Table 10: Pattern matrix for five-factor solution with coefficients sorted by size and coefficients >.5 suppressed

Items	**Factor**				
	1	**2**	**3**	**4**	**5**
MIMHS17	-.681				
MIMHS31	.646				
MIMHS25	-.572				
MIMHS3	.557				
MIMHS13	-.517				
MIMHS26	.511				
MIMHS27					
MIMHS32					
MIMHS18					
MIMHS28					
MIMHS36					
MIMHS34					
MIMHS23		.700			
MIMHS16		.670			
MIMHS15		.576			
MIMHS22		.560			
MIMHS29		.558			
MIMHS2		.548			
MIMHS1		.544			
MIMHS24		.523			
MIMHS11					
MIMHS33					
MIMHS4					
MIMHS19			.773		
MIMHS30			.719		
MIMHS14			.615		
MIMHS12					
MIMHS5					
MIMHS7				.593	
MIMHS6					
MIMHS9					
MIMHS8					
MIMHS35					
MIMHS21					.662
MIMHS20					.592
MIMHS10					

Table 11: Item communalities with five-factor solution

Items	Communalities
MIMHS1	.420
MIMHS2	.413
MIMHS3	.435
MIMHS4	.052*
MIMHS5	.207*
MIMHS6	.408
MIMHS7	.340*
MIMHS8	.119*
MIMHS9	.239*
MIMHS10	.122*
MIMHS11	.457
MIMHS12	.249*
MIMHS13	.276*
MIMHS14	.400
MIMHS15	.497
MIMHS16	.482
MIMHS17	.505
MIMHS18	.205*
MIMHS19	.647
MIMHS20	.336*
MIMHS21	.495
MIMHS22	.461
MIMHS23	.514
MIMHS24	.396*
MIMHS25	.342*
MIMHS26	.417
MIMHS27	.451
MIMHS28	.231*
MIMHS29	.528
MIMHS30	.624
MIMHS31	.458
MIMHS32	.363*
MIMHS33	.219*
MIMHS34	.191*
MIMHS35	.099*
MIMHS36	.170*

* denotes communalities >.4

6.8.4 Comparison of factor solutions

The three factor solutions were compared in order to establish which solution was most appropriate, see Table 13. The key item retention criteria previously discussed in this chapter were considered when comparing factor solutions, namely that items with communality < .4 should not be retained, nor should any items cross-loading on multiple factors >.32. Furthermore, one-item factors are not permissible. The three robust factors that emerged when a five-factor solution was forced from the data met these criteria, in that all items loaded on the factors >.5, communalities were >.4. Therefore, this factor solution appears to be the most appropriate choice for the current data.

However, conceptual interpretability has been deemed the definitive factor-retention (and therefore, item retention) criterion (Worthington & Whittaker, 2006). DeVellis (2017, p. 408) states, "A factor is considered interpretable to the extent that the items associated with it appear similar to one another and make theoretical and logical sense as indicators of a coherent construct". The factors and their constituent items are presented in Table 12.

Table 12: Item loadings on each factor for conceptual interpretation

Factor	Item
1	17. I would tell X to stop being so dramatic (negative loading, indicating need for reversal when scoring)
	31. I would listen to X in an understanding way
	3. I would talk to X about his/her feelings
	26. I would tell X that I am concerned about him/her
2	23. I would encourage X to seek help from a crisis hotline
	16. I would call a crisis hotline for help and advice
	15. I would give X information on how to make an appointment to see a mental health professional
	22. I would encourage X to seek advice from a website or online support forum
	29. I would ring a professional for help and advice about the situation
	2. I would make an appointment for X to see a professional
	1. I would suggest X seek professional help
	24. I would seek help from a website or online support forum
3.	19. I would tell X's parent or key caregiver about the situation
	30. I would contact X's family about my concern
	14. I would tell a teacher or another member of school staff (e.g., school counsellor) about X's situation

The constituent items of each factor come together to align with four of the main ALGEE 'actions' recommended by the MHFA programme (Kitchener, Jorm, & Kelly, 2013). Factor 1 appears to fall in line with the 'Listen non-judgementally' action; factor 2 can be aligned with the 'Give support and information' and 'Encourage appropriate professional help' actions; and factor 3 can be associated with 'Encourage other supports'. These factors also corroborate research that suggests parents and peers may provide 'insular' support (Byrne, Swords, & Nixon, 2015) and may also act as 'referral agents', supporting young people to engage with 'formal' or professional sources of help (Dulcan et al., 1990). Thus, the factors meet DeVellis' criteria, and are deemed conceptually coherent, further supporting the selection of this factor solution for the current data.

It is proposed that the first factor should be called 'Generic Support', as the support behaviours encompassed in this factor are not necessarily specific to the provision of support in a mental health context, but rather are indicative of the type of support an individual may provide to a peer who is struggling with a problem of any nature. The behaviours described in the items of the second factor are more specifically related to supporting an individual with mental health problems. The items include information-seeking (e.g., '*I would ring a professional for help and advice*') as well as a recognition that professional support is required (e.g., '*I would give X information on how to make an appointment to see a mental health professional*'). Therefore, it is proposed to call this factor 'Seeking Expertise'. The third factor describes behaviours that involve informing adults about the situation. Key to this factor is the fact that the adults mentioned are those with whom adolescents may have regular, informal contact; their friends' parents, and their teachers. It is proposed to call this factor 'Informing Adults'.

Table 13: Comparison of potential factor structures in the adolescent sample

	Factor structure with items that load > .5 on each factor	**Pros and cons of factor structure**
Three-factor solution	**Factor 1:** MIMHS17 ‘I would tell X to stop being so dramatic’ MIMHS32 ‘I would talk to X firmly about getting his/her act together’ MIMHS6 ‘I would tell X that his/her new pattern of behaviour is unacceptable’ MIMHS25 ‘I would ignore the subject unless X brought it up first’ MIMHS31 ‘I would listen to X’s problems in an understanding way’ MIMHS13 ‘I would not say or do anything’ **Factor 2:** MIMHS23 ‘I would encourage X to seek help from a crisis hotline’ MIMHS16 ‘I would call a crisis hotline (e.g., Samaritans, Childline) for help and advice’ MIMHS15 ‘I would give X information on how to make an appointment to see a mental health professional’ MIMHS29 ‘I would ring a professional for help and advice about the situation’ MIMHS2 ‘I would make an appointment for X to see a professional’ MIMHS1 ‘I would suggest X seek professional help’ MIMHS22 ‘I would encourage X to seek advice from a website or online support forum’ MIMHS24 ‘I would seek help from a website or online support forum’ **Factor 3:** MIMHS19 ‘I would tell X’s parent or key caregiver about the situation’ MIMHS30 ‘I would contact X’s family about my concern’ MIMHS9 ‘I would encourage X to look on the bright side of things’	**Pros:** N/A **Cons:** • Items in grey cannot be retained as their communality is < .4. Thus Factor 3 in its entirety should not be retained. • Additionally, item 32 has a cross-loading on two factors >.32 • Removing items with communality < .4 from Factor 1 would result in a one-item factor, which is not permissible • Deleting Factor 1 would result in a one-factor solution, which is not supported by the KMO and does not meet the operational definition of informal mental health support, which is thought to be multimodal

Four-factor solution	**Factor 1:** MIMHS17 ‘I would tell X to stop being so dramatic’ MIMHS32 ‘I would talk to X firmly about getting his/her act together’ MIMHS6 ‘I would tell X that his/her new pattern of behaviour is unacceptable’ MIMHS25 ‘I would ignore the subject unless X brought it up first’ MIMHS31 ‘I would listen to X’s problems in an understanding way’ **Factor 2:** MIMHS23 ‘I would encourage X to seek help from a crisis hotline’ MIMHS16 ‘I would call a crisis hotline (e.g., Samaritans, Childline) for help and advice’ MIMHS22 ‘I would encourage X to seek advice from a website or online support forum’ MIMHS15 ‘I would give X information on how to make an appointment to see a mental health professional’ MIMHS24 ‘I would seek help from a website or online support forum’ MIMHS29 'I would ring a professional for help and advice about the situation’ MIMHS1 ‘I would suggest X seek professional help’ MIMHS2 ‘I would make an appointment for X to see a professional’ **Factor 3:** MIMHS19 ‘I would tell X’s parent or key caregiver about the situation’ MIMHS30 ‘I would contact X’s family about my concern’ MIMHS14 ‘I would tell a teacher or another member of school staff (e.g. school counsellor) about X’s situation’ **Factor 4:** MIMHS7 ‘I would talk X out of his/her negative feelings’	**Pros:** N/A **Cons:** • Items in grey have communality < .4 and thus should not be retained. This results in Factors 3 and 4 being deleted in their entirety • Factor 1 would be a one-item factor, which is not permissible. • Deleting Factor 1 would result in a one-factor solution (Factor 2 only), which is not supported by the KMO. • In any case, Factor 2 does not meet the criterion of conceptual interpretability.

Five-factor solution	**Factor 1:** MIMHS17 ‘I would tell X to stop being so dramatic’ (reverse-scored) MIMHS31 ‘I would listen to X’s problems in an understanding way’ MIMHS25 ‘I would ignore the subject unless X brought it up first’ MIMHS3 ‘I would talk to X about his/her feelings’ MIMHS13 ‘I would not say or do anything’ MIMHS26 ‘I would tell X that I am concerned about him/her’ **Factor 2:** MIMHS23 ‘I would encourage X to seek help from a crisis hotline’ MIMHS16 ‘I would call a crisis hotline (e.g., Samaritans, Childline) for help and advice’ MIMHS15 ‘I would give X information on how to make an appointment to see a mental health professional’ MIMHS22 ‘I would encourage X to seek advice from a website or online support forum’ MIMHS29 ‘I would ring a professional for help and advice about the situation’ MIMHS2 ‘I would make an appointment for X to see a professional’ MIMHS1 ‘I would suggest X seek professional help’ MIMHS24 ‘I would seek help from a website or online support forum’ **Factor 3:** MIMHS19 ‘I would tell X’s parent or key caregiver about the situation’ MIMHS30 ‘I would contact X’s family about my concern’ MIMHS14 ‘I would tell a teacher or another member of school staff (e.g., school counsellor) about X’s situation’ **Factor 4:** MIMHS7 ‘I would talk X out of his/her negative feelings’ **Factor 5:** MIMHS21 ‘I would talk to one of X’s friends about my concern for X’ MIMHS20 ‘I would express my concern about X to others’	**Pros:** • When items with communality < .4 removed, a robust three factor solution emerges. • The items within each factor are conceptually related. **Cons:** • There are unequal numbers of items in each factor.
Rationale for selection of factor solution: **The three robust factors that emerged when a five-factor solution was forced from the data met scale development criteria, in that all items loaded on the factors >.5, communalities were >.4, and the factors had conceptual interpretability. Thus, this factor solution was selected.**		

6.8.5 Conclusion: MIMHS scale in an adolescent sample

The final version of the MIMHS scale, as used with an adolescent sample, consists of 15 items. Each item presents participants with a statement, and they are asked to rate how likely it is that they would perform the behaviour described in the statement, from '*Extremely unlikely*' (1), '*Unlikely*' (2), '*Likely*' (3), and '*Extremely likely*' (4). The scale comprises three factors (or subscales): Generic Support (four items), Seeking Expertise (eight items), and Informing Adults (three items). A higher rating on the items within each subscale indicates a greater likelihood of participants to engage in the type of support encapsulated by the subscale. There is one exception to this, the item '*I would tell X to stop being so dramatic*' on the subscale Generic Support. Participants' ratings on this item should be reverse scored in analysis so that a rating of 4 now means that they are, in fact, extremely unlikely to engage in the behaviour described.

6.9 Testing factor solutions with data from the caregiver sample

Principal-axis factoring (PAF) was again chosen as the method of factor extraction, as similar to the data from the adolescent sample, the data were not normally distributed. Promax rotation again appears appropriate for use, especially as we have learned that the factors that emerged in the adolescent sample were relatively uncorrelated.

6.9.1 Three-factor solution

The three factors that were extracted explained 33.5% of the variance, with factor one explaining 15.8%, factor two explaining 10.4%, and factor three explaining 7.3%. The pattern matrix was generated, suppressing coefficients loading <.5, with items sorted by size of loading on each factor. This pattern matrix can be viewed in Table 14. The highest correlation between any two factors was .36, indicating that the factors were satisfactorily independent. However, a large number of item communalities were below the cut-off of .4 (see Table 15), indicating that this three-factor solution was not appropriate for the data.

Table 14: Pattern matrix for three-factor solution, with coefficients <.5 suppressed, and coefficients sorted by size of loading on each factor

Items	**Factor**		
	1	**2**	**3**
MIMHS1	.680		
MIMHS23	.664		
MIMHS16	.614		
MIMHS2	.605		
MIMHS22	.579		
MIMHS24	.553		
MIMHS11	.533		
MIMHS29			
MIMHS15			
MIMHS21			
MIMHS30			
MIMHS33			
MIMHS5			
MIMHS20			
MIMHS26		.655	
MIMHS27		.605	
MIMHS28		.568	
MIMHS31		.542	
MIMHS12			
MIMHS3			
MIMHS25			
MIMHS19			
MIMHS36			
MIMHS13			
MIMHS14			
MIMHS34			
MIMHS35			
MIMHS4			
MIMHS32			.642
MIMHS9			.621
MIMHS7			.567
MIMHS6			.565
MIMHS8			.524
MIMHS17			
MIMHS18			
MIMHS10			

Table 15: Item communalities for three-factor solution

Items	Communalities
MIMHS1	.558
MIMHS2	.538
MIMHS3	.248
MIMHS4	.105
MIMHS5	.132
MIMHS6	.341
MIMHS7	.319
MIMHS8	.262
MIMHS9	.372
MIMHS10	.134
MIMHS11	.484
MIMHS12	.231
MIMHS13	.213
MIMHS14	.269
MIMHS15	.217
MIMHS16	.349
MIMHS17	.337
MIMHS18	.118
MIMHS19	.170
MIMHS20	.145
MIMHS21	.270
MIMHS22	.312
MIMHS23	.423
MIMHS24	.269
MIMHS25	.231
MIMHS26	.411
MIMHS27	.355
MIMHS28	.276
MIMHS29	.408
MIMHS30	.238
MIMHS31	.268
MIMHS32	.446
MIMHS33	.159
MIMHS34	.134
MIMHS35	.058
MIMHS36	.245

6.9.2 Four-factor solution

The four-factor solution explained 38.63% of the variance; the fourth factor contributed 5.14%. The highest correlation between any two factors was .300. Again, the pattern matrix was generated, suppressing coefficients loading <.5, with items sorted by size of loading on each factor, see Table 16. Items that loaded satisfactorily on a factor were noted, and the communalities of these items were assessed (see 5). Item 16 from Factor 1, items 27, 28 and 31 on Factor 2, item 7 on Factor 3, and items 20, 12, and 21 on Factor 4 all had communalities <.4, the accepted cut-off. Item communalities thus did not support the presence of two of the four factors. The factor structure that remained suggested that items 1 ('*I would suggest X seek professional help*'), 2 ('*I would make an appointment for X to see a professional*'), 11 ('*I would offer to accompany X to an appointment with a mental health professional*'), 29 ('*I would ring a professional for help and advice about the situation*'), and 23 ('*I would encourage X to seek help from a crisis hotline*') loaded on one factor, and items 9 ('*I would encourage X to look on the bright side of things*'), 8 ('*I would try to distract X from his/her problems*'), and 32 ('*I would talk to X firmly about getting his/her act* together') loaded on a second factor. Cronbach's α was .780 for the first factor, and .680 for the second factor. It was proposed to assess the five-factor solution, to determine which solution might provide a more interpretable and/or reliable factor solution (DeVellis, 2017).

Table 16: Pattern matrix for four-factor solution, with coefficients <.5 suppressed, and coefficients sorted by size of loading on each factor

Items	Factor			
	1	2	3	4
MIMHS1	.796			
MIMHS2	.763			
MIMHS11	.678			
MIMHS29	.518			
MIMHS16	.516			
MIMHS23	.506			
MIMHS15				
MIMHS24				
MIMHS22				
MIMHS33				
MIMHS5				
MIMHS26		.615		
MIMHS27		.602		
MIMHS28		.584		
MIMHS31		.542		
MIMHS3				
MIMHS25				
MIMHS17				
MIMHS13				
MIMHS34				
MIMHS35				
MIMHS9			.766	
MIMHS8			.710	
MIMHS32			.596	
MIMHS7			.542	
MIMHS6				
MIMHS36				
MIMHS18				
MIMHS4				
MIMHS20				.589
MIMHS12				.533
MIMHS21				.510
MIMHS30				
MIMHS19				
MIMHS14				
MIMHS10				

Table 17: Item communalities for four-factor solution

Items	**Communalities**
MIMHS1	.634
MIMHS2	.640
MIMHS3	.273
MIMHS4	.123
MIMHS5	.131
MIMHS6	.350
MIMHS7	.321
MIMHS8	.427
MIMHS9	.515
MIMHS10	.138
MIMHS11	.581
MIMHS12	.385
MIMHS13	.224
MIMHS14	.272
MIMHS15	.234
MIMHS16	.347
MIMHS17	.351
MIMHS18	.124
MIMHS19	.229
MIMHS20	.344
MIMHS21	.364
MIMHS22	.332
MIMHS23	.427
MIMHS24	.279
MIMHS25	.238
MIMHS26	.406
MIMHS27	.375
MIMHS28	.302
MIMHS29	.418
MIMHS30	.272
MIMHS31	.280
MIMHS32	.437
MIMHS33	.160
MIMHS34	.134
MIMHS35	.059
MIMHS36	.277

6.9.3 Five-factor solution

The fifth factor explained 4.47% of the variance, bringing the cumulative total to 43.10%. The pattern matrix, with loadings <.5 suppressed, and items sorted by size of loading, can be viewed in Table 18. Communalities of all items are displayed in Table 19. The highest correlation between any two factors was .393. The items that loaded >.5 on any factor were noted, and the communalities of these items were assessed. Items 31, 28, and 27 on Factor 2, item 7 on Factor 3, and item 20 on Factor 5 all had communalities <.4, thereby resulting in both Factors 2 and 5 comprising one item only. As one-item subscales are not recommended (Worthington & Whittaker, 2006), the data therefore suggested a supported factor solution whereby items 2 ('*I would make an appointment for X to see a professional*', 1 ('*I would suggest X seek professional help*'), 11 ('*I would offer to accompany X to an appointment with a mental health professional*') and 29 ('*I would ring a professional for help and advice about the situation*') loaded on one factor, items 9 ('*I would encourage X to look on the bright side of things*'), 8 ('*I would try to distract X from his/her problems*'), and 32 ('*I would talk to X firmly about getting his/her act together*') loaded on a second factor, and items 22 ('*I would encourage X to seek advice from a website or online support forum*'), 24 ('*I would seek help from a website or online support forum*'), and 23 ('*I would encourage X to seek help from a crisis hotline*') loaded on a third factor. Cronbach's α was .853 for the first factor, .680 for the second factor, and .778 for the third factor.

Table 18: Pattern matrix for five-factor solution, with coefficients <.5 suppressed, and coefficients sorted by size of loading on each factor

Items	**Factor**				
	1	**2**	**3**	**4**	**5**
MIMHS2	.947				
MIMHS1	.914				
MIMHS11	.696				
MIMHS29	.529				
MIMHS33					
MIMHS5					
MIMHS31		.674			
MIMHS26		.572			
MIMHS28		.567			
MIMHS27		.540			
MIMHS3					
MIMHS17					
MIMHS25					
MIMHS13					
MIMHS34					
MIMHS35					
MIMHS9			.753		
MIMHS8			.687		
MIMHS32			.589		
MIMHS7			.519		
MIMHS6					
MIMHS18					
MIMHS4					
MIMHS22				.791	
MIMHS24				.745	
MIMHS23				.655	
MIMHS16					
MIMHS15					
MIMHS20					.646
MIMHS12					.629
MIMHS30					
MIMHS21					
MIMHS19					
MIMHS14					
MIMHS36					
MIMHS10					

Table 19: Item communalities for five-factor solution

Items	Communalities
MIMHS1	.747
MIMHS2	.780
MIMHS3	.275
MIMHS4	.129
MIMHS5	.129
MIMHS6	.400
MIMHS7	.326
MIMHS8	.420
MIMHS9	.509
MIMHS10	.137
MIMHS11	.578
MIMHS12	.427
MIMHS13	.253
MIMHS14	.307
MIMHS15	.256
MIMHS16	.343
MIMHS17	.372
MIMHS18	.123
MIMHS19	.233
MIMHS20	.381
MIMHS21	.352
MIMHS22	.578
MIMHS23	.511
MIMHS24	.503
MIMHS25	.254
MIMHS26	.411
MIMHS27	.374
MIMHS28	.313
MIMHS29	.425
MIMHS30	.312
MIMHS31	.374
MIMHS32	.481
MIMHS33	.158
MIMHS34	.151
MIMHS35	.058
MIMHS36	.283

6.9.4 Comparison of factor solutions

The factor solutions were compared, see Table 22. The two factors that emerge when a four-factor solution is forced, and the three factors that emerged when a five-factor solution was forced, meet criteria in that all items loaded on the factors >.5, and communalities were >.4. In order to make a determination of the best factor solution for these data, conceptual interpretability was employed as the definitive criterion (Worthington & Whittaker, 2006). As such, the results of both factor solutions (see Table 20 and Table 21) were analysed for conceptual and theoretical coherence.

Table 20: Factor loading of items following extraction of four-factor solution

Factor	Item
1	1. I would suggest X seek professional help
	2. I would make an appointment for X to see a professional
	11. I would offer to accompany X to an appointment with a mental health professional
	29. I would ring a professional for help and advice about the situation
	23. I would encourage X to seek help from a crisis hotline
2	9. I would encourage X to look on the bright side of things
	8. I would try to distract X from his/her problems
	32. I would talk to X firmly about getting his/her act together

The specification of a four-factor solution resulted in the presence of two robust factors, once item retention criteria had been reviewed. Factor 1 includes four items, and factor 2 comprises three items. Three of the items in Factor 1 describe caregivers' facilitation of their child receiving professional support (e.g., '*I would make an appointment for X to see a professional*'). These three items are conceptually similar and cohere well together. The fourth item in this factor, however, introduces a slightly different form of support; this item addresses the use of a crisis hotline. Given the congruity of the first three items in terms of the mode of support described, this fourth item appears to diverge somewhat.

The second factor consists of three items which detail responses that, while potentially well-intentioned, are not necessarily very effective in reducing the impact of depressive symptoms (e.g., '*I would try to* *distract X from his/her problems*') or empathic (e.g., '*I would talk to X firmly about getting his/her act together*'). The responses could be seen as trivialising the young person's feelings and experiences. The responses focus on the behaviours and symptoms displayed by the young person, without addressing the cause of said symptoms. Additionally, these responses are not necessarily specific to a situation where a caregiver's child is experiencing mental health problems; rather, a caregiver could respond to their child in this way when the child is experiencing any type of problem. The factor is relatively conceptually congruent.

While these two factors address two different modes of responding to a young person showing signs of depression, all of the responses included in the first factor are not conceptually aligned. This is problematic given that conceptual clarity and interpretability is considered the key criterion for the selection of a factor solution.

Table 21: Factor loading of items following extraction of five-factor solution

Factor	Item
1	2. I would make an appointment for X to see a professional 1. I would offer to accompany X to an appointment with a mental health professional 29. I would ring a professional for help and advice about the situation
2	9. I would encourage X to look on the bright side of things 8. I would try to distract X from his/her problems 32. I would talk to X firmly about getting his/her act together
3	22. I would encourage X to seek advice from a website or online support forum 24. I would seek help from a website or online support forum 23. I would encourage X to seek help from a crisis hotline

Following item retention guidelines, the specified five-factor extraction results in three robust factors, with each factor consisting of three items. All three items in the first factor represent helping responses that involve facilitating the young person's engagement with a mental health professional. The responses encompassed in the second factor are directed towards the mood and behaviour of the young person with depression, rather than addressing the underlying causes of these behaviours. The third factor comprises items associated with seeking help from information resources (e.g., ‘*I would seek help from a website or online support forum*’). This mode of responding suggests a recognition that the child is experiencing an issue, but that further information is required.

Overall, this factor solution supports three different modes of help-giving responses. Each factor is conceptually meaningful, and the items within the factor cohere together well. Thus, this factor solution meets DeVellis’ (2017) criteria for conceptual interpretability. In addition, the factors relate to the findings of other research on this topic, which has found that caregivers may act as ‘referral agents’ for mental health services (Dulcan et al., 1990; Stiffman et al., 2004), may respond in a way that they perceive as helpful but would not be endorsed by mental health professionals (Jorm & Wright, 2007; Jorm et al., 2007a), and/or may respond by consulting informational sources (Altweck, Marshall, Ferenczi, & Lefringhausen, 2015).

As these factors describe coherent, interpretable and meaningful modes of caregiver responding, it was decided that this factor solution should be chosen to inform the subscales of the MIMHS in the caregiver sample. It is proposed that the first factor should be called ‘Facilitation of Professional Support’, with the second factor to be named ‘Problem Minimisation’, and the third factor called ‘Support Resource Utilisation’.

Table 22: Comparison of potential factor structures in the caregiver sample

	Factor structure, when including items that load >.5	**Pros and cons of factor structure**
Three-factor solution	**Factor 1:** MIMHS1 ‘I would suggest X seek professional help’ MIMHS23 ‘I would encourage X to seek help from a crisis hotline’ MIMHS16 ‘I would call a crisis hotline (e.g. Samaritans, Childline) for help and advice’ MIMHS2 ‘I would make an appointment for X to see a professional’ MIMHS22 ‘I would encourage X to seek advice from a website or online support forum’ MIMHS24 ‘I would seek help from a website or online support forum’ MIMHS11 ‘I would offer to accompany X to an appointment with a mental health professional’ **Factor 2:** MIMHS26 ‘I would tell X that I am concerned about him/her’ MIMHS27 ‘I would encourage X to talk to his/her family’ MIMHS28 ‘I would ask X if anything is wrong’ MIMHS31 ‘I would listen to X’s problems in an understanding way’ **Factor 3:** MIMHS32 ‘I would talk to X firmly about getting his/her act together’ MIMHS9 ‘I would encourage X to look on the bright side of things’ MIMHS7 ‘I would talk X out of his/her negative feelings’ MIMHS6 ‘I would tell X that his/her new pattern of behaviour is unacceptable’ MIMHS8 ‘I would try to distract X from his/her problems’	**Pros:** N/A **Cons:** • Items in grey have communalities < .4 and thus should not be retained according to item retention guidelines • Thus, Factor 2 should be deleted in its entirety • Removing items with communality < .4 would mean Factor 3 becomes a one-item factor, which is not permissible • Deleting Factor 3 (as a one-item factor) would result in a one-factor solution (Factor 1 only), which is not supported by the KMO and does not meet the operational definition of informal mental health support, which is thought to be multimodal • What’s more, Factor 1 does not meet the criterion of conceptual interpretability

Four-factor solution	**Factor 1:** MIMHS1 ‘I would suggest X seek professional help’ MIMHS2 ‘I would make an appointment for X to see a professional’ MIMHS11 ‘I would offer to accompany X to an appointment with a mental health professional’ MIMHS29 ‘I would ring a professional for help and advice about the situation’ MIMHS16 ‘I would call a crisis hotline (e.g. Samaritans, Childline) for help and advice’ MIMHS23 ‘I would encourage X to seek help from a crisis hotline’ **Factor 2:** MIMHS26 ‘I would tell X that I am concerned about him/her’ MIMHS27 ‘I would encourage X to talk to his/her family’ MIMHS28 ‘I would ask X if anything is wrong’ MIMHS31 ‘I would listen to X’s problems in an understanding way’ **Factor 3:** MIMHS9 ‘I would encourage X to look on the bright side of things’ MIMHS8 ‘I would try to distract X from his/her problems’ MIMHS32 ‘I would talk to X firmly about getting his/her act together’ MIMHS7 ‘I would talk X out of his/her negative feelings’ **Factor 4:** MIMHS20 ‘I would express my concern about X to others’ MIMHS12 ‘I would tell one of my family members about the situation’ MIMHS21 ‘I would talk to one of X’s friends about my concern for X’	**Pros:** • When items in grey are removed (due to communalities < .4), two factors remain, which both have an acceptable number of items **Cons:** • MIMHS23 does not cohere well with other items in Factor 1

Five-factor solution	**Factor 1:** MIMHS2 ‘I would make an appointment for X to see a professional’ MIMHS1 ‘I would suggest X seek professional help’ MIMHS11 ‘I would offer to accompany X to an appointment with a mental health professional’ MIMHS29 ‘I would ring a professional for help and advice about the situation’ **Factor 2:** MIMHS31 ‘I would listen to X’s problems in an understanding way’ MIMHS26 ‘I would tell X that I am concerned about him/her’ MIMHS28 ‘I would ask X if anything is wrong’ MIMHS27 ‘I would encourage X to talk to his/her family’ **Factor 3:** MIMHS9 ‘I would encourage X to look on the bright side of things’ MIMHS8 ‘I would try to distract X from his/her problems’ MIMHS32 ‘I would talk to X firmly about getting his/her act together’ MIMHS7 ‘I would talk X out of his/her negative feelings’ **Factor 4:** MIMHS22 ‘I would encourage X to seek advice from a website or online support forum’ MIMHS24 ‘I would seek help from a website or online support forum’ MIMHS23 ‘I would encourage X to seek help from a crisis hotline’ **Factor 5:** MIMHS20 ‘I would express my concern about X to others’ MIMHS12 ‘I would tell one of my family members about the situation’	**Pros:** • When items in grey are removed (due to communalities < .4), three robust factors remain • All items cohere well within each factor • There is an acceptable number of items within each factor • Aligns with empirical evidence that one mode of support offered by caregivers may be facilitation of service engagement **Cons:** • N/A
Rationale for selection of factor solution: **The three robust factors that emerged when a five-factor solution was forced from the data met scale development criteria in that all items loaded on the factors >.5, communalities were >.4, and the factors had conceptual interpretability.**		

6.9.5 Conclusion: MIMHS scale in a caregiver sample

The final version of the MIMHS scale, as used with a caregiver sample, consists of 12 items. Each item presents participants with a statement, and they are asked to rate how likely it is that they would perform the behaviour described in the statement, from '*Extremely unlikely*' (1), '*Unlikely*' (2), '*Likely*' (3), and '*Extremely likely*' (4). The scale comprises three factors (or subscales): Facilitation of Professional Support (three items), Problem Minimisation (three items), and Support Resource Utilisation (three items). A higher rating on each item indicates a greater likelihood of participants to engage in the type of support encapsulated by the subscale to which the item belongs.

6.10 Key next steps

Although beyond the scope of the current study, greater assessment of the validity and reliability of the MIMHS is key to the further development of the scale. As stated by Clark and Watson (2019), in their recent update to their seminal 1995 paper (L. A. Clark & Watson, 1995), "good scale construction is an iterative process involving an initial cycle of preliminary measure development, data collection, and psychometric evaluation, followed by at least one additional cycle of revision of *both* measure *and* construct, data collection, psychometric evaluation, revision, and so forth" (L. A. Clark & Watson, 2019, p. 9). As such, further exploratory factor analyses with cross-validation samples are recommended, followed by confirmatory factor analyses to determine the goodness-of-fit between the hypothesised three-factor structure in both adolescent and caregiver populations. Additionally, future studies should aim to further evaluate the face, convergent, discriminant, and predictive validity of the scale. While any future study using the MIMHS is, in essence, an assessment of its validity (Strauss & Smith, 2008), specific tests should also be implemented in order to calculate validity more directly.

For example, while the piloting of the scale in the current study helped to establish face validity, this could be further examined by conducting interviews with young people and caregivers and asking for their feedback on whether the items in the scale are meaningful, relevant, clear, understandable, and easy to answer (Connell et al., 2018). In order to assess convergent validity, future studies could include comparison (anchor) scales – potentially, a measure of intentions to seek help for oneself, such as the Orientations to Seeking Professional Help scale (Fischer et al., 1970), which was found to be the measure of help-seeking intentions with the most complete assessment of all facets of this behaviour (White, Clough, & Casey, 2018). Convergent validity can also be assessed through cross-method analysis, which involves examining convergence in responses across fundamentally different methods (Campbell & Fiske, 1959) – for example, evaluating the similarity between a participant's response to a self-report questionnaire (the method employed for the MIMHS) and their response to the same questions when posed in an interview. Appraisal of discriminant validity involves checking that two constructs which are theorised to be unrelated are, in fact, unrelated. Therefore, the discriminant validity of the MIMHS may be assessed in future studies by including a measure of an unconnected construct, such as self-esteem. Given that the MIMHS measures participants' behavioural *intentions*, predictive validity may be assessed through the measurement of participants' 'real-world' support-giving behaviour. As noted elsewhere in the current thesis (see section 5.4.2.4, Chapter 5), the direct and naturalistic observation of support-giving behaviour is likely to be difficult, requiring ethnographic work. However, multiple time points of data collection in future studies may facilitate determination of the relationship between participants' stated behavioural intentions, and self-reported performed behaviour.

In order to measure internal consistency (reliability) of the MIMHS, Cronbach's alpha values achieved in future studies could be compared to those reported in this initial study. Test-retest reliability can also measure the stability of the MIMHS over time, and again should be assessed in any future studies deploying the scale across multiple time points (Rattray & Jones, 2007). Assessment of reliability also ensures that differences in responses can be attributed to differences across participants, rather than differences in how the questions were understood. Consequently, standardisation is also important; future studies could ensure that the administration of the scale is consistent with that described in the current thesis (Boynton & Greenhalgh, 2004; Domino & Domino, 2006).

6.11 Conclusion

This chapter documented the process of developing the Modes of Intended Mental Health Support (MIMHS) scale. An item pool was generated based on a review of the literature, from which the final versions of the scale were refined through exploratory factor analyses. The subscales that ultimately emerged for the adolescent and caregiver versions of the scale represent different types or 'modes' of support-giving. In the next three chapters of this thesis, the results of the current study are presented, in which participants' support-giving responses are explored.

Chapter 7 Comparison of support-giving responses between groups

7.1 Introduction

This chapter reports the results of statistical analysis of the data pertaining to the following research questions:

1. *How do caregivers and peers respond to the expression of depressive symptoms in an adolescent character portrayed in a vignette?*
2. *Are there significant differences between caregivers' and peers' responses?*
3. *Do caregivers' and peers' responses differ according to sex?*
4. *Do adolescents' responses differ according to age?*

7.2 Comparison of adolescents' and caregivers' responses

To answer the first and second research questions of the current study, adolescents' and caregivers' responses to the vignette characters were reported at group level, and then compared through analysis of differences in each group's scores across the study variables, see Table 23. Statistically significant differences were found across a number of variables. Adolescents displayed significantly greater anger (small effect size) and significantly less sympathy (medium effect size) towards the vignette character than did caregivers. Caregivers showed a significantly higher level of concern (medium effect size), were significantly more likely to identify depression (small association), and identified a significantly greater number of symptoms (large effect size), than did adolescents. Additionally, caregivers, on average, estimated a significantly longer recovery time than did adolescents (medium effect size)

As the proportion of female participants was greater in the caregiver sample than in the adolescent sample, ANCOVAs were conducted to control for the effect of gender for each continuous variable, with post hoc analyses performed with a Bonferroni adjustment, see Table 24. In all cases, the differences between caregivers' and adolescents' responses remained significant when controlling for gender. For ordinal variables (i.e., level of concern and beliefs about prognosis), the datafile was split by gender, and a Mann-Whitney *U* test was conducted to assess the difference between male caregivers and male adolescents, and female caregivers and female adolescents, see Table 25. The differences between caregivers and adolescents also remained statistically significant.

A significantly greater proportion of caregivers than adolescents identified each of the six 'symptoms' of depression referenced in the vignette, see Table 26 for details.

Table 23: Comparison of adolescents’ and caregivers' responses

Variable	**Possible range of scores**	**Adolescents**	**Caregivers**	***p***	**Effect size**
Level of concern (*Mdn*)	1– 4	3.00	4.00	<.001	η^2 = .067, *d* = .54
Identification of depression (% correctly identified)	-	46.7%	66.7%	<.001	*w* = .194, *p* <.001
Number of symptoms identified – M (*SD*)	0 – 9	2.10 (*1.21*)	3.13 (*1.51*)	<.001	*d* = .75
Beliefs about prognosis (*Mdn*)	1 – 4	3.00	4.00	<.001	η^2 = .06, *d* = .51
Believed target needed help	-	91.8%	93.5%	>.05	-
Anger - M (*SD*)	1 – 9	2.35 (*1.51*)	1.87 (*1.26*)	<.001	*d* = .35
Sympathy - M (*SD*)	1 – 9	7.52 (*1.25*)	8.14 (*1.26*)	<.001	*d* = .49
Perceived controllability of symptoms - M (*SD*)	1 – 9	3.93 (*1.55*)	3.08 (*1.35*)	<.001	*d* = .58
Perceived norms about support-giving - M (*SD*)	1 – 5	3.69 (*.70*)	4.14 (*.76*)	<.001	*d* = .62
Attitudes towards support-giving - M (*SD*)	1 – 7	5.63 (*.63*)	5.74 (*.65*)	<.05	*d* = .17
PBC of support-giving - M (*SD*)	1 – 5	3.63 (*.62*)	4.22 (*.60*)	<.001	*d* = .97

Table 24: Results of ANCOVAs on continuous variables to assess difference between caregivers' and adolescents' responses while controlling for the effect of gender, including post hoc analyses with Bonferroni adjustment applied

Variable	***df, N***	***F***	***p***	η^2	**Adjusted (Bonferroni)**
Anger	1, 851	11.654	<.001	.014	M_{diff} = .353, *SE* = .103, *p* = .001, [95% CI, .150 to .556].
Sympathy	1, 851	33.951	<.001	.038	M_{diff} = .501, *SE* = .086, *p* = .001, [95% CI, .333 to .670].
Perceived controllability	1, 851	51.291	< .001	.057	M_{diff} = .770, *SE* = .108, *p* = .001, [95% CI, .558 to .981].
Norms	1, 851	60.994	<.001	.067	M_{diff} = .412, *SE* = .053, *p* = .001, [95% CI, .308 to .515].
Attitudes	1, 851	6.426	< .05	.007	M_{diff} = .120, *SE* = .047, *p* = .05, [95% CI, .027 to .212].
PBC	1, 851	168.780	<.001	.166	M_{diff} = .582, *SE* = .045, *p* = .001, [95% CI, .494 to .670].

Table 25: Results of Mann Whitney U tests to assess differences between caregivers' and adolescents' responses on ordinal variables, with participants aggregated by gender

	Mdn				
Variable	**Caregivers**	**Adolescents**	***U***	***p***	η^2, ***d***
Beliefs about prognosis	Male: 4.00	Male: 3.00	6013.0	< .001	.10, .66
	Female: 4.00	Female: 3.00	25149.5	< .001	.03, .34
Level of concern	Male: 4.00	Male: 3.00	7427.0	< .001	.04, .39
	Female: 4.00	Female: 4.00	23369.0	< .001	.04, .39

Table 26: Proportion of adolescents and caregivers that identified each symptom referenced in the vignette

	%		**$\chi^2(1)$**	***w***
Symptom	**Adolescents**	**Caregivers**		
Depressed mood	68.0	80.7	16.201**	.194**
Diminished interest	50.1	65.4	19.113**	.149**
Insomnia	35.7	60.4	49.600**	.241**
Diminished concentration	20.0	40.8	43.282**	.225**
Feelings of worthlessness	18.3	30.5	16.947**	.141**
Fatigue	17.6	34.9	32.938**	.196**

** = statistically significant at $p < .001$

Caregivers' and adolescents' beliefs about the helpfulness and harmfulness of various responses were also compared, see Table 28[17]. Adolescents were more likely than caregivers to believe that the actions, '*Listen to X's problems in an understanding way*' and '*Encourage X to become more physically active*' would make no difference, while caregivers were more likely than adolescents to believe that these would be helpful responses. Adolescents were also more likely than caregivers to believe that '*Ignore X until he/she gets over it*' would make no difference to the young person showing signs of depression. More caregivers than adolescents believed that '*Make an appointment for X to see a GP*' and '*Ask X whether he/she is feeling suicidal*' would be helpful responses. In comparison, adolescents were more likely than caregivers to believe that '*Keep X busy to keep his/her mind off his/her problems*' and '*Rally friends to cheer X up*' would be helpful responses. Adolescents were more likely than caregivers to believe that '*Suggest X has a few drinks to forget his/her troubles*' would make no difference, while caregivers were more likely than adolescents to believe that this response would be harmful.

7.3 Comparison of male and female participants' responses

In order to answer the third research question, male and female participants' responses were compared, for both the caregiver and adolescent samples.

7.3.1 Adolescents

Statistically significant differences were found between male and female adolescents across a number of variables under investigation, see

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[17] Note that participants' responses to this section of the questionnaire are compared at the item level, as the questions are not conceptualised as a scale and therefore responses cannot be summed across items, or otherwise computed as an overarching score – see Chapter 5, section 5.8.

Table 30. Girls reported significantly less anger (small effect size) and significantly more sympathy (small effect size) towards the vignette character than did boys. Girls' level of concern for the vignette character was significantly greater than boys' level of concern (medium effect size), and girls perceived significantly longer recovery time than did boys (medium effect size).

The only significant difference between male and female adolescents' identification of individual symptoms was for 'feelings of worthlessness'; significantly more boys (22.0%) than girls (14.5%) identified this symptom, $\chi^2(1) = 5.079$, $p < .05$, but analysis of *w* showed that this relationship was negligible. See Table 27 for comparison of the proportions of girls and boys that identified each symptom

Table 27: Proportion of male and female adolescents who identified each of the symptoms of depression referenced in the vignette

	%		**χ^2(1)**	***w***
Symptom	**Girls**	**Boys**		
Depressed mood	69.9	66.1	.908	-
Diminished interest	48.8	51.3	.316	-
Insomnia	36.3	35.0	.100	-
Diminished concentration	19.5	20.6	.091	-
Feelings of worthlessness	14.5	22.0	5.079*	-.098
Fatigue	18.0	17.3	.038	-

* = statistically significant at $p < .05$

Table 28: Proportions of adolescents and caregivers who thought each response was 'helpful', 'harmful', or would 'make no difference'

Response	**Helpful** **% (adjusted std. residual)**	**Harmful** **% (adjusted std. residual)**	**Make no difference** **% (adjusted std. residual)**	$\chi^2(2)$	***w***
Listen to X's problems in an understanding way	Adolescents: 97.8 (-2.2) Caregivers: 99.7 (2.2)	Adolescents: 0.4 (.1) Caregivers: 0.3 (-.1)	Adolescents: 1.9 (2.5) Caregivers: 0.0 (-2.5)	6.098	.084
Talk to X firmly about getting his/her act together	Adolescents: 16.3 (2.0) Caregivers: 11.2 (-2.0)	Adolescents: 72.0 (-2.0) Caregivers: 78.2 (2.0)	Adolescents: 11.8 (.5) Caregivers: 10.6 (-.5)	4.852	.075
Suggest X seek professional help	Adolescents: 69.3 (-6.6) Caregivers: 89.1 (6.6)	Adolescents: 13.6 (2.6) Caregivers: 7.8 (-2.6)	Adolescents: 17.0 (6.1) Caregivers: 3.1 (-6.1)	49.032 **	.239 **
Make an appointment for X to see a GP	Adolescents: 54.6 (-10.0) Caregivers: 87.9 (10.0)	Adolescents: 28.0 (7.6) Caregivers: 6.5 (-7.6)	Adolescents: 17.4 (5.0) Caregivers: 5.6 (-5.0)	100.977 **	.343 **
Ask X whether he/she is feeling suicidal	Adolescents: 34.8 (-7.3) Caregivers: 60.4 (7.3)	Adolescents: 52.7 (5.2) Caregivers: 34.6 (-5.2)	Adolescents: 12.5 (3.6) Caregivers: 5.0 (-3.6)	55.904 **	.256 **
Suggest X has a few drinks to forget his/her troubles	Adolescents: 6.9 (4.3) Caregivers: 0.6 (-4.3)	Adolescents: 83.6 (-5.1) Caregivers: 95.3 (5.1)	Adolescents: 9.5 (3.0) Caregivers: 4.0 (-3.0)	28.667 **	.183 **
Rally friends to cheer X up	Adolescents: 75.0 (6.1) Caregivers: 54.8 (-6.1)	Adolescents: 10.3 (-2.4) Caregivers: 15.9 (2.4)	Adolescents: 14.8 (-5.1) Caregivers: 29.3 (5.1)	38.069 **	.211 **
Ignore X until he/she gets over it	Adolescents: 1.1 (-.5) Caregivers: 1.6 (.5)	Adolescents: 91.4 (-2.0) Caregivers: 95.0 (2.0)	Adolescents: 7.5 (2.4) Caregivers: 3.4 (-2.4)	6.102	.084
Keep X busy to keep his/her mind off his/her problems	Adolescents: 69.0 (8.1) Caregivers: 40.8 (-8.1)	Adolescents: 7.1 (-5.2) Caregivers: 18.7 (5.2)	Adolescents: 23.9 (-5.1) Caregivers: 40.5 (5.1)	69.058 **	.284 **
Encourage X to become more physically active	Adolescents: 76.3 (-4.6) Caregivers: 89.1 (4.6)	Adolescents: 3.9 (2.9) Caregivers: 0.6 (-2.9)	Adolescents: 19.8 (3.7) Caregivers: 10.3 (-3.7)	23.446 **	.165 **

** = statistically significant at $p < .001$ – note that this is the threshold for significance employed in order to account for multiple tests, see section 5.8, Chapter 5.

Adolescents' beliefs about the helpfulness and harmfulness of various responses were also compared according to gender, see Table 31. Significantly more girls than boys believed that the actions, '*Suggest X seek professional help*' and '*Ask X if he/she is feeling suicidal*' would be helpful. Girls were also significantly more likely than boys to believe that the actions, '*Rally friends to cheer X up*' and '*Encourage X to become more physically active*' would make no difference, while boys were significantly more likely to believe that these would be helpful responses. Boys were significantly more likely than girls to believe that the action, '*Suggest X has a few drinks to forget his/her troubles*' would be a helpful response.

7.3.2 Caregivers

Fewer statistically significant differences were found between female and male caregivers' responses, see Table 30. Female caregivers reported significantly greater sympathy towards the vignette character than did male caregivers (large effect size), and perceived a significantly longer recovery time would be required (small effect size). Female caregivers were significantly more likely to endorse norms about support-giving than were male caregivers (small effect size), and reported significantly greater PBC than their male counterparts (medium effect size). There were no significant differences between the proportions of male and female caregivers that identified each of the referenced symptoms of depression, see Table 29. Female and male caregivers differed significantly in their beliefs about the harmfulness of only one response provided: male caregivers were significantly more likely to believe that rallying friends would be harmful, see Table 32.

Table 29: Proportion of female and male caregivers who identified each of the symptoms of depression referenced in the vignette

	%		$\chi^2(1)$	*w*
Symptom	**Female caregivers**	**Male caregivers**		
Depressed mood	80.7	90.2	2.599	-
Diminished interest	66.4	65.4	.587	-
Insomnia	79.9	70.6	2.538	-
Diminished concentration	40.6	41.2	.006	-
Feelings of worthlessness	27.5	35.3	1.263	-
Fatigue	33.6	39.2	.587	-

Table 30: Comparison of male and female participants responses

	Adolescents				**Caregivers**			
	Male	**Female**	***p***	**Effect size**	**Male**	**Female**	***p***	**Effect size**
Level of concern (*Mdn*)	3.00	3.00	<.001	$\eta^2 = .04$, *d* = .40	4.00	4.00	>.05	-
Identified depression	44.8%	48.4%	>.05	-	58.4%	69.3%	>.05	-
Number of symptoms identified – M (*SD*)	2.12 (*1.25*)	2.07 (*1.17*)	>.05	-	3.37 (*1.47*)	3.07 (*1.51*)	>.05	-
Beliefs about prognosis (*Mdn*)	3.00	4.00	<.001	$\eta^2 = .04$, *d* = .40	4.00	4.00	<.05	$\eta^2 = .018$, *d* = .27
Believed target needed help	91.3%	92.9%	>.05	-	92.2%	93.9%	>.05	-
Anger - M (*SD*)	2.57 (*1.62*)	2.10 (*1.35*)	<.001	*d* = .32	2.13 (*.20*)	1.77 (*.07*)	>.05	-
Sympathy - M (*SD*)	7.32 (*1.36*)	7.74 (*1.09*)	<.001	*d* = .35	7.56 (*1.23*)	8.25 (*.06*)	<.001	*d* = .79
Perceived controllability of symptoms - M (*SD*)	4.01 (*1.57*)	3.82 (*1.48*)	>.05	-	3.34 (*1.35*)	2.98 (*1.36*)	>.05	-
Perceived norms about support-giving - M (*SD*)	2.76 (*.50*)	2.68 (*.49*)	>.05	-	3.95 (*.83*)	4.20 (*.73*)	<.05	*d* = .33
Attitudes towards support-giving - M (*SD*)	5.64 (*.64*)	5.60 (*.63*)	>.05	-	5.70 (*.68*)	5.76 (*.63*)	>.05	-
PBC of support-giving - M (*SD*)	3.63 (*.64*)	3.62 (*.60*)	>.05	-	4.07 (*.66*)	4.27 (*.57*)	<.05	*d* = .54

Table 31: Proportions of boys and girls that thought each response was 'helpful', 'harmful', or would 'make no difference'

Response	**Helpful** **% (A.S.R.)**	**Harmful** **% (A.S.R.)**	**Make no difference** **% (A.S.R.)**	$\chi^2(2)$	***w***
Listen to X’s problems in an understanding way	Boys: 97.8 (.1) Girls: 97.7 (-.1)	Boys: 0.4 (-.1) Girls: 0.4 (.1)	Boys: 1.8 (-.1) Girls: 2.0 (.1)	.019	
Talk to X firmly about getting his/her act together	Boys: 19.9 (2.3) Girls: 12.5 (-2.3)	Boys: 68.2 (-1.9) Girls: 75.8 (1.9)	Boys: 11.9 (.1) Girls: 11.7 (-.1)	5.470	
Suggest X seek professional help	Boys: 64.6 (-2.4) Girls: 74.2 (2.4)	Boys: 17.0 (2.3) Girls: 10.2 (-2.3)	Boys: 18.4 (.9) Girls: 15.6 (-.9)	6.882 *	
Make an appointment for X to see a GP	Boys: 55.6 (.6) Girls: 53.1 (-.6)	Boys: 28.2 (.0) Girls: 28.1 (.0)	Boys: 16.2. (-.8) Girls: 18.8 (.8)	.628	
Ask X whether he/she is feeling suicidal	Boys: 29.6 (-2.6) Girls: 40.2 (2.6)	Boys: 56.3 (1.6) Girls: 49.2 (-1.6)	Boys: 14.1 (1.2) Girls: 10.5 (-1.2)	6.940 *	
Suggest X has a few drinks to forget his/her troubles	Boys: 8.7 (1.6) Girls: 5.1 (-1.6)	Boys: 79.4 (-2.6) Girls: 87.9 (2.6)	Boys: 11.9 (1.9) Girls: 7.0 (-1.9)	6.922 *	
Rally friends to cheer X up	Boys: 80.1 (2.9) Girls: 69.1 (-2.9)	Boys: 9.7 (-.5) Girls: 10.9 (.5)	Boys: 10.1 (-3.2) Girls: 19.9 (3.2)	10.979 *	
Ignore X until he/she gets over it	Boys: 1.1 (-.1) Girls: 1.2 (.1)	Boys: 91.3 (.0) Girls: 91.4 (.0)	Boys: 7.6 (.1) Girls: 7.4 (-.1)	.014	
Keep X busy to keep his/her mind off his/her problems	Boys: 73.6 (2.3) Girls: 64.5 (-2.3)	Boys: 6.1 (-.9) Girls: 8.2 (.9)	Boys: 20.2 (-1.9) Girls: 27.3 (1.9)	5.279	
Encourage X to become more physically active	Boys: 81.6 (3.0) Girls: 70.7 (-3.0)	Boys: 3.2 (-.9) Girls: 4.7 (.9)	Boys: 15.2 (-2.7) Girls: 24.6 (2.7)	8.790 *	

A.S.R. = adjusted standardised residual; * = statistically significant at $p < .05$

Table 32: Proportions of female and male caregivers that thought each response was 'helpful', 'harmful', or would 'make no difference'

Response	**Helpful % (A.S.R.)**	**Harmful % (A.S.R.)**	**Make no difference % (A.S.R.)**	**$\chi^2(2)$**	***w***
Listen to X's problems in an understanding way	Female: 99.6 (-.5) Male: 100.0 (.5)	Female: 0.4 (.5) Male: 0.0 (-.5)	Female: 0.0 (-) Male: 0.0 (-)	.210[18]	-
Talk to X firmly about getting his/her act together	Female: 9.4 (-1.3) Male: 15.7 (1.3)	Female: 80.3 (1.5) Male: 70.6 (-1.5)	Female: 10.2 (-.7) Male: 13.7 (.7)	2.553	-
Suggest X seek professional help	Female: 90.6 (1.7) Male: 82.4 (-1.7)	Female: 7.0 (-.7) Male: 9.8 (.7)	Female: 2.5 (-1.9) Male: 7.8 (1.9)	4.382	-
Make an appointment for X to see a GP	Female: 90.2 (1.6) Male: 82.4 (-1.6)	Female: 5.7 (-.6) Male: 7.8 (.6)	Female: 4.1 (-1.7) Male: 9.8 (1.7)	3.297	-
Ask X whether he/she is feeling suicidal	Female: 62.3 (1.5) Male: 51.0 (-1.5)	Female: 33.6 (-1.0) Male: 41.2 (1.0)	Female: 4.1 (-1.1) Male: 7.8 (1.1)	2.834	-
Suggest X has a few drinks to forget his/her troubles	Female: 0.8 (.6) Male: 0.0 (-.6)	Female: 95.9 (.6) Male: 94.1 (-.6)	Female: 3.3 (-.9) Male: 5.9 (.9)	1.199	-
Rally friends to cheer X up	Female: 55.3 (1.3) Male: 45.1 (-1.3)	Female: 13.5 (-3.1) Male: 31.4 (3.1)	Female: 31.1 (1.1) Male: 23.5 (-1.1)	9.735*	.182*
Ignore X until he/she gets over it	Female: 1.2 (-1.4) Male: 3.9 (1.4)	Female: 95.9 (1.1) Male: 92.2 (-1.1)	Female: 2.9 (-.4) Male: 3.9 (.4)	2.019	-
Keep X busy to keep his/her mind off his/her problems	Female: 40.6 (.2) Male: 39.2 (-.2)	Female: 18.0 (-.6) Male: 21.6 (.6)	Female: 41.4 (.3) Male: 39.2 (-.3)	.351	-
Encourage X to become more physically active	Female: 91.8 (2.1) Male: 82.4 (-2.1)	Female: 0.4 (-1.2) Male: 2.0 (1.2)	Female: 7.8 (-1.8) Male: 15.7 (1.8)	4.790	

A.S.R. = adjusted standardised residual; * = statistically significant at $p < .05$

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[18] There is only 1 degree of freedom, because no caregivers selected 'make no difference' in response to this item.

7.4 Comparison of younger and older adolescents' responses

Addressing the fourth research question of the current study, adolescents'' responses were compared on the basis of age, see Table 33. Older adolescents had significantly greater sympathy for the vignette character (small effect size) than younger adolescents, and showed significantly greater concern (small effect size). Older adolescents were significantly more likely to identify depression than were younger adolescents (small association). Older adolescents perceived a statistically significantly longer recovery time for the vignette character than did younger adolescents (medium effect size), while younger adolescents perceived symptoms to be significantly more controllable than did older adolescents (small effect size). Younger adolescents' attitudes were significantly more positive than older adolescents' attitudes (small effect size).

There were no significant differences between the proportions of younger and older adolescents who identified each of the referenced symptoms of depression, see Table 33.

Table 33: Proportion of younger and older adolescents who identified each of the symptoms of depression referenced in the vignette

	%		**$\chi^2(1)$**	***w***
Symptom	**Younger**	**Older**		
Depressed mood	68.3	67.9	.013	-
Diminished interest	51.3	50.1	.171	-
Insomnia	31.7	35.7	2.256	-
Diminished concentration	21.1	20.0	.242	-
Feelings of worthlessness	20.1	18.3	.673	-
Fatigue	14.1	17.6	2.680	-

Adolescents' beliefs about the helpfulness and harmfulness of certain responses were also examined for age differences, see Table 35.

Younger adolescents were more likely than older adolescents to think that '*Talk to X firmly about getting his/her act together*' would be a helpful response. Older adolescents were more likely to believe that the actions '*Rally friends to cheer X up*' and '*Keep X busy to keep his/her mind off his/her problems*' would make no difference, while younger adolescents were more likely to believe that these actions would be helpful. Older adolescents were more likely than younger adolescents to think that '*Listen to X's problems in an understanding way*' would be a helpful response, while younger adolescents were more likely to think that this response would make no difference. Older adolescents were more likely than younger adolescents to believe that the actions '*Suggest X seek professional help*', and '*Ask X whether he/she is feeling suicidal*' would be helpful responses.

Table 34: Comparison of younger and older adolescents' responses

	Younger	**Older**	***p***	**Effect size**
Level of concern (*Mdn*)	3.00	3.00	<.05	η^2 =.011, d = .215
Identified depression	37.7%	52.1%	<.001	w = -.139, p = .001
Number of symptoms identified – M (*SD*)	2.07 (*1.24*)	2.12 (*1.24*)	>.05	-
Beliefs about prognosis (*Mdn*)	3.00	4.00	<.001	η^2 = .056, d = .489
Believed target needed help	91.3%	92.9%	>.05	-
Anger - M (*SD*)	2.50 (*1.60*)	2.25 (*1.46*)	>.05	-
Sympathy - M (*SD*)	7.36 (*1.28*)	7.61 (*1.22*)	<.05	d = .20
Perceived controllability of symptoms - M (*SD*)	4.22 (*1.48*)	3.75 (*1.56*)	<.05	d = .31
Perceived norms about support-giving - M (*SD*)	2.71 (*.48*)	2.74 (*.50*)	>.05	-
Affective attitudes towards support-giving - M (*SD*)	5.78 (*.62*)	5.54 (*.63*)	<.001	d = .38
Perceived behavioural control of support-giving - M (*SD*)	3.63 (*.67*)	3.62 (*.59*)	>.05	-

Table 35: Proportions of younger and older adolescents who thought each response would be ‘helpful’, ‘harmful’, or would ‘make no difference’

Response	**Helpful % (A.S.R.)**	**Harmful % (A.S.R.)**	**Make no difference % (A.S.R.)**	$\chi^2(2)$	***w***
Listen to X’s problems in an understanding way	Younger: 95.5 (-2.7) Older: 99.1 (2.7)	Younger: 1.0 (1.8) Older: 0.0 (-1.8)	Younger: 3.5 (2.2) Older: 0.9 (-2.2)	8.152 *	.123 *
Talk to X firmly about getting his/her act together	Younger: 24.1 (3.8) Older: 11.6 (-3.8)	Younger: 64.3 (-3.0) Older: 76.5 (3.0)	Younger: 11.6 (-.1) Older: 11.9 (.1)	14.618 **	.165 *
Suggest X seek professional help	Younger: 62.3 (-2.7) Older: 73.5 (2.7)	Younger: 19.1 (2.8) Older: 10.4 (-2.8)	Younger: 18.6 (.8) Older: 16.1 (-.8)	9.627 *	.134 *
Make an appointment for X to see a GP	Younger: 53.8 (-.3) Older: 55.1 (.3)	Younger: 28.1 (.0) Older: 28.0 (.0)	Younger: 18.1 (.3) Older: 17.0 (-.3)	.131	-
Ask X whether he/she is feeling suicidal	Younger: 28.1 (-2.5) Older: 38.7 (2.5)	Younger: 57.8 (1.8) Older: 49.7 (-1.8)	Younger: 14.1 (.8) Older: 11.6 (-.8)	6.157 *	.107 *
Suggest X has a few drinks to forget his/her troubles	Younger: 7.0 (.1) Older: 6.8 (-.1)	Younger: 82.4 (-.5) Older: 84.2 (.5)	Younger: 10.6 (.6) Older: 8.9 (-.6)	.402	-
Rally friends to cheer X up	Younger: 79.9 (2.0) Older: 72.0 (-2.0)	Younger: 10.6 (.2) Older: 10.1 (-.2)	Younger: 9.5 (-2.6) Older: 17.9 (2.6)	6.901 *	.114 *
Ignore X until he/she gets over it	Younger: 1.5 (.7) Older: 0.9 (-.7)	Younger: 88.9 (-1.6) Older: 92.9 (1.6)	Younger: 9.5 (1.4) Older: 6.3 (-1.4)	2.448	-
Keep X busy to keep his/her mind off his/her problems *	Younger: 74.9 (2.3) Older: 65.5 (-2.3)	Younger: 7.0 (.0) Older: 7.1 (.0)	Younger: 18.1 (-2.4) Older: 27.4 (2.4)	6.111 *	.107 *
Encourage X to become more physically active	Younger: 77.4 (.5) Older: 75.6 (-.5)	Younger: 4.5 (.5) Older: 3.6 (-.5)	Younger: 18.1 (-.8) Older: 20.8 (.8)	.019	-

A.S.R. = adjusted std. residual; * = statistically significant at $p < .05$, ** = statistically significant at $p < .001$

Chapter 8 Analysis of the association between identified factors and types of support-giving responses offered

8.1 Aim of chapter

The aim of this chapter is to outline the statistical analyses that were employed to address the fifth research question of this study, '*What is the relationship between each of the theoretically-grounded factors included in the conceptual framework of this study (namely: attitudes, norms, perceived behavioural control, previous experience engaging in the behaviour, perceived controllability, sympathy, anger, trait empathy, identification of depression, and level of contact) and the types of support-giving responses offered by caregivers and peers towards the character depicted in the vignette?'*, and to report the results of these analyses. In Chapter 6 of this thesis, the initial testing of the Modes of Intended Mental Health Support (MIMHS) scale with the current sample was documented. This testing captured participants' intended support-giving responses. Chapter 7 then detailed participants' responses on a range of different factors, all of which related directly to the situation depicted in the vignette, and outlined the differences found between groups of participants.

Building on this description of participants' responses, the current chapter commences by outlining participants' responses to measures of three person-specific (in contrast to situation-specific) factors. The chapter then describes the analytical method chosen to address the research question at hand, and the assumptions associated with this method. Next, the chapter progresses to describe the results of a series of hierarchical multiple regression analyses. These analyses assessed whether there was a statistically significant association between a range of identified variables and participants' scores on the three subscales of the MIMHS.

8.2 Person-specific factors

Three variables under investigation in this study are most aptly considered characteristics specific to the participants themselves, rather than a function of the participants' response to the scenario depicted in the vignette stimulus. These variables are: 'trait' empathy, level of exposure to mental illness, and previous experience providing support to an individual showing signs of depression. This section will provide an overview of participants' scores on these variables.

8.2.1 Empathy

'Trait' empathy was measured using the Basic Empathy Scale (BES; Joliffe & Farrington, 2006) with higher scores indicating greater trait empathy.

8.2.1.21 Adolescent participants

Adolescent participants mean BES score was 3.70 (SD = .44). Female adolescent participants had higher mean BES scores (M = 3.87, SD = .39) than did male adolescent participants (M = 3.55, SD = .44), and the difference was statistically significant, M = - .32, SE = .04, t (529.64) = -8.89, $p < .001$, with a medium-to-large effect size, Cohen's d = .77. Overall, older adolescents had higher mean BES scores (M = 3.73, SD = .43) than did younger adolescent participants (M = 3.65, SD = .46). This difference was also statistically significant, M = - .08, SE = .04, t (533) = -2.116, $p < .05$, but the effect size was small, Cohen's d = .18.

8.2.1.22 Caregiver participants

Caregiver participants' mean BES score was 3.60 (SD = .35). The difference between adolescents' and caregivers' mean scores was statistically significant, M = .10, SE = .03, t (797.213) = 3.591, $p < .001$, with a small effect size, Cohen's d = .25. Female caregivers had higher mean BES scores (*M* = 3.65, *SD* = .33) than did male caregivers (*M* = 3.43, *SD* = .35). Again, this difference was statistically significant, *M* = .22, *SE* = .05, *t* (293) = 4.227, *p* < .001, with a medium effect size, Cohen's *d* = .65.

8.2.2 Level of exposure to mental illness

Participants' exposure to mental illness was measured using a revised version of the Level of Contact Report (LCR; Tsang, Tam, Chan, & Cheung, 2003). Each participant was instructed 'tick all items that apply to you'; in analysis, the items are ranked in order of level of exposure, and the participant's highest-ranking item is deemed indicative of their level of exposure (see section 5.4.2.9 of Chapter 5 for more details). Higher LCR scores are indicative of greater exposure to mental illness.

8.2.2.23 Adolescent participants

The mean LCR score for adolescent participants was 5.78 (*SD* = 2.93), with the possible range being 0 to 9. Just over one-tenth (11.2%) of all adolescent participants selected '*I have had a mental illness*', which, in the LCR, is considered the greatest level of exposure to mental illness. In comparison, approximately one-fifth (19.2%) of adolescents selected '*None of the above is true*', indicating that they had no exposure to mental illness. These proportions were echoed among male and female adolescents, with 10.1% of male and 11.7% of female adolescents selecting '*I have had a mental illness*', and 19.5% of male and 18.8% of female adolescents stating, '*None of the above is true*'. The mean LCR score for adolescent girls was slightly higher (*M* = 4.84, *SD* = 2.80) than the mean for adolescent boys (*M* = 4.44, *SD* = 2.64). This difference was not statistically significant however, *M* = - .40, *SE* = .24, *t* (529.207) = -1.712, *p* > .05. Older adolescents also had higher LCR scores, on average (*M* = 5.19, *SD* = 2.69) than did younger adolescents (*M* = 3.74, *SD* = 2.55). This difference was statistically significant, *M* = -1.452, *SE* = .23, *t* (433.542) = .376, *p* < .001, with a medium effect size, Cohen's *d* = 0.55.

8.2.2.24 *Caregiver participants*

Caregivers' average level of contact with mental illness was higher (*M* = 5.78, *SD* = 2.93) than was that of adolescents (*M* = 4.65, *SD* = 2.73). This difference was statistically significant, *M* = -1.13, *SE* = .20, *t* (636.776) = -5.594, *p* < .001, with a small effect size, Cohen's *d* = .40. Almost one-third (28.0%) of caregiver participants selected '*I have had a mental illness*', with 11.9% selecting '*None of the above is true*'. Again, these proportions were similar among female and male caregivers, with 30.3% of female caregivers and 31.4% of male caregivers selecting '*I have had a mental illness*', and 11.8% of female caregivers and 11.8% of male caregivers selecting '*None of the above is true*'. While on average, female caregivers had greater exposure to mental illness (*M* = 5.94, *SD* = 2.93) than did male caregivers (*M* = 5.84, *SD* = 2.89), this difference was not statistically significant, *M* = .10, *SE* = .45, *t* (293) = .221, *p* > .05.

8.2.3 Previous experience helping an individual showing signs of depression

Participants' past support-giving behaviour was measured using a series of questions that were originally used by Yap and Jorm (2011, 2012).

8.2.3.25 *Adolescent participants*

Participants were asked "*In the past year, has anyone in your family or close circle of friends had a problem similar to X's?*". The majority (49.6%) of adolescent participants selected '*No*' as their response, with 12.0% choosing '*Don't Know'* and 38.4% selecting '*Yes*'. Seven adolescent participants did not respond to this question. Among boys, the majority (53.3%) answered '*No*', with 30.7% answering '*Yes*' and 16.1% answering '*Don't Know*'. In comparison, among girls, 45.6% answered '*No*', with 46.8% answering '*Yes*' and 7.5% answering '*Don't Know*'. This difference between boys and girls was statistically significant, $\chi^2(2) = 18.438$, *p* < .001. Review of the adjusted standardised residuals indicated that significantly more boys than girls answered 'Don't

Know' and significantly more girls than boys answered 'Yes', see Table 36.

Table 36: Proportion (and associated adjusted standardised residual) of male, female and all adolescents who gave each response option

In the past year, has anyone in your family or close circle of friends had a problem similar to X's?	**Male** **% (A.S.R.)**	**Female** **% (A.S.R.)**	**Total** **%**	$\chi^2(2)$
No	53.3 (1.8)	45.6 (-1.8)	49.6	18.438 **
Don't Know	16.1 (3.0)	7.5 (-3.0)	12.0	
Yes	30.7 (-3.8)	46.8 (3.8)	38.4	

A.S.R. = adjusted standardised residual; ** = $p < .001$

Participants who selected '*Yes*' were then asked a series of further questions, to learn more about their experiences. First, participants were asked "*Did just one person have the problem, or more than one?*"; the majority (61.4%) stated '*Just one*' with 38.6% stating '*More than one*'. Those who selected '*More than one*' were told '*Because you know more than one person who had a problem similar to X's, for the next few questions, I want you to think about the person you know best*'. Participants were asked the person's age; 2.1% stated that the person was aged 0 to 9 years, with 77.1% indicating that the person was 10- to 19-years-old, 7.5% stating that the person was aged 20-29 years, 3.3% stating that the person was aged 30-39 years, 5.8% stating that the person was aged 40-49 years, 1.3% stating that the person was aged 50-59 years, and 1.3% stating that the person was aged 60 years or over. A small proportion (1.7%) of participants stated that they did not know the person's age. Participants were asked to indicate the person's gender, with 39.6% stating the person was male, 58.3% stating the person was female, and 2.1% stating that the person did not identify as male or female. Male adolescents were more likely to know a male individual who experienced depression (67.9%) than to know a female individual experiencing depression (30.2%); similarly, female adolescents were more likely to know a female individual who had experienced depression (81.9%) than to know a male individual experiencing these problems (16.5%). This difference was statistically significant, $\chi^2(2) = 64.72, p < .001$, verified by inspection of the adjusted standardised residuals, see Table 37.

Table 37: Proportion (and associated adjusted standardised residual) of male, female and all adolescents who gave each response option

What was this person's gender?	**Male** **% (A.S.R.)**	**Female** **% (A.S.R.)**	**Total** **%**	$\chi^2(2)$
Male	67.9 (8.0)	16.6 (-8.0)	39.9	64.72**
Female	30.2 (-8.0)	81.9 (8.0)	58.4	
Other	1.9 (.2)	1.6 (-.2)	1.7	

A.S.R. = adjusted standardised residual; ** = $p < .001$

Participants were asked to indicate whether the person was a family member or a friend; 45.1% of participants stated that the person was a family member, and 54.9% stated that the person was a friend. The majority (85.2%) of participants answered '*Yes*' when asked, '*In the past year, have you done anything to help this person?*'; 14.8% answered '*No*'. Participants that answered '*Yes*' will henceforth be referred to as 'helpers', for simplicity. The proportion of helpers was greater among girls, of which 87.9% were helpers, than among boys, of which 82.0% were helpers. This was not a statistically significant difference, $\chi^2(1) = 1.620, p > .05$. In addition, the proportion of helpers (86.0%) was greater in the older adolescent age group than the proportion of helpers (83.1%) among younger participants, but again, this was not a statistically significant difference, $\chi^2(1) = .330, p > .05$.

Participants were next asked '*What did you do [to help this person]?*' and were provided with space to write about their actions. The responses to this open-ended question were then analysed using conventional content analysis, according to the guidelines set out by Hsieh and Shannon (2005). Eleven categories of support-giving behaviours were determined. If a response detailed more than one support-giving behaviour, and these fell into different categories, it was coded for each. The frequency of each category (among participants who said that they helped someone with symptoms similar to Michael/Michelle) is provided in Table 38. Support-giving behaviour that included comforting, reassuring, listening, and talking to the person was the most frequently referenced category of behaviour, with three-quarters (76.4%) of participants mentioning this. The next most frequently mentioned category, mentioned by 10.6% of participants, described encouraging the person to engage with professional care. This was closely followed by the frequency of responses referencing encouraging the person to practice self-care (9.5%), such as getting adequate sleep, partaking in physical activity, etc.

Engaging an adult was the next most frequently mentioned response, with 9.0% of participants mentioning that they contacted a parent, teacher, or other member of school staff in order to recruit their support for the person. The frequency of responses that detailed encouraging the person to look on ‘the bright side’, be optimistic, cheer up or change their perspective was 8.0%. Distracting the person was mentioned by 5.5% of participants; this typically involved organising activities such as going to cinema together. A small proportion of participants (4.5%) mentioned that they became actively involved in the person receiving professional care (e.g., attending counselling sessions with the person), which was distinguished from simply encouraging the person to seek professional support. Discouraging the person from engaging in actions that could have a negative impact on mental health (e.g. alcohol consumption) was mentioned by 3.0% of participants. The same proportion of participants (3.0%) responded inappropriately to the person, for example, telling the person, “Get on with life” (Girl, aged 17). Some participants (2.5%) described monitoring the person’s behaviour for symptoms, and the same proportion (2.5%) described supporting the person by providing practical assistance – for example, by babysitting, helping with farm work, or helping with homework. A small proportion (1.0%) of participants mentioned that they responded by discussing their concerns with peers (i.e., non-adults) and engaging their support.

Table 38: Categories of adolescent participants' previous helping behaviour, with sample of quote coded for each category and frequency of each category among participants’ responses

Category	**Sample quote**	**Frequency (%)**
Comforted	“I always talked to them, I did my best to comfort them, I reassured her that it will get better and we had long deep talks about the situation” (Boy, aged 16)	76.4
Encouraged self-care	“Tried to encourage him to go to bed earlier so he can get up for school and not be aggravated” (Girl, aged 15)	9.5
Encouraged professional care	“Encouraged them to speak to professional” (Girl, aged 18)	10.6
Engaged an adult	“Informed members of staff who helped her” (Girl, aged 13)	9.0
Discouraged negative actions	“Tried to get her to stop drinking, tried to talk her out of self-harming” (Boy, aged 16)	3.0
Distracted	“Clear their head by distracting them with things they like” (Boy, aged 16)	5.5
Encouraged positive thinking	“Try motivate her to look at the positive side of life” (Boy, aged 15)	8.0
Monitored behaviour	“Watched them closely for next few weeks but never directly mentioned it to that person” (Boy, aged 16)	2.5
Practical help	“I took care of her children” (Girl, aged 15)	2.5
Active involvement in professional care	“Spoke to him, went to counselling session with them” (Girl, aged 17)	4.5
Talked to peers	“Discussed with friends” (Girl, aged 16)	1.0
Inappropriate responses	“Told him to get over it” (Boy, age 14)	3.0

8.2.3.26 Caregiver participants

When asked '*In the past year, has anyone in your family or close friends had a problem similar to X's?*', 48.6% of caregiver participants answered '*Yes*', with 46.5% stating '*No*' and 4.1% selecting '*Don't Know*'. Four participants did not answer this question. Caregivers' sex was not associated with any statistically significant differences; 49.2% of female caregivers answered '*Yes*' and 47.1% answered '*No*', while 41.2% of male caregivers answered '*Yes*' and 54.9% answered '*No*', $\chi^2(3) = 1.349, p > .05$.

Those who answered '*Yes*' were asked a series of further questions, the first of which read, '*Did just one person have the problem, or more than one?*'. The majority (69.0%) of participants selected '*Just one*', with 31.0% selecting '*More than one*'. Those who answered '*More than one*' were directed to answer all following questions by thinking about the person that they know best. Participants were asked to indicate the age of the person; 2.2% stated that the person was aged 0-9 years, 58.0% stated that the person was 10-19 years old, 8.0% stated the person was 20-29 years old, 10.9% stated that the person was aged 30-39 years, 10.9% stated that the person was 40-49 years, 8.7% stated that the person was 50-59 years, and 1.4% stated that the person was 60 years or over. Over half (58.6%) of participants said that the person was female, while 41.4% stated the person was male. Female caregivers were more likely to know a female individual with mental health problems (63.1%) than to know a male individual with these problems (36.9%). Male caregivers, on the other hand, were more likely to know a male individual with mental health problems (57.1%) than a female individual with these issues (42.9%). This difference between female and male caregivers was statistically significant, $\chi^2(1) = 3.00, p < .05$. Participants were asked whether the person was a family member or a friend; 87.9% indicated that the person was a family member while 12.1% said that the person was a friend.

The vast majority (92.8%) of caregivers answered '*Yes*' when asked '*In the past year, have you done anything to help this person?*', with 7.2% answering '*No*'. The proportion of helpers was slightly larger among male caregivers, of which 95.0% were helpers, than among female caregivers, of which 92.7% were helpers. This difference was not statistically significant, $\chi^2(1) = .136, p > .05$. Caregivers were next asked '*What did you do [to help this person]?*' and were provided with space to write about their actions. The responses to this open-ended question were then analysed using conventional content analysis (Hsieh & Shannon, 2005). In the same manner as the analysis of adolescent participants' responses, if responses mentioned support-giving behaviours that fell into multiple categories, responses were coded for the presence of each of these categories. Eight categories of responses were identified; the frequency of responses (from participants that stated they helped someone with symptoms similar to those displayed by Michael/Michelle) that were coded for each category, and sample quotes for each category, are presented in Table 39. The most frequently-mentioned category of response involved comforting, talking and listening to the person, which was mentioned by 56.8% of participants. This was followed by responses that described engaging professional care for the person, which was mentioned by 48.4% of participants. A quarter (25.0%) of participants reported that they encouraged the person to practice self-care, for example, by encouraging a healthy diet. School staff were contacted by 10.4% of participants, while 8.0% of participants engaged the support of another adult (typically, another family member or friend). Some (7.2%) participants stated that they encouraged the person to seek professional care, which was distinguished from "actively engaged the support of a mental health professional". A small proportion of participants (3.2%) described responding by providing support to members of the person's family. Some participants (3.2%) described supporting the person in practical ways, for example by babysitting the person's children.

Table 39: Categories of caregiver participants' examples of previous helping behaviour, with samples of quotes

Category	Sample quote	Frequency (%)
Encouraged professional care	"Encouraged her to get medical assistance" (Mother)	7.2
Encouraged self-care	"Try to encourage them to do different activities which might affect mood" (Father)	25.0
Engaged professional care	"Made GP appointment, made psychology appointment" (Mother)	48.4
Engaged another adult	"Sought help off my mother" (Mother)	8.0
Engaged school staff	"I contacted the school and made them aware of the situation and the school handled it brilliantly" (Mother)	10.4
Comforted/talked	"Phoned/met up with her/listened to her" (Mother)	56.8
Supported family	"Provided support to this person's family" (Mother)	3.2
Practical help	"Let him move into my house" (Mother)	3.2

8.3 Hierarchical Multiple Regression

A review of the literature (see Chapter 3) led to the identification of several key variables as being potentially associated with intentions to provide support to a young person showing signs of depression. For adolescent participants, these were: sex, age, attitudes towards support-giving, norms regarding support-giving, perceived behavioural control (PBC) regarding support-giving, empathy, perceived controllability of symptoms, anger, sympathy, previous experience of support-giving, identification of depression (as a proxy for MHL), and exposure to mental illness. For caregiver participants, these were: child sex, child age, caregivers' own gender, attitudes towards support-giving, norms regarding support-giving, perceived behavioural control (PBC) regarding support-giving, empathy, perceived controllability of symptoms, anger, sympathy, previous experience of support-giving, identification of depression, and exposure to mental illness.

The second research question of the current study sought to explore the influence of these variables on participants' intentions to engage in different types of support-giving (as assessed by the subscales of the MIMHS). In order to address this question, hierarchical multiple regression (HMR) was employed. Regression analyses are the main recommended analyses for the TPB (Ajzen, 1991), a theoretical framework which has helped guide this study. Furthermore, comparable studies have used regression analyses – for example, to assess the relationship between a set of variables and (a) an individual's stated intention to intervene when another individual displays suicidality (Aldrich, 2015), (b) resident assistants' intentions to refer students to counselling (Servaty-Seib et al., 2013), and (c) parents' and siblings' supportive behaviour toward a family member with intellectual disability (Rimmerman & Chen, 2012). Thus, it was decided to conduct analyses in which the identified variables were regressed in a hierarchical fashion on each of the three subscales of the MIMHS, for both adolescents and caregivers.

8.3.1 Assumptions

The theory underpinning HMR is based on a set of assumptions, against which the data must be checked. These assumptions are detailed below.

8.3.1.27 Sample size

Recommendations vary with regards to the appropriate sample size for hierarchical regression analyses, however many experts (Field, 2018; Tabachnik & Fidell, 2007) suggest Green's (1991) calculation, where the minimum sample size should equal 104 + k (where k is the number of predictors), is suitable. In analyses of the adolescent sample, twelve variables are of interest, suggesting that the minimum sample size should be 116; the adolescent sample is therefore adequate (n = 535). In the caregiver sample, there are thirteen predictors, which results in a minimum sample size of 117. As such, the caregiver sample (n = 321) is also adequate.

8.3.1.28 Outliers

Outliers can have a disproportionate impact on the regression solution, and additionally affect the precision of estimation of regression. However, a point's influence is thought to be more problematic than the fact that it is an outlier, with Chatterjee and Hadi (1986, p. 381) stating, "If an observation has little influence on the results, there is little point in agonizing over how deviant it appears". Stevens (2002) suggests that, instead, the indicator of most pertinence here is Cook's Distance, which is measure of the difference between the regression parameter estimates, and the change of same if the *i*th data point is deleted. Cases for which Cook's Distance >1 are influential, and should not be included in the analysis (Chatterjee, Hadi, & Price, 2000). Also of relevance is a point's leverage, for which values should be <.1.

8.3.1.29 *Absence of multicollinearity and singularity*

Multicollinearity (and, relatedly, singularity) causes issues for regression analyses when correlations between predictor variables are greater than .9 (Tabachnik & Fidell, 2007). Additionally, multicollinearity can be assessed through the Variance Inflation Factor (VIF); VIF values above 10 indicate cause for concern (Myers, 1990). Related to VIF is the tolerance statistic, which is its reciprocal. As such, values below 0.1 indicate serious problems (Field, 2018).

8.3.1.30 *Normality, linearity, and homoscedasticity of residuals*

In regression modelling, the shape of the distribution of the predictors does not typically have an impact on the model; however, the distribution of the residuals (or errors) can have a significant impact (Babyak, 2004). The normality and linearity of the distribution of the residuals can be assessed through inspection of a histogram and a normal probability plot (Q-Q plot). The assumption of homoscedasticity requires that the variance of residuals is constant. Violation of these assumptions does not invalidate an analysis so much as weaken it (Hayes, 2013).

8.3.1.31 *Independence of errors*

Independence of errors is also testable through analysis of the residuals; ‘independence’ in this context refers to the assumption that errors of prediction are independent of one another. The value of relevance is the Durbin-Watson statistic, which measures autocorrelation of errors over the sequence of cases. The Durbin-Watson statistic can vary between 0 and 4, with a value approximating 2 meaning that the residuals are uncorrelated (Field, 2018).

8.3.1.32 *Order of entry*

In hierarchical regression, “known predictors should be entered into the model first, in order of their importance in predicting the outcome” (Field, 2005, p. 212). Demographic variables are typically entered in the first step, followed by the predictor variables that have strongest theoretical or empirical evidence. In the current study, variables were entered in accordance with the review of theory outlined in Chapter 3. Variables that are being explored in the current analysis (i.e., those that have not been substantially tested previously) should be entered last. After the initial analysis, the regression should be repeated, excluding any variables that were statistically redundant (Field, 2018). By excluding the predictor variables that are not correlated with the outcome variable, the researcher can thus conserve statistical power.

8.4 Adolescent sample

8.4.1 Checking the assumptions

Leverage values were all <.1 and all Cook's Distance values were <1, indicating that there were no highly influential cases. Spearman's ρ correlation statistics indicated no strong relationships (>.9) existed between any of the predictor variables (see Table 40). Tolerance values were >.1 and VIF values <10 for all predictors, demonstrating that there was no evidence of multicollinearity in the data. Inspection of Q-Q plots of studentised residuals for each subscale indicated the residuals were approximately normally distributed. Finally, there was independence of residuals, as indicated by Durbin-Watson values of 1.909 for the Generic Support subscale, 1.908 for the Seeking Expertise subscale, and 1.950 for the Informing Adults subscale.

Participant gender (0 = male, 1 = female) and age were entered in the first step of the hierarchical analysis. In the second step, the TPB variables – namely, mean attitudes, mean norms, and mean PBC were entered. In the third step, the variables suggested by the AEMHB – mean controllability, mean anger, mean sympathy, and mean (trait) empathy were entered. The exploratory variables of previous helping experience (0 = no previous experience, 1 = previous experience), identification of depression (0 = did not identify, 1 = identified), and exposure to mental illness were added individually in steps four, five, and six.

Table 40: Spearman's ρ correlations between predictor variables

	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**
1. Attitudes	1												
2. Norms	.238**	1											
3. PBC	-.361**	-.389**	1										
4. Empathy	-.049	-.252**	.331**	1									
5. Perceived controllability	.072	.144**	-.098*	-.214**	1								
6. Sympathy	-.190**	-.281**	.299**	.414**	-.337**	1							
7. Anger	.305**	.235**	-.290**	-.310**	.328**	-.395**	1						
8. Previous experience helping	.064	.015	.110*	.238**	-.061	.094*	-.042	1					
9. Identification of depression	.037	-.106*	.063	.145**	-.144**	.172**	-.076	.082	1				
10. Exposure to mental illness	.115**	.006	.071	.191**	-.155**	.114**	-.054	.412**	-.204**	1			

* *p* < .05 (2-tailed), ** *p* < .01 (2-tailed)

8.4.2 Results of HMR analyses of predictor variables on three subscales of the MIMHS with adolescent sample

8.4.2.33 Generic Support

For the Generic Support subscale, the full model was significant with $R^2 = .428$, $F(12, 517) = 32.251$, $p < .001$, adjusted $R^2 = .415$. Thus, the variables accounted for approximately 40% of the variance in participants' intentions to provide generic support. A summary of model results is provided in Table 41. As can be identified in the table, the addition of 'identification of depression' and 'exposure to mental illness' did not contribute significantly to the model.

Table 41: Summary of results for the overall model of predictors on the Generic Support subscale

	R^2	Adjusted R^2	*F* Change
Gender, age	.097	.093	28.258**
+ TPB variables	.298	.291	50.066**
+ AEMHB variables	.418	.408	26.914**
+ previous helping experience	.426	.414	6.371
+ identification of depression	.426	.414	.277
+ exposure to mental illness	.428	.415	2.072

** $p < .001$

Through examination of the regression coefficients, the impact of each variable can be further explored, see Table 42. Gender was found to have a significant effect on adolescents' intentions to provide Generic Support ($\beta = .180$, $p = .001$); girls had higher mean scores than did boys. Norms significantly predicted scores ($\beta = -.169$, $p = .001$), with higher perceived norms regarding support-giving associated with lower intentions to provide support. PBC also had a significant association ($\beta = .171$, $p = .001$), with higher PBC associated with higher mean intention scores. Higher empathy was significantly associated with intentions to provide support, $\beta = .152, p = .001$, as was greater sympathy for the young person showing signs of depression, $\beta = .268, p = .001$.

Table 42: Standardised estimates, unstandardised estimates, and standard errors for all potential predictors of adolescents' intentions to provide generic support

Predictor Variable	**Generic Support**		
	β	**B**	**SE**
Age	-.015	-.004	.010
Gender (ref. male)	.180**	.159	.032
Attitudes	-.009	.006	.027
Norms	-.169**	-.107	.024
PBC	.171**	.122	.029
Empathy	.152**	.151	.042
Controllability	.000	4.664E-5	.011
Sympathy	.268**	.094	.014
Anger	-.048	-.014	.011
Previous helping experience	.067	.061	.034
Identification of depression	.011	.010	.030
Exposure to mental illness	.055	.009	.006

** $p < .001$

In order to conserve power, the regression analysis was re-run, without the variables that did not have a significant association with intentions to provide generic support. As such, the regression analysis included gender, norms, PBC, empathy, and sympathy. This model was statistically significant, $R^2 = .416$, $F(5, 527) = 75.002$, $p < .001$, adjusted $R^2 = .410$. These variables alone thus accounted for approximately 40% of the variance in participants’ intentions to provide generic support. Each of the variables had a statistically significant association with participants’ mean scores on the Generic Support subscale, see Table 43.

Table 43: Standardised estimates, unstandardised estimates, and standard errors for significant predictors of adolescents' intentions to provide generic support

Predictor Variable	**Generic Support**		
	β	**B**	**SE**
Gender	.183**	.162	.032
Norms	-.171**	-.109	.023
PBC	.188**	.134	.027
Empathy	.171**	.170	.040
Sympathy	.288**	-.101	. 013

* $p < .05$, ** $p < .001$

8.4.2.34 *Seeking Expertise*

For the Seeking Expertise subscale, the full model was significant, $R^2 = .221$, $F\ (12, 517) = 12.230$, $p < .001$, adjusted $R^2 = .203$. The model thus accounted for approximately 20% of the variance in participants' intention to seek expertise to support a young person showing signs of depression. A summary of model results is provided in Table 44. As can be identified in the table, the addition of 'previous helping experience' and 'exposure to mental illness' did not contribute significantly to the model.

Table 44: Summary of results for the overall model of predictors on the Seeking Expertise subscale

	R^2	**Adjusted** R^2	F **Change**
Gender, age	.005	.001	1.298
+ TPB variables	.172	.164	35.207**
+ AEMHB variables	.191	.177	3.125*
+ previous helping experience	.194	.178	1.495
+ identification of depression	.221	.204	18.207**
+ exposure to mental illness	.221	.203	.078

* $p < .05$, ** $p < .001$

Exploring the regression coefficients (see Table 45), one can identify that PBC was significantly associated with adolescents' intentions to seek expertise, $\beta = .378$, $p = .001$, as was participants' sympathy ($\beta = .130$, $p = .006$). Thus, participants who had greater PBC, and greater sympathy for the individual, had higher scores on the Seeking Expertise subscale. Participants' identification of depression had a significant association with intentions to seek expertise ($\beta = .168, p = .001$); as this is a dichotomous variable coded 0 = Did Not Identify, 1 = Identified, this can be interpreted as meaning that participants who identified depression had higher scores on the Seeking Expertise subscale.

Table 45: Standardised estimates, unstandardised estimates, and standard errors for all potential predictors of adolescents' intentions to seek expertise

Predictor Variable	**Seeking Expertise**		
	β	**B**	**SE**
Age	.008	.003	.014
Gender	.057	.059	.043
Attitudes	.043	.035	.037
Norms	-.069	-.051	.032
PBC	.378**	.315	.039
Empathy	-.057	-.067	.057
Controllability	-.034	-.011	.015
Sympathy	.130*	.053	.019
Anger	.064	.022	.015
Previous helping experience	-.061	-.064	.046
Identification of depression	.168**	.173	.041
Exposure to mental illness	.012	.002	.008

* $p < .05$, ** $p < .001$

As with the Generic Support subscale, the regression analysis was re-run, excluding the variables that did not have a significant association with intentions to seek expertise. As such, the regression analysis included PBC, sympathy, and identification of depression. This model was statistically significant, $R^2 = .210$, $F(3, 531) = 46.970$, $p < .001$, adjusted $R^2 = .205$. These variables alone thus accounted for approximately 20% of the variance in participants' intentions to seek expertise. Each of the variables had a statistically significant association with participants' mean scores on the Seeking Expertise subscale, see Table 46.

Table 46: Standardised estimates, unstandardised estimates, and standard errors for significant predictors of adolescents' intentions to seek expertise

Predictor Variable	**Seeking Expertise**		
	β	**B**	**SE**
PBC	.360**	.299	.033
Sympathy	.111*	.046	.017
Identification of depression	.177**	.182	.040

* $p < .05$, ** $p < .001$

8.4.2.35 Informing Adults

The full model was significant for the Informing Adults subscale, $R^2 = .317$, $F\ (12, 517) = 17.862$, $p < .001$, adjusted $R^2 = .277$. The model thus accounted for approximately 28% of the variance in participants' intention to inform an adult regarding a young person showing signs of depression. A summary of model results is provided in Table 47. As can be identified in the table, the addition of the variables proposed by the AEMHB, 'identification of depression', and 'exposure to mental illness' did not contribute significantly to the model.

Table 47: Summary of results for the overall model of predictors on the Informing Adults subscale

	R^2	**Adjusted** R^2	F **Change**
Gender, age	.101	.098	29.739**
+ TPB variables	.271	.264	40.663**
+ AEMHB variables	.283	.271	2.191
+ previous helping experience	.292	.278	6.274*
+ identification of depression	.292	.277	.336
+ exposure to mental illness	.293	.277	.645

* $p < .05$, ** $p < .001$

Exploring the regression coefficients (see Table 48), one can identify that participants' age was significantly associated with adolescents' intention to inform an adult ($\beta = -.295$, $p = .000$), with older participants having lower scores on the Informing Adults subscale. The norms variable was significantly and negatively associated with intentions to inform an adult, *β* = -.124, *p* = .003. PBC was significantly associated with adolescents' intentions to inform an adult, *β* = .384, *p* = .001, as was participants' sympathy (*β* = .092, *p* = .042). Thus, participants who had greater PBC, and greater sympathy for the individual, had higher scores on the Informing Adults subscale. Participants' previous helping experience had a significant association with intentions to seek expertise (*β* = -.083, *p* = .045); as this is a dichotomous variable coded 1 = Does not have previous helping experience, 2 = Has previous helping experience, this can be interpreted as meaning that participants who have previous helping experience had lower scores on the Informing Adults subscale.

Table 48: Standardised estimates, unstandardised estimates, and standard errors for all potential predictors of adolescents' intentions to inform an adult

Predictor Variable	**Informing Adults**		
	β	**B**	**SE**
Age	-.295**	-.138	.019
Gender	-.039	-.058	.060
Attitudes	-.046	-.054	.050
Norms	-.124*	-.133	.045
PBC	.384**	.462	.054
Empathy	-.071	-.119	.079
Controllability	-.040	-.019	.020
Sympathy	.092*	.055	.027
Anger	.057	.028	.021
Previous helping experience	-.083	-.128	.064
Identification of depression	-.018	.026	.057
Exposure to mental illness	-.034	-.009	.012

* $p < .05$, ** $p < .001$

As with both previous subscales, the regression analysis was re-run, excluding the variables that did not have a significant association with intentions to inform adults. As such, the regression analysis included age, norms, PBC, sympathy, and previous helping experience. This model was statistically significant, $R^2 = .279$, $F(5, 526) = 40.786$, $p < .001$, adjusted $R^2 = .273$. These variables alone thus accounted for approximately 27% of the variance in participants' intentions to inform an adult. Each of the variables had a statistically significant association with participants' mean scores on the Informing Adults subscale, apart from Sympathy, which did not[19], see Table 49.

Table 49: Standardised estimates, unstandardised estimates, and standard errors for significant predictors of adolescents' intentions to inform an adult

Predictor Variable	**Informing Adults**		
	β	**B**	**SE**
Age	-.296**	-.139	.018
Norms	-.109*	-.116	.044
PBC	.348**	.418	.049
Sympathy	.050	.029	.023
Previous helping experience	-.113*	-.173	.058

* $p < .05$, ** $p < .001$

8.5 Results of HMR analyses of predictor variables on three subscales of the MIMHS with caregiver sample

8.5.1 Checking assumptions

Leverage values were all <.1 and all Cook's Distance values were <1, indicating that there were no highly influential cases. Spearman's ρ correlation statistics indicated no strong relationships (>.9) existed between any of the predictor variables (see Table 50). Tolerance values were >.1 and VIF values <10 for all predictors, demonstrating that there was no evidence of multicollinearity in the data. Inspection of Q-Q plots of studentised residuals for each subscale indicated the residuals were approximately normally distributed. Finally, there was independence of residuals, as indicated by a Durbin-Watson values of 2.008 for the Facilitation of Professional Support subscale, 2.058 for the Problem Minimisation subscale, and 2.054 for the Support Resource Utilisation subscale.

Participant gender (0 = male, 1 = female), child's gender (0 = male, 1 = female), and child's age were entered in the first step of the

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[19] Note that $p = .045$ for Sympathy in the full model (i.e., very close to .05).

hierarchical analysis. In the second step, the TPB variables, mean attitudes, mean norms, and mean PBC were entered. In the third step, the variables suggested by the AEMHB, mean controllability, mean anger, mean sympathy, and mean (trait) empathy were entered. The exploratory variables of previous support-giving experience (0 = no previous experience, 1 = previous experience), identification of depression (0 = did not identify depression, 1 = identified depression), and exposure to mental illness were added individually in steps four, five, and six.

Table 50: Spearman’s ρ correlations between predictor variables for caregiver sample

	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Attitudes	1												
2. Norms	.106	1											
3. PBC	.240**	.333**	1										
4. Empathy	.010	.114*	.109	1									
5. Perceived controllability	-.053	-.228**	-.122*	-.076	1								
6. Sympathy	.138*	.222**	.285**	.228**	-.282**	1							
7. Anger	-.286**	-.285**	-.321**	-.113*	.262**	-.317**	1						
8. Previous helping experience	-.034	.091	.072	.070	-.153**	.062	-.068	1					
9. Identification of depression	-.052	-.137*	-.127*	.183**	.201**	-.191**	.103	-.162**	1				
10. Exposure to mental illness	-.037	.132*	.176**	.042	-.209**	.022	-.151**	.278**	-.119*	1			

* $p < .05$ (2-tailed), ** $p < .01$ (2-tailed)

8.5.2 Results of HMR analyses of predictor variables on three subscales of MIMHS with caregiver sample

8.5.2.36 Facilitation of Professional Support

The full model was significant for the Facilitation of Professional Support subscale, $R^2 = .246$, $F(13, 280) = 7.019$, $p < .001$, adjusted $R^2 = .211$. The model thus accounted for approximately 21% of the variance in participants' intentions to facilitate professional support. A summary of model results is provided in Table 51. As can be identified in the table, the addition of 'previous helping experience', and 'exposure to mental illness' did not contribute significantly to the model.

Table 51: Summary of results for the overall model of predictors on the Facilitation of Professional Support subscale

	R^2	**Adjusted** R^2	F **Change**
Gender, child's age, child's gender	.065	.056	6.765**
+ TPB variables	.149	.132	9.435**
+ AEMHB variables	.188	.159	3.356*
+ previous helping experience	.198	.167	3.740
+ identification of depression	.246	.214	17.626**
+ exposure to mental illness	.246	.211	.007

* $p < .05$, ** $p < .001$

Through examination of the regression coefficients, the impact of each variable can be further explored, see Table 52. Gender was found to have a significant effect on caregivers' intentions to facilitate professional support ($\beta = .133, p = .016$); women had higher mean scores than did men. Child age significantly predicted caregivers' intentions to facilitate professional support, such that caregivers with older children had higher scores on the Facilitation of Professional Support subscale ($\beta = .122$, $p = .028$). Norms significantly predicted scores ($\beta = .238$, $p = .001$), with higher perceived norms regarding support-giving associated with higher intentions to facilitate professional support. Participants' identification of depression had a significant association with intentions to seek expertise

($\beta = .233$, $p = .001$); as this is a dichotomous variable coded 0 = Did not identify depression, 1 = Identified depression, this can be interpreted as meaning that participants who identified depression had higher scores on the Facilitation of Professional Support subscale.

Table 52: Standardised estimates, unstandardised estimates, and standard errors for all potential predictors of caregivers' intentions to facilitate professional support

Predictor Variable	**Facilitation of Professional Support**		
	β	**B**	**SE**
Gender (ref male)	.133*	.228	.094
Child gender (ref male)	-.031	-.041	.073
Child age	.122*	.050	.022
Attitudes	-.005	-.005	.056
Norms	.238**	.207	.049
PBC	-.007	-.007	.064
Empathy	-.039	-.073	.105
Perceived controllability	-.083	-.039	.027
Sympathy	.118*	.073	.036
Anger	.022	.012	.032
Previous helping experience (ref no exp.)	.077	.102	.074
Identification of depression (ref no ID)	.233**	.322	.077
Exposure to mental illness	-.005	-.001	.013

* $p < .05$, ** $p < .001$

As with the adolescent MIMHS subscales, the regression analysis was re-run, excluding the variables that did not have a significant association with intentions to facilitate professional support. As such, the regression analysis included gender, child age, norms, sympathy, and identification of depression. This model was statistically significant, $R^2 = .232$, F (5, 293) = 17.409, $p < .001$, adjusted $R^2 = .219$. These variables alone thus accounted for approximately 22% of the variance in participants’ intentions to facilitate professional support. Each of the variables had a statistically significant association with participants’ mean scores on the Facilitation of Professional Support subscale, see Table 53.

Table 53: Standardised estimates, unstandardised estimates, and standard errors for significant predictors of caregivers' intentions to facilitate professional support

Predictor Variable	**Facilitation of Professional Support**		
	β	**B**	**SE**
Gender (ref male)	.126*	.216	.091
Child age	.125*	.051	.021
Norms	.246**	.214	.046
Sympathy	.121*	.075	.034
Identification of depression (ref no ID)	.249**	.345	.073

* $p < .05$, ** $p < .001$

8.5.2.37 Problem Minimisation

The full model was significant for the Problem Minimisation subscale, $R^2 = .206$, $F(13, 280) = 5.577$, $p < .001$, adjusted $R^2 = .169$. The model thus accounted for approximately 17% of the variance in participants' intentions to minimise the young person's problems. A summary of model results is provided in Table 54. As can be identified in the table, only the addition of the AEMHB variables appeared to contribute significantly to the overall model.

Table 54: Summary of results for the overall model of predictors on the Problem Minimisation subscale

	R^2	**Adjusted R^2**	***F* Change**
Gender, child's age, child's gender	.017	.006	1.625
+ TPB variables	.041	.021	2.418
+ AEMHB variables	.194**	.165	13.422
+ previous helping experience	.195	.164	.480
+ identification of depression	.196	.161	.157
+ exposure to mental illness	.206	.169	3.568

* $p < .05$, ** $p < .001$

Through examination of the regression coefficients, the impact of each variable can be further explored, see Table 55. Child age significantly predicted caregivers' intentions to trivialise problems, such that caregivers with younger children had higher scores on the Problem Minimisation subscale (β = -.114, p = .046). Perceived controllability of symptoms significantly predicted scores (β = .269, p = .001), with higher perceived controllability associated with higher intentions to trivialise problems. Participants with greater sympathy also had higher scores on the Problem Minimisation subscale, β = .164, p = .007. Participants' anger also had a significant association with intentions to minimise problems (β = .237, p = .001), such that participants with higher anger scores also had higher scores on the Problem Minimisation subscale.

Table 55: Standardised estimates, unstandardised estimates, and standard errors for all potential predictors of caregivers' intentions to minimise adolescents' problems

Predictor Variable	**Problem Minimisation**		
	β	**B**	**SE**
Gender (ref male)	.008	.015	.099
Child gender (ref male)	.085	.113	.076
Child age	-.114*	-.047	.023
Attitudes	.058	.060	.059
Norms	-.068	-.060	.052
PBC	.073	.081	.067
Empathy	-.092	-.178	.110
Perceived controllability	.269**	.130	.029
Sympathy	.164*	.103	.038
Anger	.237**	.129	.033
Previous helping experience (ref no exp.)	.069	.093	.078
Identification of depression (ref no ID)	-.017	-.023	.080
Exposure to mental illness	-.110	-.025	.013

* $p < .05$, ** $p < .001$

The regression analysis was re-run, excluding the variables that did not have a significant association with intentions to trivialise problems. As such, the regression analysis included child age, perceived controllability, sympathy and anger. This model was statistically significant, R^2 = .167, F (4, 289) = 14.493, $p < .001$, adjusted R^2 = .156. These variables alone thus accounted for approximately 16% of the variance in participants' intentions to trivialise problems. Each of the variables had a statistically significant association with participants' mean scores on the Problem Minimisation subscale, see Table 56.

Table 56: Standardised estimates, unstandardised estimates, and standard errors for significant predictors of caregivers' intentions to minimise adolescents' problems

Predictor Variable	**Problem Minimisation**		
	β	**B**	**SE**
Child age	-.107*	-.044	.022
Perceived controllability	.295**	.143	.028
Sympathy	.170*	.108	.036
Anger	.225**	.122	.031

* $p < .05$, ** $p < .001$

8.5.2.38 Support Resource Utilisation

The full model was not significant for the Support Resource Utilisation subscale, $R^2 = .042$, $F(13, 280) = .935$, $p > .05$, adjusted $R^2 = -.003$. A summary of model results is provided in Table 57.

Table 57: Summary of results for the overall model of predictors on the Support Resource Utilisation subscale

	R^2	**Adjusted R^2**	***F* Change**
Gender, child's age, child's gender	.023	.013	2.294
+ TPB variables	.029	.009	.571
+ AEMHB variables	.034	.000	.371
+ previous helping experience	.034	-.003	.041
+ identification of depression	.041	.000	2.065
+ exposure to mental illness	.042	-.003	.107

Through examination of the regression coefficients, the impact of each variable can be further explored, see Table 58. None of the variables had a significant association with participants' scores on the Support Resource Utilisation subscale.

Table 58: Standardised estimates, unstandardised estimates, and standard errors for all potential predictors of caregivers' intentions to utilise support resources

Predictor Variable	**Support Resource Utilisation**		
	β	**B**	**SE**
Gender (ref male)	.137	.251	.114
Child gender (ref male)	.089	.125	.088
Child age	-.001	.000	.027
Attitudes	.038	.041	.067
Norms	-.021	-.020	.059
PBC	.070	.081	.077
Empathy	-.061	-.124	.127
Controllability	-.004	-.002	.033
Sympathy	-.060	-.040	.043
Anger	.000	.000	.038
Previous helping experience (ref no exp.)	-.030	-.042	.090
Identification of depression (ref no ID)	.088	.131	.093
Exposure to mental illness	.021	.005	.015

8.6 Conclusion

This chapter reported on the results of a series of regression models, which explored the associations between a set of variables and participants' intentions to provide different types of support to a young person showing signs of depression. For adolescents, scores on the Generic Support subscale were associated with gender, norms, PBC, empathy, and sympathy, with scores on the Seeking Expertise subscale associated with PBC, sympathy, and identification of depression, and scores on the Informing Adults subscale associated with age, norms, PBC, and previous helping experience. For caregiver participants, scores on the Facilitation of Professional Support subscale were associated with gender, child age, norms, and identification of depression, and scores on the Problem Minimisation subscale were associated with child age, perceived controllability, sympathy and anger.

Chapter 9 Discussion

9.1 Aim of chapter

This chapter begins by reviewing the rationale and aims of the current study. It then provides a synthesis of the research findings, and afterwards progresses to discuss these findings with reference to the literature. The theoretical and practical significance of these findings is next considered. Limitations of the study are examined. Throughout the chapter, potential future directions for this research topic are proposed.

9.2 Rationale and aims of this study

The literature suggests that caregivers' and peers' responses to an adolescent's expression of depressive symptoms may play a crucial role in determining the subsequent course of the illness (Herres & Kobak, 2014; Perry & Pescosolido, 2015; Perry, Pullen, & Pescosolido, 2017). For example, caregivers and peers may detect symptoms, and identify the underlying cause (Lawrence & Ureda, 1990; Roberts, Alegría, Roberts, & Chen, 2005). They may play an important role in facilitating or encouraging adolescents' access to professional mental health support (Fröjd et al., 2007; Godoy, Mian, Eisenhower, & Carter, 2013). Beyond this role as 'gateway providers' (Stiffman et al., 2004) to formal mental health services, it has also been proposed that these important figures may themselves provide support to young people in distress, which could intrinsically reduce distress and expedite recovery (Burton, Stice, & Seeley, 2004; Pössel et al., 2018). However, the specific nature and different types of 'informal' support caregivers and peers provide remain unclear, and little literature exists on how and why support is provided, thus leaving a substantial gap in our understanding. In addition, the factors that influence different responses have yet to be addressed. In response to this gap, the current study aimed to explore caregivers' and peers' roles as providers of support in the context of youth depression. Five research questions were established:

1. *How do caregivers and peers respond to the expression of depressive symptoms in an adolescent character portrayed in a vignette?*
2. *Are there significant differences between caregivers' and peers' responses?*
3. *Do caregivers' and peers' responses differ according to sex?*
4. *Do adolescents' responses differ according to age?*
5. *What is the relationship between each of the theoretically-grounded factors included in the conceptual framework of this study (namely: attitudes, norms, perceived behavioural control, previous experience engaging in the behaviour, perceived controllability, sympathy, anger, trait empathy, identification of depression, and level of contact) and the types of support-giving responses offered by caregivers and peers towards the character depicted in the vignette?*

These research questions were addressed through the development of a vignette-based questionnaire, which was administered to a sample of 12- to 18-year-old adolescents and a sample of adult caregivers of 12- to 18-year-old adolescents. The results of the study extend the small base of existing research on informal support-giving. Importantly, this research is underpinned by a theoretically-driven framework, in contrast to other studies on this topic, which tend to be atheoretical in nature. The current study thus provides a test of the Theory of Planned Behaviour and the Attribution-Empathy Model of Helping Behaviour, with regards to their usefulness in explaining support-giving of different modes. The results of the study raise important questions with regards to the optimisation of caregivers' and peers' role in supporting young people in distress. To the best of the author's knowledge, this is the first study worldwide to explore the types of support offered by both caregivers and peers, two of the most important groups within a young person's social network. The study is also the first to examine support-giving intentions towards a person with depression in Ireland, and makes an important contribution to the limited body of research on Irish people's knowledge of mental illness.

9.3 Key findings

Key findings from this study are identified below, and are discussed with reference to existing theory and research.

9.3.1 Caregivers' responses reflect greater mental health literacy than adolescents', with adolescents' responses becoming more similar to those of caregivers with increasing age

Less than half of adolescent participants labelled the cluster of symptoms displayed by Michael/Michelle as 'depression', compared to two-thirds of caregivers. In addition, almost one-tenth of adolescents did not identify any signs of depression in the vignette characters' behaviour. Although it must be recognised that the adolescent sample in the current study represents young people who are currently engaged in education, whose caregivers consented to their participation, and who reside in the Leinster region of Ireland only, this rate of recognition among adolescents aligns with that found in other industrialised countries over the past decade (Coles et al., 2016; Jorm et al., 2007a; Kelly et al., 2006), and in previous Irish research (S. Byrne et al., 2015; E. Doyle et al., 2017). Remaining cognisant of the representativeness of these samples, the fact remains that recognition of depression among adolescent participants in these studies continues to be low, which is discouraging. The Irish government has recently proposed to increase mental health education provision for secondary school students (Department of Education and Skills, 2017b), and the current results lend support to the need for such initiatives.

Caregivers' superior rate of symptom recognition suggested their mental health literacy was more advanced than adolescents, and this was also evident across other components of the questionnaire. Caregiver participants perceived the vignette characters' symptoms as more serious than did adolescent participants, and were more concerned about the characters' wellbeing; they were more likely than adolescents to recognise the benefit of professional support, and had greater perceived behavioural control regarding their own capacity to provide support. Adolescents' responses, however, appeared to become more aligned with those of caregivers with increasing age. For example, younger adolescents were the least likely to endorse the helpfulness of support-giving actions promoted by mental health professionals for young people with depression (Jorm, Morgan, & Wright, 2008a; Jorm et al., 2008c): younger adolescents were least likely to think that '*Listen to X's problems in an understanding way*', '*Suggest X seek professional help*', and '*Ask X whether he/she is feeling suicidal*' would be helpful responses. This pattern of increasing MHL appears to correspond with participants' increasing exposure to peers and community members who experience signs of mental distress. Caregivers' mean self-reported level of contact with mental illness was significantly higher than adolescents', and older adolescents' self-reported level of contact was significantly higher than younger adolescents. This could be attributed simply to increasing prevalence of depression across adolescence and young adulthood (Mojtabai et al., 2016). Additionally important, though, is the socioemotional development that occurs over the course of adolescence (Camras & Halberstadt, 2017). Adolescent development is associated with a growth of interest and investment in peer friendships (B. B. Brown & Larson, 2009), and of awareness of negative emotions and emotional cues (Booker & Dunsmore, 2017; Denham, 2007; N. V. Garcia & Scherf, 2015). Future research may benefit from inclusion of a measure of socioemotional competence. This would help to facilitate analysis which could determine whether adolescents become more perceptive to signs of mental health difficulties in others, even without increased exposure.

9.3.2 Sex differences exist in both caregivers' and adolescents' responses

In contrast to previous studies (e.g., Cotton, Wright, Harris, Jorm, & McGorry, 2006), there were no statistically significant sex differences in caregivers' or adolescents' ability to label the cluster of symptoms as 'depression', or in the mean number of symptoms identified. However, adolescent girls were significantly more likely than boys to believe in the helpfulness of assessing suicide risk, and the harmfulness of going for a few drinks. Furthermore, girls were less likely than boys to believe that rallying friends and encouraging physical activity would be helpful to the vignette character. Girls additionally thought that the character's recovery would take longer than did boys. Overall, this indicates greater mental health literacy among girls than boys, a finding that aligns with an overarching trend in the literature (Georgakakou-Koutsonikou & Williams, 2017). Other studies have also found sex to be a predictor of total MHFA scores, which in turn have been found to be associated with support-giving intentions (Mason et al., 2015; A. Rossetto et al., 2014a). In the current study, girls and female caregivers reported feeling significantly greater sympathy for the vignette characters than did boys and male caregivers, and concurrently scored higher in trait empathy. Girls also reported feeling significantly greater concern and lower anger towards the vignette character than did boys. While empathic responses such as these bode favourably for the provision of compassionate and sensitive support to a peer in distress (J. G. Miller, Nuselovici, & Hastings, 2016; Wilhelm & Bekkers, 2010), it is important to also remain cognisant of the risk of emotional contagion. Contagion of negative affect is particularly likely among girls (Prinstein, 2007; Prinstein et al., 2005), and female adult support-givers (Magen & Konasewich, 2011). This heightened risk is theorised to be linked specifically to gender differences in empathy (Christov-Moore et al., 2014; Schulte-Rüther, Markowitsch, Shah, Fink, & Piefke, 2008).

Furthermore, adolescent girls had significantly higher scores on the 'Generic Support' subscale than did boys in the current study, and female caregivers had higher scores on the Facilitation of Professional Support subscale than did male caregivers. This aligns with consistent patterns in the literature - it is recurrently reported that males are less likely than females to exchange emotional support or share unhappy feelings (Buhrmester, 1996; Burleson, 2003; Gore, Aseltine Jr., & Colten, 1993; Jarvinen & Nicholls, 1996; Lempers & Clark-Lempers, 1993; Maccoby, 1990; Parker & Asher, 1993; Rose & Asher, 2004; Rose & Rudolph, 2006), and research on the provision of support specifically for mental health problems have found that females are more likely than males to provide assistance (Lubman, Cheetham, Jorm, et al., 2017; Mueller & Waas, 2002; Norton, Durlak, & Richards, 1988; Wellman & Wellman, 1986). This is particularly important given that perceived support from classmates is a robust unique predictor of psychological and academic adjustment for boys (Rueger, Malecki, & Demaray, 2010), meaning that having supportive peers may be particularly impactful for young males. It is also important to highlight here, however, that the 'Generic Support' subscale for adolescents involved items such as, "*I would talk to X about his/her feelings*", and as such may be associated with risk of co-rumination. As discussed in section 2.7.2 in Chapter 2, engagement in co-rumination is linked with negative mental health outcomes (Stone et al., 2011), and is particularly reported among girls (Tompkins, Hockett, Abraibesh, & Witt, 2011). Therefore, girls' higher scores on this subscale may indicate that co-rumination needs to be monitored in future research on support-giving.

It has been suggested that these reported differences are not inherently sex-based, but rather reflect gender-role prescriptions (Amato, 1990; Ashton & Fuehrer, 1993; Barbee et al., 1993; Trobst et al., 1994). This was alluded to, for example, by a participant in one study of emotions in adolescent boys' friendships and peer groups, who stated, "*I totally think [talking about fears and worries] is okay. I just don't think it happens a whole lot, or not as much as it should… It's totally therapeutic and it totally helps you to talk about that stuff. But boys, I think, kind of adhere to the crazy macho thing and it ends up really hurting*" (Oransky & Marecek, 2009, p. 234). Younger men have been found to be particularly likely to endorse a hegemonic view of masculinity where men 'should' be reluctant to seek help (O'Brien, Hunt, & Hart, 2005). Thus, it is possible that gender roles may be the key to understanding observed gender differences in the provision of support (Burleson, Holmstrom, & Gilstrap, 2005). Future research may benefit from measuring participants' alignment with gender roles, as well as recording participants' sex and/or gender identity.

9.3.3 Caregivers and adolescents have very different beliefs about the helpfulness of suicide risk assessment

Adolescents' and caregivers' responses to the vignette character differed sharply in their beliefs about the helpfulness or harmfulness of several support-giving behaviours. For example, the majority of adolescents thought that asking about suicide would be harmful, whereas the same action was deemed helpful by the majority of caregivers; this was a statistically significant difference. Furthermore, older adolescents and girls were significantly more likely than younger adolescents and boys to believe assessing suicide risk would be helpful, aligning with patterns of responses across other items, and corroborating the results of previous research (e.g., Yap et al., 2012). Beliefs regarding suicide risk assessment are important to highlight, as increased suicide-related knowledge has been found to exert a positive effect on intentions to provide adequate help to distressed individuals (Arendt, Scherr, Niederkrotenthaler, Krallmann, & Till, 2017).

The literature is clear that suicide risk does not increase after assessment (Dazzi, Gribble, Wessely, & Fear, 2014; de Beurs, Ghoncheh, Geraedts, & Kerkhof, 2016; DeCou & Schumann, 2017; Gould et al., 2005; Mathias et al., 2012; Peña & Caine, 2006; Abigail M. Ross et al., 2016). In fact, a review of the evidence concluded that asking about suicide may reduce, rather than increase, suicidal ideation (Dazzi et al., 2014), and suicide prevention experts (Kelly, Jorm, Kitchener, & Langlands, 2008) and mental health professionals endorse the helpfulness of this action (Schurtz, Cerel, Rodgers, & Schurtz, 2010). Despite this, concerns about the iatrogenic risk of asking about suicide are commonly expressed by laypeople (Yoshioka, Reavley, Rossetto, & Jorm, 2015). For example, a previous vignette-based study found that a third of adolescents, but less than 2% of GPs, psychiatrists, and psychologists, thought that asking the vignette character if they were feeling suicidal would be harmful (Jorm et al., 2008c). While it is therefore encouraging that most caregivers in the current study appeared to recognise the helpfulness of suicide risk assessment, the fact that the majority of adolescent participants thought this would be harmful may be cause for concern. These findings reinforce the overall pattern of results that suggest caregivers' responses to the vignette characters were more appropriate, and reflected greater knowledge of depression, than those of adolescent participants.

9.3.4 Young people tend to encourage 'insular' support

Adolescents did not tend to endorse support-giving behaviour that involved adults. Almost one-fifth (17%) of adolescents thought that suggesting professional help would '*make no difference*', in comparison to just 3% of caregivers. Additionally, just ten percent of adolescents with previous support-giving experience described having encouraged the person to engage with professional care. In fact, simply having previous support-giving experience was negatively associated with scores on the Informing Adults subscale of the MIMHS. This may suggest that having previous experience of support provision increases adolescents' confidence that they can provide support on their own. However, adolescents' reluctance to involve adults has been documented in previous studies. Research with Australian adolescents similarly found that a significant number of participants stated that they would not personally recruit an adult's help, or encourage a peer to connect with an adult, and that this trend emerged whether the peer displayed depression with (Mason et al., 2015) or without (Jorm et al., 2007a; Kelly et al., 2006) suicidal thoughts. The provision of peer-to-peer support without adult assistance has been termed 'insular' support (Kelly et al., 2006).

Insular support-giving aligns with many other characteristics of adolescent friendships, in which the principle of mutual trust plays an instrumental role – "specifically, the expectation that friends will not reveal confidences, will not break promises" (Stanton-Salazar & Spina, 2005, p. 386). In addition, adolescents frequently cite concerns about broken confidentiality with regards to their mental health (Carlisle, Shickle, Cork, & McDonagh, 2006; Del Mauro & Jackson Williams, 2013), in particular with regards to information being shared with their parents (Georgakakou-Koutsonikou & Williams, 2017). This implied contract of confidentiality in adolescent friendships may therefore act as a deterrent to young people informing an adult of concerns that they have regarding a friend's mental health. Indeed, this was expressed by participants in a study of university students who had supported a friend with mental health difficulties, with one stating, "*We have previously had to alert my friend's family to relapses or particularly worrying episodes, as we were scared for her well-being and were aware of the fact that no one else knew… one of the things I found hardest about this was that when my friend was still very ill she often resented me for trying to help her in this way and she felt I had betrayed her trust*" (Warren & Byrom, 2006, p. 22). In fact, a recent Australian study of secondary school students that found half of participants believed that family and friends are legally obliged to keep their secrets (Lubman, Cheetham, Blee, et al., 2017). One study suggested that this response may also reflect stigma, "with participants expressing concern about damaging a close friendship by suggesting their friend needed professional help" (Curtis, 2010, p. 712), indicating negative connotations associated with requiring professional support for mental health issues.

Seeming to belie the trend of increasing mental health literacy with age that was otherwise evident in participants' responses, older adolescents in the current study had lower scores than younger adolescents on the 'Informing Adults' subscale of the MIMHS. This indicated that they were less likely to tell a (non-professional) adult if they were worried about a friend's mental health. While children and young adolescents remain dependent on adults, young people increasingly turn to friends, rather than parents, for intimacy, companionship and emotional support throughout the adolescent period (Bokhorst et al., 2010; B. B. Brown & Larson, 2009; Buhrmester & Furman, 1987; del Valle et al., 2010; Furman & Buhrmester, 1992; Helsen et al., 2000; Levitt et al., 2005). In tandem, research has demonstrated that the need for autonomy affects young people's mental health help-seeking behaviour (Leavey, Rothi, & Paul, 2011; C. J. Wilson, Rickwood, Bushnell, Caputi, & Thomas, 2011). Taken together, this suggests that older adolescents in the current study may have felt that they had the capacity to help their peer without requiring an adult's assistance.

Adolescents' preference for 'insular' support is problematic due to the possibility that this may facilitate the continuation and 'cross-fertilisation' of depressive symptoms through co-rumination (Stone et al., 2011). Adolescents establish and maintain friendship groups with peers who are similar in their levels of internalised distress (Hogue & Steinberg, 1995; van Zalk, Kerr, Branje, Stattin, & Meeus, 2010; Van Zalk, Kerr, Branje, Stattin, & Meeus, 2010; Veed, McGinley, & Crockett, 2019); adolescents' best friends' depressive symptoms are prospectively associated with the adolescents' own symptoms and depressogenic attributional style (E. A. Stevens & Prinstein, 2005). Levels of internalising symptoms in a peer network have also been found to predict adolescents' self-reported internalising symptoms (Fortuin, van Geel, & Vedder, 2014; Veed et al., 2019), as depressive symptoms tend to converge or approach the average of the group (Kiuru, Burk, Laursen, Nurmi, & Salmela-Aro, 2012; Mercer & Derosier, 2010). In a mutually-reinforcing cycle, research shows that co-rumination is also positively correlated with closeness and positive ratings of friendship quality (Rose, 2002), close friendship intensity amplifies increases in internalising symptoms over time (M. A. Costello, Narr, Tan, & Allen, 2019)

and that emotional support tends to be reciprocally provided (M. L. Clark & Ayers, 1993). Indeed, one can observe that "the growing importance of peer relationships during adolescence parallels the rise in depression levels" (Oppenheimer & Hankin, 2011, p. 380).

Consistent with previous research with Irish adolescents (S. Byrne et al., 2015; Swords, Hennessy, et al., 2011a), adolescents in the current study appeared to recognise professional support as beneficial, endorsing its helpfulness, but did not appear to recognise their own ability to refer a peer to these sources of support. A recent Chinese study of college students reported similar results, where participants "rationally knew that they should choose to seek such professional help… although they were emotionally reluctant" (Wang & Xia, 2017, p. 212), and a large-scale German study recently found that most participants recommended seeking help from a professional but a much lower proportion actually engaged in this behaviour (Schnyder et al., 2018). This discrepancy between knowledge and behaviour in relation to professional support warrants further and more comprehensive exploration in future research. Cumulatively, the current evidence suggests that young people may require additional education regarding (a) the importance of telling an adult if concerned about a peers' mental health, (b) their role as potential 'gateway providers' to professional support, and (c) the limits of confidentiality that can be assured to a friend. Interestingly, in a Delphi consensus study on the development of key messages for adolescents on providing support to a peer experiencing mental health problems, young adult mental health consumer advocates strongly endorsed the importance of messages relating to 'being a good friend' *and* the topic of mandated reporting (Anna M. Ross, Hart, Jorm, Kelly, & Kitchener, 2012).

9.3.5 Some caregivers attempt to minimise adolescents' problems

While the results of this study indicate that, overall, caregivers respond appropriately to their adolescent children experiencing distress, it would be remiss to overlook the fact that Problem Minimisation emerged as a subscale of the MIMHS for caregivers. A qualitative study investigating depression stigma in rural Ireland identified dismissal of symptoms as a prominent theme (Kennedy, 2017). Trivialisation of mental health issues has also been examined in social media discourse, and found to be relatively common (P. Robinson, Turk, Jilka, & Cella, 2018). Problem minimisation has been characterised as a dysfunctional emotional support strategy, as it implies the target's feelings are unwarranted or illegitimate (Burleson, 2003a; Lehman, Ellard, & Wortman, 1986; Lehman & Hemphill, 1990; Wortman & Lehman, 1985). This strategy is considered to exist on the lower range of 'person-centredness' (R. A. Clark, MacGeorge, & Robinson, 2008), which "reflects the extent to which messages explicitly acknowledge, elaborate, legitimise, and contextualise the distressed other's feelings and perspective" (Burleson, 2008, p. 208). Both children and adults frequently adopt this strategy in everyday situations (Burleson, 1982; MacGeorge, Gillihan, Samter, & Clark, 2003), and a study examining undergraduate students' helping intentions towards depressed peers similarly reported that some participants responded by attempting to minimise the problem (Amarasuriya et al., 2017). 'Disconfirmation' was also cited by adolescents in an early study as a commonly-enacted response from peers (R. J. Burke & Weir, 1979). A recent study of 18- to 24-year-old young people found that one-fifth of participants reported receiving messages from family members that minimised mental health issues (Greenwell, 2018).

Although the use of this strategy may be well-intentioned (Burleson & MacGeorge, 2002), children, adolescents, and young adults poorly evaluate this response to their distress (R. A. Clark et al., 2008; Greenwell, 2018). Dismissive messages are often perceived as intentionally hurtful, and have been associated with relational distancing (Vangelisti & Young, 2000). Adolescents often seek legitimisation of their problems from adults (Murray, 2005), and minimising responses from others have been shown to increase both the level of distress experienced by the recipient, and the use of avoidant coping mechanisms (Adrian et al., 2018; Burleson & MacGeorge, 2002; Eisenberg & Fabes, 1994; Eisenberg, Fabes, & Murphy, 1996; Feeney & Collins, 2015; Maisel & Gable, 2009; Marigold, Holmes, Wood, & Cavallo, 2014; Reis & Clark, 2013; Shipman et al., 2007). Adolescents who receive invalidating responses may respond by escalating emotions and behaviours in order to be taken more seriously (Crowell, Beauchaine, & Linehan, 2009). Research has indicated that receipt of minimising messages about mental health was significantly associated with less relational closeness with the message provider, and more negative help-seeking attitudes (Greenwell, 2018).

Although there was no statistically significant relationship between identification of depression and caregivers' responses to the 'Problem Minimisation' subscale, it is interesting to note that some young mental health service-users have highlighted the legitimation and validation that accompanies receipt of a diagnostic label (Karterud, Risør,

& Haavet, 2015; Kranke, Jackson, Taylor, Landguth, & Floersch, 2015; Tan, 2018). It is interesting to consider this in light of the substantial body of literature demonstrating significant discrepancies between caregiver and adolescent accounts of adolescents' mental health problem severity and the need to seek treatment (Ferdinand et al., 2004; Yeh & Weisz, 2001). These discrepancies are most prominently observed when a child is experiencing internalising or depressive symptoms (Cleridou, Patalay, & Martin, 2017; Wahlin & Deane, 2012; Wu et al., 1999). Should parents rate the level of distress experienced as lower than the child's self-rating, this may be interpreted by the child as a minimisation of their experience.

It is especially concerning that caregivers' scores on the Problem Minimisation subscale were negatively associated with their child's age, meaning that caregivers of younger adolescents were more likely to engage in such responses. Early adolescence has been described as a time of emotional volatility (Steinberg, 2008), with heightened stress reactivity (McLaughlin, Rith-Najarian, Dirks, & Sheridan, 2015; Romeo, 2010) co-occurring with many transitional changes (Simmons & Blyth, 1987). Additionally, the level of distress experienced by young people in early adolescence appears to be increasing over time, particularly for girls (Fink et al., 2015; Sweeting, Young, & West, 2009). For example, the National Self-Harm Registry in Ireland reported an 89% increase in instances of self-harm among 10- to 14-year-old girls in the period from 2007 to 2015 (Griffin, 2017). At this age, young people remain relatively dependent on parental support, and the perceived parent-child relationship bears more influence on depressive symptoms than in late adolescence (Greenberger & Chen, 1996). Research has also demonstrated that the strongest predictor of child mental health service access is parents' perceived burden (Alegría et al., 2004; Farmer et al., 2003; Sourander et al., 2005). The dismissal of young adolescents' distress is therefore, at minimum, unwarranted, and potentially quite detrimental. Furthermore, results from the current study suggest that young adolescents are particularly unlikely to receive adequate support from their same-age peers, increasing the importance of an appropriate response from caregivers. However, one must be careful that discouragement of problem minimisation does not introduce the encouragement of helicopter parenting as a corollary. Helicopter parenting, defined as “a form of over-parenting in which parents apply overly involved and developmentally inappropriate tactics to their children” (Segrin, Woszidlo, Givertz, Bauer, & Taylor Murphy, 2012, p. 237), has been shown to significantly predict young adults’ depressive symptoms in Irish (Reilly & Semkovska, 2018) and international (Schiffrin et al., 2014) research. A tension therefore exists between facilitating autonomy and resilience, and remaining a source of support for adolescent children.

9.3.6 Labelling is associated with increased intentions to encourage or facilitate professional support

Labelling the behaviours displayed by the vignette characters as ‘depressed’ was associated with increased intentions to ‘seek expertise’ among adolescents, and increased intentions to ‘facilitate professional support’ among caregivers. These results substantiate previous Australian studies, in which accurate labelling of depression was associated with recommendations of professional help for an individual with depression, among both adolescents (A. Wright et al., 2007; A. Wright, Jorm, & Mackinnon, 2012; Yap, Reavley, & Jorm, 2013), and adults (Jorm, Blewitt, et al., 2005; Reavley & Jorm, 2011; A. Rossetto, Jorm, & Reavley, 2014b). Accurate labelling has also be found to predict less stigmatising attitudes towards individuals with mental illness (Yap, Reavley, Mackinnon, & Jorm, 2013), as has the classification of disorders such as depression, drug addiction, and schizophrenia as mental illnesses (Rusch, Evans-Lacko, & Thornicroft, 2012). In contrast, inaccurate attributions of mental illness have been found to be related to the use of non-evidence-based interventions among American college students (Coles & Coleman, 2010). These results, taken together, reinforce theories of mental health service access which propose that recognition of a problem is the first step in the pathway towards receiving care (Godoy et al., 2013; Goldberg & Huxley, 1980; Logan & King, 2002; Oh & Bayer, 2015; Pescosolido et al., 2008; Stiffman et al., 2004; Teagle, 2002; Thurston, Phares, Coates, & Bogart, 2015).

The association between accurate labelling and endorsement of professional support also suggests that psychoeducation and other informational or awareness interventions may hold promise for increasing the provision of appropriate informal support (Yap, Reavley, Mackinnon, et al., 2013). Research additionally demonstrates that accurate labelling is beneficial once professional mental health support has been engaged; patients are more likely to be accurately diagnosed with depression or anxiety if they present their symptoms to their doctor in a psychologising, rather than normalising, style (D. Kessler, Lloyd, Lewis, Gray, & Heath, 1999). Furthermore, mental health advocates also promote the importance of accurate language use, as they argue that labels "give kids the words to understand their lives" (Sauder, 2017). It therefore appears positive that, in the current study, symptom identification appears to bear a positive effect on support-providers' facilitation and encouragement of professional help-seeking.

However, other research and theory suggests that labelling induces negative responses from others (Link, 1987; Link et al., 1987; Scheff, 1974; Timimi, 2014, 2015); for example, one study found that a diagnostic label increased the likelihood of parents responding in a stigmatised manner to a hypothetical child (Ohan, Visser, Moss, & Allen, 2013). Often situated in a wider discussion of psychological essentialism, labelling is interpreted by some academics as a reification of the psychiatric (or more specifically, biomedical) understanding of human emotional experiences (Kokanovic, Bendelow, & Philip, 2013; Kvaale, Gottdiener, & Haslam, 2013; May, 2007; Spence, 2012). Categorisation of emotional expression as 'pathological' (or otherwise) is necessarily predicated upon (Western) shared understandings of 'normality' and 'acceptability' (R. F. G. Williams, 2009); as discussed in a recent editorial in the *Journal of Child Psychology and Psychiatry*, "How upset is too upset? How often is too often?" (Gregory, 2017, p. 649), and previously in the *British Journal of General Practice*, "Is diagnosing depression in young people just medicalising moodiness?" (Iliffe et al., 2009, p. 156). This has long been recognised as a core conundrum within the study of mental health (Romelli, Frigerio, & Colombo, 2016). To that end, the association between endorsement of a psychiatric label and endorsement of professional support among participants in the current study could be understood as logical, but alarming – or even dangerous (Dowrick & Frances, 2013).

This further contrasts with the beliefs of other theorists who suggest that labelling conveys little impact on responses or behaviour (Farina, 1998). Interestingly, a recent Irish experimental study found that including a depression label in describing a vignette character (i.e., "*it is important to note that X would receive a diagnosis of clinical depression from a psychiatrist or clinical psychologist*") was not associated with any significant differences in male adolescents' emotional responses towards the character, nor their evaluations of the character's mental health status (Dolphin & Hennessy, 2017). Other research with adults has similarly found that labelling had 'practically no effect' on public attitudes towards people with major depression (Angermeyer & Matschinger, 2003). Individuals with depression and other mental health issues also qualitatively report mixed experiences associated with illness labels (see C. O'Connor, Kadianaki, Maunder, & McNicholas, 2018 for one systematic review). This heterogeneity may also be observed in support-giving, as one study suggested that labels activate "beneficial social processes within core networks and detrimental ones among peripheral ties" (Perry, 2011, p. 460) – the so-called 'labelling paradox'.

9.4 What are the theoretical implications of these findings?

In Chapter 3 of this thesis, several theories were examined with respect to their relevance and applicability to caregivers' and peers' support-giving behaviour. In particular, the Theory of Planned Behaviour (TPB; Ajzen, 1991) and the Attribution-Empathy Model of Helping Behaviour (AEMHB; Betancourt, 1990) appeared promising. While the review indicated that no one theory had directly established a comprehensive account of support-giving behaviour, a range of potential contributing factors were identified that provide a useful explanatory framework for the current study. The variables selected for exploration in the current study accounted for 15-40% of variance in adolescents' and caregivers' support-giving intentions across all 'modes' of informal support. As more than half of the variance remains unexplained, it appears that existing theory does not adequately explain support-giving intentions in this context, and that more research in this area is therefore warranted. Nevertheless, the results demonstrate that various aspects of these theories, taken in conjunction, do help to shed some light on the antecedents of this behaviour. As such, the current thesis is positioned to provide foundational knowledge that can be used to inform future theory refinement and development. Moreover, it has been acknowledged by other researchers that "it is manifestly difficult to develop a theory of helping… that could incorporate all these divergent antecedents of behaviour" (Rudolph, Roesch, Greitemeyer, & Weiner, 2004, p. 816).

It should be noted here that the variables selected were, on the whole, more successful in accounting for variance in peers' responses (40% of variance in responses to the 'Generic Support' subscale, 20% of variance in responses to the 'Seeking Expertise' subscale, and 27% of variance in responses to the 'Informing Adults' subscale) than those of caregivers (22% of variance in responses to the 'Facilitation of Professional Support' subscale and 16% of variance in responses to the 'Problem Minimisation' subscale), therefore implying that the provision of support by a caregiver to their adolescent child may be governed by a different set of determinants. One such determinant may be caregivers' own psychopathology; a recent study found that higher levels of depressive symptoms among parents was associated with more negative responses to adolescent depression (Johnco & Rapee, 2018). Another factor worthy of investigation is the nature and quality of the parent-child relationship. As discussed in section 2.5.1, Chapter 2, a sizable body of literature has established that the parent-child relationship has an impact on the development of mental health issues, including depression (Alaie, Låftman, Jonsson, & Bohman, 2019) and suicide-related behaviour (Victor, Hipwell, Stepp, & Scott, 2019). Aspects of the parent-child relationship have been found to be associated with discrepancies between parents and children regarding the child's internalising and externalising behaviours (Kolko & Kazdin, 1993; Treutler & Epkins, 2003). It is possible that the quality of the parent-child relationship may also impact on the ways in which parents respond to adolescents' expression of depressive symptoms. In addition, the level of burden experienced by the caregiver as a result of their child's mental health problems has been found to determine caregivers' facilitation of service access (Angold et al., 1998; Brannan, Heflinger, & Foster, 2003). Further exploration of perceived 'burdensomeness' may provide insight to caregivers' responses. Investigation of these and other variables in future research may therefore enhance our understanding of caregivers' support-giving.

With respect to the AEMHB, it was demonstrated that empathy was significantly associated with adolescent participants' scores on the 'Generic Support' subscale, with higher trait empathy scores corresponding with increased intentions to provide support of this nature. A recent Irish study found that empathy did not exert a substantial influence on adolescents' explicit or implicit stigmatising responses towards a peer with mental health difficulties (Silke et al., 2017). The contrast between the results of Silke's study and those of the current study raises interesting questions regarding the nature of the relationship between stigmatising and support-giving responses – specifically, whether these should be viewed as separate forms of behaviour or whether they exist along a continuum. Also of interest is that, while girls had been shown to score significantly higher in trait empathy than boys in the current study, the results of the hierarchical regression model demonstrate that trait empathy remains a significant predictor, even after controlling for the effect of sex on intentions. This is noteworthy given that studies commonly report sex differences in individuals' responses to others with depression (Davies et al., 2016; Jorm, Blewitt, et al., 2005; Leahy, 2009; D. P. Olsson & Kennedy, 2010; A. Rossetto et al., 2014a; Yap et al., 2012, 2011a), but these studies have not measured participants' trait empathy. It therefore appears that, because sex differences in empathy are very robust (Christov-Moore et al., 2014; Garaigordobil, 2009; Schulte-Rüther et al., 2008), participants' sex may have potentially acted as a proxy of sorts for trait empathy. Comparisons may be drawn between this postulation and research demonstrating that empathy mediates the effect of sex on moral decision-making (Rosen, Brand, & Kalbe, 2016). Intriguingly, a study of Israeli adolescents found a relationship between empathy and sex, but also that there was a relationship between empathy and femininity (Karniol, Gabay, Ochion, & Harari, 1998). Thus, boys scored lower in empathy than girls, and individuals of any sex who scored highly in a measure of femininity had higher empathy. Further analysis of the relative contribution of gender and femininity revealed that it was gender-role orientation (the degree to which one conforms to gender-role prescriptions) that influenced levels of empathy in adolescence (Karniol et al., 1998).

The current findings thus indicate that future research would benefit from inclusion of empathy and gender-role orientation as variables to facilitate further investigation. Should these investigations replicate the results of the current study, this would portend favourably for any efforts to increase and improve support-giving behaviour. While an individual's gender identity is neither accessible to nor appropriate for intervention[20], recent research asserts that it is possible to increase empathy through the provision of training, and that receipt of empathy training is effective in increasing helping and prosocial behaviour among children, adolescents, and adults (Georgi, Petermann, & Schipper, 2014; Gibbs, Potter, Barriga, & Liau, 1996; M. T. Greenberg, Kusche, Cook, & Quamma, 1995; Jazaieri et al., 2013; Klimecki, Leiberg, Lamm, & Singer, 2013; Klimecki, Leiberg, Ricard, & Singer, 2013; Leiberg, Klimecki, & Singer, 2011; Mascaro, Rilling, Tenzin Negi, & Raison, 2013; Weng et al., 2013).

Apropos the TPB, the results of the current study reveal that PBC is particularly relevant to the study of support-giving behaviour among adolescents; greater PBC was significantly associated with increased intentions to provide support across all MIMHS subscales. This extends

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[20] Gender identity refers to a person's deeply-felt identification as male, female, or some other gender. This may or may not correspond to the sex they were assigned at birth ("Trans Terms," n.d.).

the results of previous research which found that adults' confidence was the strongest predictor of intentions to help an individual with mental health difficulties (A. Rossetto et al., 2016). In another study, PBC was also the strongest predictor of university students' intentions to intervene with a suicidal individual (Aldrich, 2017). It is important to note that PBC represents participants' stated confidence in providing support, and not their actual competence to appropriately support an individual showing signs of depression. It is not possible to establish whether participants' confidence is appropriately matched to their level of competence. Ideally, an individual's confidence and competence would be highly correlated. However, a large body of work suggests that humans tend to demonstrate a psychological bias towards overestimation of their personal capabilities (D. D. P. Johnson & Fowler, 2011). Should caregivers and adolescents feel *over*confident in their support-giving abilities, their motivation to increase their knowledge and improve their skills may be low, due to an assumption such efforts are unnecessary. Thus, it is imperative that future research assesses informal support-givers competence in delivering appropriate support to young people with depression.

Previous research has found attitudes to be the weakest predictor of intentions to assist a peer demonstrating suicidal ideation (Aldrich, 2017). A South Korean study of young adults similarly found that attitudes had no effect on intentions to help a peer seek professional help for depression (S. H. Lee et al., 2015). The current study corroborates this previous work, as attitudes were not significantly associated with support-giving intentions for adolescents or caregivers. Another factor from the TPB, subjective norms, played a distinct role for adolescents and caregivers. Adolescent participants who had stronger perceptions that similar others would provide support (i.e., greater endorsement of support-giving norms) had *lower* intentions to inform an adult. In contrast, caregivers who strongly endorsed support-giving norms tended to score highly on the 'Facilitation of Professional Support' subscale. Given the clear socially-defined responsibilities of parents towards their children (Eekelaar, 1991), it is possible that norms about obtaining professional care for your child are salient for caregivers. Meanwhile, the literature is clear regarding the importance of confidentiality and secret-keeping among adolescent friends (e.g., Stanton-Salazar & Spina, 2005), it may be the case that this norm was more salient for participants in the current study. Salience is a critically important dimension of normative influence; as stated by Kallgren, Reno, and Cialdini (2000, pp. 1010–1011), "If there is no salience, behaviour will be largely unguided by normative considerations… this helps resolve some of the puzzling inconsistencies in normative effects in the literature… Indeed, such attentional shifts may explain the functioning of contradictory norms within the same society (e.g., the norm for getting involved and the norm for minding one's own business)".

An alternative explanation of the effect of norms on adolescents' responses may involve the 'bystander effect': a classic phenomenon in social psychology, whereby the physical presence of others reduces or diffuses an individual's perceived responsibility to intervene (Latané & Darley, 1968, 1969). Research has confirmed that a similar effect can be observed even when these 'others' are not physically present, but merely implied or imagined (S. M. Garcia, Weaver, Darley, & Spence, 2009; S. M. Garcia, Weaver, Moskowitz, & Darley, 2002). By asking participants to rate how likely it was that 'other people like me' would engage in the support-giving behaviour, it is possible that this primed the presence of implicit bystanders. On the whole, however, it appears that the impact of subjective norms on support-giving intentions in this context requires revisiting in future studies (Aldrich, 2017).

9.5 What are the practical implications of these findings?

Firstly, the results of the current study confirm that informal support-giving regularly occurs. Approximately 40% of adolescents and 50% of caregivers stated that someone in their family or close circle of friends had, in the past year, experienced a problem similar to that described in the vignette. Of these participants, approximately 85% of adolescents and over 90% of caregivers stated that they had done something to try and help this person. The results also demonstrate that caregivers seek direction regarding the appropriateness of their responses. In response to the item, '*I would ring a professional for help and advice about the situation*', 84.1% of caregivers stated that they would be '*Likely*' or '*Extremely likely*' to engage in this behaviour. Caregivers have also been reported to actively seek knowledge about support-giving in other studies (Andershed et al., 2017). However, low MHL may impact upon chosen sources of information; parents whose children have not engaged with mental health services have been reported to place similar emphasis on seeking information from their own social networks as from mental health professionals (O'Connor & Langer, 2018).

Information-seeking was also evident in the adolescent sample of the current study, as 'Seeking Expertise' subscale emerged as a subscale of the MIMHS. Adolescent participants in a qualitative study of supporters of peers engaging in self-harm also reported a desire for guidance on specific actions and information, with one participant saying "…I think having some actual steps to know how to deal with it would be very helpful… I want to know what to do…" (Fisher et al., 2017, p. 152). The need for information about appropriate support-giving also relates to psychoeducational interventions for young people – while such interventions are common, few have focused explicitly on teaching adolescents how to support their peers, or successfully demonstrated improvements in the support offered (Lubman, Cheetham, Blee, et al., 2017). The significance of providing such education to adolescents expands when one considers that most adolescents do not receive such training but instead derive their knowledge of support-giving from the observation of others' behaviours, meaning that in instances where behavioural 'models' are poor, incompetence in support-giving is perpetuated (Burleson, 2003a; Burleson & Kunkel, 1996; Eisenberg, 1998). This point also stresses the value of training caregivers in providing appropriate and sensitive support, given that parents are likely to be among the most prominent behavioural models for children and young people. Despite this, the translation of research evidence into interventions for parents has been slow (Ong & Caron, 2008; Yap, Fowler, Reavley, &

Jorm, 2015). This may be, in part, due to concerns about avoiding parent blame and criticism of parenting skills, which have been shown to decrease caregivers' engagement (J. Brown, 2018; Iachini, Hock, Thomas, & Clone, 2015; Penzo & Harvey, 2008). Rather, it has been suggested that an effective approach to the development of parent training is one that views parents as "active agents of assistance and support for young people with mental illness… neither [focusing] on changing parents nor [implying] causal responsibility" (Honey et al., 2014), but instead helping parents to find and use the most effective responses when supporting their child.

The results of this study have important implications for guiding these efforts to improve the support that caregivers and peers may provide to young people experiencing symptoms of depression. In particular, the results highlight several factors which may be potentially modifiable, and therefore suitable to target through intervention. For example, the results suggest that psychoeducational interventions focused on providing information about the details of depression may not be effective in increasing peer referrals among older adolescents, who appear to have good mental health literacy but still demonstrate a tendency towards the provision of insular peer support. Rossetto et al. (2014a) also discuss how the possession of knowledge may not be enough to ensure the conversion of this knowledge into action. Instead, interventions that focus on the limits of confidentiality between friends, address young people's desire for self-reliance, and underscore the importance of involving adults, may be more impactful (Gulliver et al., 2010; Mason et al., 2015; Xu et al., 2018). Given that PBC was significantly associated with adolescents' intentions to provide help across all MIMHS subscales, interventions may also benefit from providing young people with the opportunity to directly practice their support-giving skills, which may increase perceived self-efficacy (Pasco, Wallack, Sartin, & Dayton, 2012).

9.6 Limitations of the current study

It is important to note that there are several limitations to this study that may impact on the generalisability of findings. These limitations are discussed below.

9.6.1 Sampling limitations

Firstly, the adolescent sample, and the majority of the caregiver sample, were recruited through post-primary schools in Leinster; the decision to restrict school-based recruitment to the Leinster region was made due to pragmatic concerns. The generalisability of the findings may thus be constrained, and it is important to remain cognisant of the nature of the sampling strategy when considering the results of the study. It is also important to mention here that the rate of school recruitment was very low (7%). Unfortunately, data were not systematically collected from non-participating schools regarding the reasons why they did not wish to facilitate the study. Anecdotally, some school principals shared that their decision was based on the limited capacity of the school to host the study due to the fact that they had already committed to facilitation of another research project. Nevertheless, this study successfully recruited schools that reflected the breakdown of single-sex and mixed-sex schools across Leinster (see section 5.3.2.1 in Chapter 5 for further details).

However, it must be noted that other characteristics of schools were not controlled in the sampling strategy. For example, of the 373 post-primary schools in Leinster, 198 (53%) are currently included in the Delivering Equality of Opportunity in Schools (DEIS) action plan for educational inclusion, which targets communities at risk of disadvantage and social inclusion (Department of Education and Skills, 2017a). In comparison, two of the fourteen schools (14%) that facilitated the current study are included in the DEIS plan; as such, it is possible that the generalisability of the current results may be affected by this lower proportion.

9.6.2 Balance of characteristics across samples

As noted in sections 5.3.3 and 5.3.4 of Chapter 5, 49.9% of female caregivers of adolescent participants had completed some level of post-secondary education. Caregiver participants were asked about the educational attainment of the primary female caregiver of their adolescent child; 57.3% had completed some level of post-secondary education. Census data suggest that 33.76% of all Leinster residents aged 15 years and over (i.e., both male and female) have completed post-secondary education (Central Statistics Office Ireland, 2017a); therefore, it is possible that participants in the current study were more likely to be identified as higher socioeconomic status than the average Leinster resident. As documented in sections 5.3.3 and 5.3.4 of Chapter 5, the ethnic and cultural background of participants appears to approximate the ethnic background of residents of Leinster.

Although students from third and sixth year are under-represented in the adolescent sample, this is likely due to the fact that the Irish State examinations, the Junior Certificate and the Leaving Certificate, take place at the end of third year and sixth year, respectively. Anecdotal evidence suggests that students are often encouraged by parents and teachers to avoid any non-academic activities in school during those years. Thus, some schools forbade the recruitment of students in third and sixth years, and even when this was permitted, students may have been less likely to consent to participation.

Few fathers or male caregivers participated in this study; this is a common issue in research with parents (Costigan & Cox, 2001; Phares et al., 2005). It also must be recognised that participants may have had a greater interest in the topic of mental health than those who did not choose to participate. However, it must be acknowledged that this is true of all research on this topic that is ethically conducted (i.e., wherein participants voluntarily consent to participation), and therefore comparison of the current results to those obtained in other studies should not be unduly affected. While it is possible that participants may have been affected by social desirability bias, all participants were informed that their responses would be anonymised and confidential.

9.6.3 Methodological limitations

In an exploratory study, the number of variables that may potentially be related to the outcome of interest can be manifold. Resources, and the ethical responsibility to reduce participant burden, limit the number of variables that can be investigated, after which specific variables are chosen based on whether there exists theoretical justification for their inclusion. The design of the current study was conducted in accordance with these pragmatic and ethical guidelines. However, there are a number of additional variables that would have been interesting to explore in the current study. Participants' help-seeking for their own mental health issues was not assessed, nor was their current mental health status. Although participants' perceptions of the controllability of symptoms was measured, the study did not measure participants' beliefs about the causes of the vignette characters problems. Additionally, the source of participants' knowledge was not examined.

The research questions of the current study did not include any investigation of differences across schools. However, emerging evidence in the literature suggests that this may be an interesting line of inquiry for future studies. Research has demonstrated a link between school culture and prosocial behaviour more broadly (Barr & Higgins-D'Alessandro, 2007; Batanova & Loukas, 2012). Furthermore, Townsend et al. (2017) found that positive school climate was associated with increased depression literacy and reduced stigma among high school students. In a sample of university students, Spiker and Hammer (2019) found that students who viewed their campus as supportive felt more capable of identifying peers' mental health concerns, and reported more personal responsibility and confidence in engaging in MHFA. Future research could benefit from further examination of school culture, and perceived connectedness to the school community, with regards to adolescents' responses to their peers.

The cross-sectional nature of the study means that the temporal order of constructs cannot be ascertained, nor can the direction of the relationship among variables. In addition, the vignette character's sex was matched to the sex of each adolescent participant (i.e., a male adolescent read about Michael and a female adolescent read about Michelle), and participants were told that the vignette character was "the same age as you". Although research demonstrates that adolescents' friendships tend to be governed by homophily in many domains including sex and age (Linden-Andersen, Markiewicz, & Doyle, 2009), an interesting line of future research could investigate whether adolescents' responses differ according to the sex and age of a depressed peer.

The alpha levels of some instruments were lower than desired, suggesting that their psychometric properties may be questioned. In addition, at the time of the study's design, a psychometrically robust measure of MHL, a core variable under investigation, could not be identified by the researcher. The paucity of suitable instruments to measure this concept has been raised by a number of researchers since the study was designed (Bale, Grové, & Costello, 2018; M. O'Connor, Casey, Clough, & O'Connor, 2014; Spiker & Hammer, 2018; Wei, McGrath, Hayden, & Kutcher, 2017). These issues are exacerbated by the fact that this is an exploratory study in an under-researched area of investigation, meaning that there are few well-tested instruments available for many of the constructs being explored. The development of the MIMHS scale was in itself an attempt to standardise the investigation of support-giving in the current study, so that future studies on this topic may benefit.

In any study, it is important not to over-interpret weak relationships in the data. As such, one must remain cognisant of the small effect sizes in many of the examined relationships, which indicate that the practical significance of these associations may be small. In addition, the maximum proportion of variance explained was 40%, suggesting that variables not accounted for in this study also influence informal support-givers' responses. It must be recognised, however, that constraints in resources and (particularly pertinent to the current exploratory study) limitations of our knowledge mean that it is virtually impossible to include all important variables in a regression model (Babyak, 2004). Statistical analyses may also have been impacted by ceiling effects.

The use of vignette methodology means that one cannot assume with confidence that participants would apply the help-giving actions they described in similar real-life situations. Thus, it may be more appropriate to conceive of participants' responses in this study as reflective of their stated confidence to act, rather than their actual competence. Pen-and-paper questionnaires may be particularly affected by ecological validity concerns in this regard; one study demonstrated that adolescents were less likely to correctly identify depression when a vignette was presented through a short film than when the information was provided in a written vignette (Marshall & Dunstan, 2013). A single vignette represents just one situation, and one particular constellation of symptoms. Other situational and relationship factors that cannot be captured in a vignette may have greater predictive power in real-life support-giving situations (A. Rossetto et al., 2016). However, it is important to recognise that, in any situation involving human interaction, there will be factors that cannot be predicted or controlled. In addition, Rossetto et al. (2016) found that participants' help-giving intentions towards a hypothetical person experiencing mental illness were associated with their real-life behaviours. Correlations between support-giving intentions and actions were also reported in a previous study by the same research group (A. Rossetto et al., 2014a). Moreover, as described by Jorm, Blewitt, et al. (2005), participants' reported support-giving intentions could be considered to reflect an upper limit on their actual responses, where if they fail to state their intentions relating to a particular action, it is unlikely that they would exhibit this action in real-life. Future research on caregivers' and peers' support-giving responses could focus on assessing the support offered to distressed adolescents in the 'real world' (Kelly et al., 2006), to further explore whether a gap exists between support-giving intentions and behaviour (A. Rossetto et al., 2016), and establish the validity of assessing support-giving intentions in order to understand support-giving behaviour (Yap & Jorm, 2012). This would also enable analysis of the *actual* competence of caregivers and adolescents with regards to providing support, in comparison to their *stated* confidence in their abilities (as measured in the current study), a critical avenue of future investigation, as discussed in section 9.4 of the current chapter. Furthermore, studies of this nature could investigate the impact of receiving (different types of) informal support on adolescents' depressive symptoms.

9.7 Conclusion

Informal support may play a key role in helping to address the 'treatment gap' evident in adolescent depression. However, several lacunae can be identified within the literature on informal support responses. This exploratory study aimed to attend to these gaps, by exploring the types of support that may be offered by caregivers and peers, two central groups within a young person's social network. As such, this thesis significantly advances knowledge of support-giving responses in this context. The study is embedded within a well-considered theoretical framework that situated support-giving by acknowledging the complexity of this behaviour: how it relates to prosociality and helping more generally, to help-seeking for one's own mental health issues, to social support and to service engagement. The results of the study illuminate the different approaches that caregivers and peers may take when responding to a young person showing signs of depression. Problematic responses, such as insular support-giving among adolescents and problem minimisation among caregivers, are highlighted. Overall, however, this study identifies much capability among caregivers and adolescents, and reinforces the importance of harnessing the potential benefits of informal support. By identifying the factors that are associated with different modes of support, the study hopefully will enable the academic and clinical fields to more clearly comprehend and optimise informal support as a recovery resource. Whilst a number of implications resulting from the study can be delineated, the results also raise a number of fascinating questions and avenues to explore in further work.

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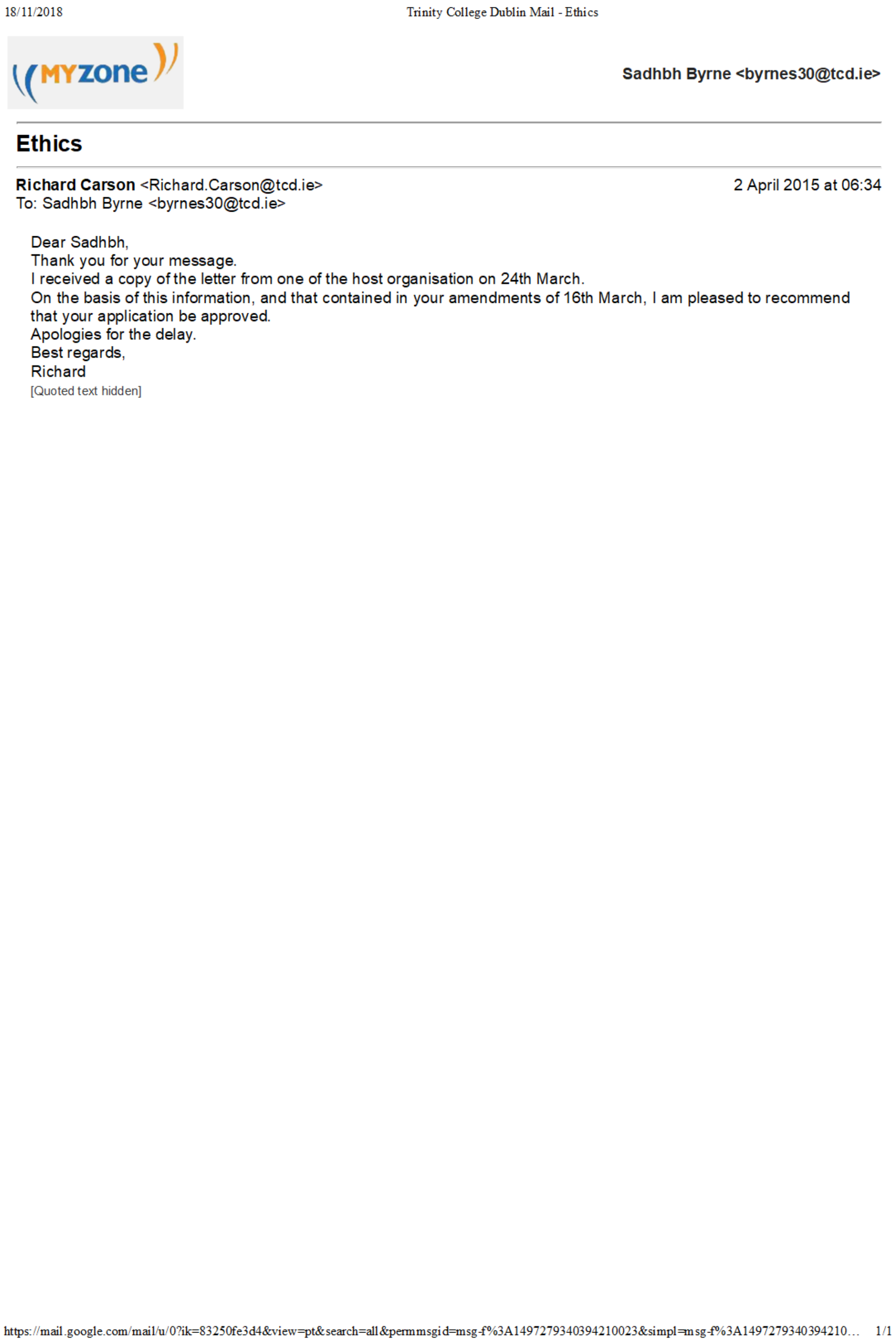
Appendix A Letter of approval from research ethics committee



18/11/2018 Trinity College Dublin Mail - Ethics

Sadhbh Byrne <byrnes30@tcd.ie>

Ethics

Richard Carson <Richard.Carson@tcd.ie> 2 April 2015 at 06:34
To: Sadhbh Byrne <byrnes30@tcd.ie>

Dear Sadhbh,
Thank you for your message.
I received a copy of the letter from one of the host organisation on 24th March.
On the basis of this information, and that contained in your amendments of 16th March, I am pleased to recommend that your application be approved.
Apologies for the delay.
Best regards,
Richard
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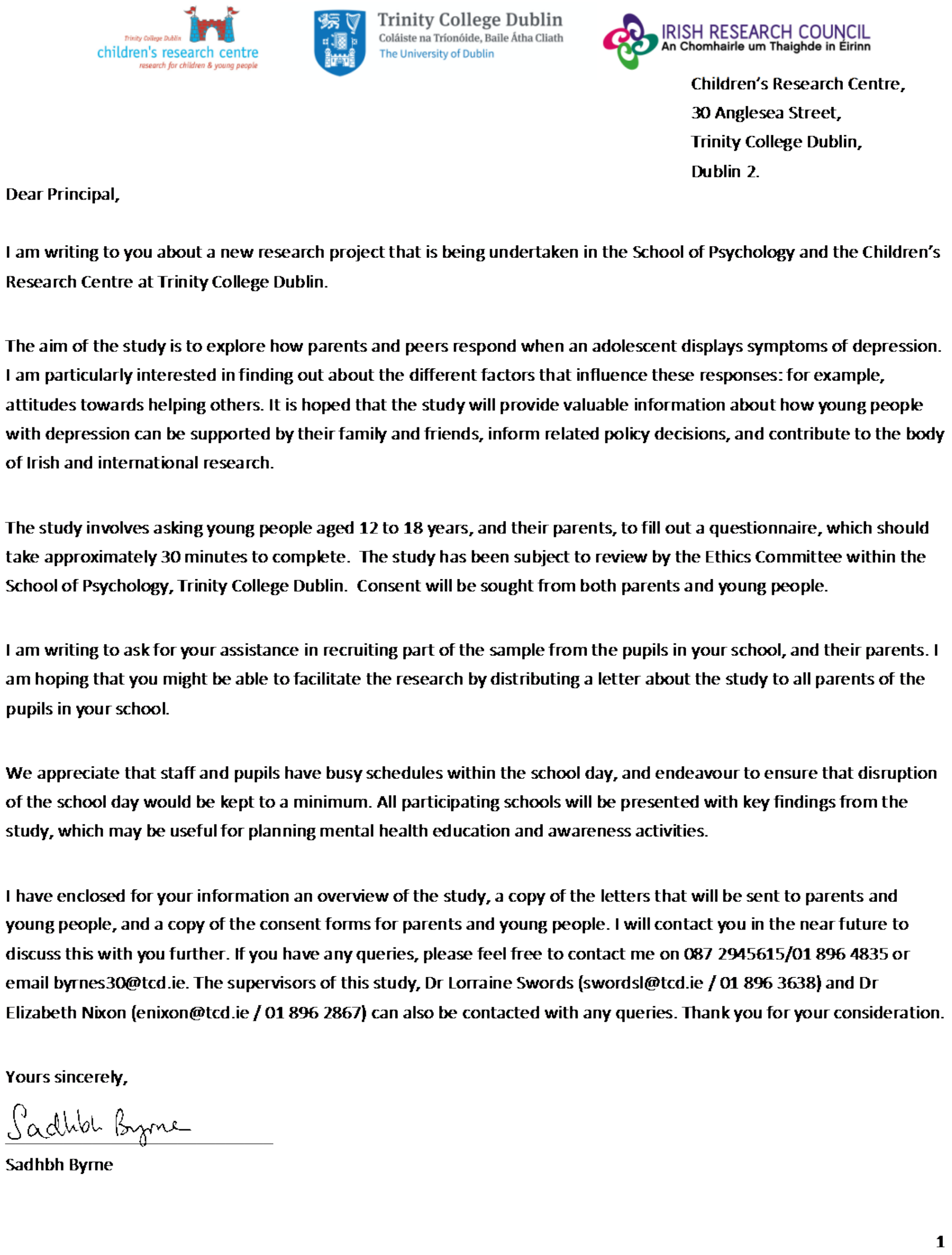
Appendix B Letter for school principals



Trinity College Dublin children's research centre research for children & young people
Trinity College Dublin Coláiste na Tríonóide, Baile Átha Cliath The University of Dublin
IRISH RESEARCH COUNCIL An Chomhairle um Thaighde in Éirinn

Children's Research Centre,
30 Anglesea Street,
Trinity College Dublin,
Dublin 2.

Dear Principal,

I am writing to you about a new research project that is being undertaken in the School of Psychology and the Children's Research Centre at Trinity College Dublin.

The aim of the study is to explore how parents and peers respond when an adolescent displays symptoms of depression. I am particularly interested in finding out about the different factors that influence these responses: for example, attitudes towards helping others. It is hoped that the study will provide valuable information about how young people with depression can be supported by their family and friends, inform related policy decisions, and contribute to the body of Irish and international research.

The study involves asking young people aged 12 to 18 years, and their parents, to fill out a questionnaire, which should take approximately 30 minutes to complete. The study has been subject to review by the Ethics Committee within the School of Psychology, Trinity College Dublin. Consent will be sought from both parents and young people.

I am writing to ask for your assistance in recruiting part of the sample from the pupils in your school, and their parents. I am hoping that you might be able to facilitate the research by distributing a letter about the study to all parents of the pupils in your school.

We appreciate that staff and pupils have busy schedules within the school day, and endeavour to ensure that disruption of the school day would be kept to a minimum. All participating schools will be presented with key findings from the study, which may be useful for planning mental health education and awareness activities.

I have enclosed for your information an overview of the study, a copy of the letters that will be sent to parents and young people, and a copy of the consent forms for parents and young people. I will contact you in the near future to discuss this with you further. If you have any queries, please feel free to contact me on 087 2945615/01 896 4835 or email byrnes30@tcd.ie. The supervisors of this study, Dr Lorraine Swords (swordsl@tcd.ie / 01 896 3638) and Dr Elizabeth Nixon (enixon@tcd.ie / 01 896 2867) can also be contacted with any queries. Thank you for your consideration.

Yours sincerely,

Sadhbh Byrne

Sadhbh Byrne

What is this study about?

The study aims to improve our understanding of how caregivers and peers support young people in adolescence. We are interested in finding out the different types of support that caregivers and peers offer to young people, and the factors that might be associated with different types of support.

Who are the study researchers?

Sadhbh Byrne, a PhD student in Psychology. The supervisors of this project are Dr Lorraine Swords, a lecturer in Child & Adolescent Psychology, and Dr Elizabeth Nixon, a lecturer in Developmental Psychology. We are based at Trinity College Dublin.

Why has this school been asked to take part?

This post-primary school was randomly selected from the Department of Education & Skills list of all post-primary schools in the Leinster region of Ireland.

What happens if I agree to facilitate the study in this school?

If you decide to facilitate the study, the researchers will provide study packs, which will include information letters about the study, consent forms for parents and young people, and questionnaires for parents. You will be asked to distribute the study packs to all students in the school.

Young people's questionnaires can be administered online, or using pen-and-paper, depending on the school's preference/facilities. Online questionnaires can be completed in the school's computer lab, and pen-and-paper questionnaires can be completed in a quiet classroom. Caregivers will be asked to complete their questionnaire at home.

What will happen to the information?

All information will be stored, on a confidential basis, on a computer and used for the purpose of the research only. In addition, all questionnaires will be coded, further protecting participants' identities. No caregiver, child, or school will be identified in anything that is published from the study. However, if the responses to any questionnaire give the researcher concern that any child is at risk, these concerns will be discussed with the supervisors of the project.
Under the Freedom of Information Act 2014, participants have the right to access all information we hold about them, and for this information to be amended where it is incomplete, incorrect or misleading.

If you have any queries or require any further information, please feel free to contact:

Sadhbh Byrne on 087 294 5615/01 896 4835 or email: byrnes30@tcd.ie
Dr Lorraine Swords on 01 896 3638 or email: swordsl@tcd.ie
Dr Elizabeth Nixon on 01 896 2867 or email: enixon@tcd.ie
School of Psychology, Áras an Phiarsaigh, Trinity College, Dublin 2.

Appendix C Information Sheet for Caregivers

Caregiver

Page 1 of 2

CAREGIVERS' AND PEERS' SUPPORT IN ADOLESCENCE

Information Sheet for Caregivers

What is this study about?

The study aims to improve our understanding of how caregivers and peers support young people in adolescence. We are interested in finding out the different types of support that caregivers and peers offer to young people, and the factors that might be associated with different types of support.

Who are the study researchers?

Sadhbh Byrne, a PhD student in Psychology. The supervisors of this project are Dr Lorraine Swords, a lecturer in Child & Adolescent Psychology, and Dr Elizabeth Nixon, a lecturer in Developmental Psychology. We are based at Trinity College Dublin.

Why have my child and I been asked to take part?

Your child is attending a post-primary school that was randomly selected from the Department of Education & Skills list of all post-primary schools in the Leinster region of Ireland.

What happens if I agree to take part?

If you decide to take part, you will be asked to fill out a questionnaire in your own time. The questionnaire will present you with a short scenario, involving a young person, and you will be asked some questions about how you would respond if you came across this situation in real life. If you later decide that you would like to withdraw from the study, you can do so at any time before the end of March 2017, without any penalty.

What happens if I agree to my child taking part?

We are asking caregivers for permission to invite their children to take part in our study. Children who return caregiver consent forms will be invited to take part in the study. Then they are free to decide whether they are happy to take part in the study or not.

We also request caregivers to provide basic family background details in order to give us a profile of the child's/adolescent's background – this means that young people will not be asked for any details on their families.

What will happen to the information?

All information will be stored, on a confidential basis, on a computer and used for the purpose of the research only. In addition, all questionnaires will be coded, further protecting participants' identities. No caregiver or child will be identified in anything that is published from the study. However, if the responses to any questionnaire give the researcher concern that any child is at risk, these concerns will be discussed with the supervisors of the project.

Under the Freedom of Information Act 2014, you have the right to access all information we hold about you, and for this information to be amended where it is incomplete, incorrect or misleading.

If you have any queries or require any further information, please feel free to contact:
Sadhbh Byrne on 01 896 8494 or email: byrnes30@tcd.ie
Dr Lorraine Swords on 01 896 3638 or email: swordsl@tcd.ie
Dr Elizabeth Nixon on 01 896 2867 or email: enixon@tcd.ie
School of Psychology, Áras an Phiarsaigh, Trinity College, Dublin 2.

Appendix D Information Sheet for Adolescents

Young Person

Page 1 of 2

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Trinity College Dublin
children's research centre
research for children & young people

IRISH RESEARCH COUNCIL
An Chomhairle um Thaighde in Éirinn

Caregivers' and peers' support in adolescence
Young Person's Information Sheet

What is this study about?

The study aims to help us understand how young people support their friends, and also how caregivers support their teenage children. We are interested in finding out the different ways that friends and caregivers support young people.

Who are we?

Sadhbh Byrne, a postgraduate student in Psychology. The supervisors of this project are Dr Lorraine Swords and Dr Elizabeth Nixon, who are lecturers in Psychology. We are based at Trinity College Dublin.

Why have my caregiver and I been asked to take part?

You are attending a post-primary school that was randomly selected from the Department of Education & Skills list of all post-primary schools in the Leinster region of Ireland.

What happens if I agree to take part?

Your caregiver has already read our letter and sent back a form saying that we can ask you whether you would like to take part in our study. But this does not mean that you have to – you do not have to take part if you do not want to.

If you decide to take part, you will be asked to fill out a questionnaire in school. The questionnaire will describe a young person, and you will be asked some questions about how you would react if you came across this situation in real life.

If you later change your mind and decide that you don't want to take part, that's okay! You can contact us any time before the end of March 2017, and we will not include your responses to the questionnaire in the study.

What will happen to the information?

The information provided by you and other students may be used to write a report about the types of support young people offer to their friends. But don't worry; we will not use your name, as all information provided is private.

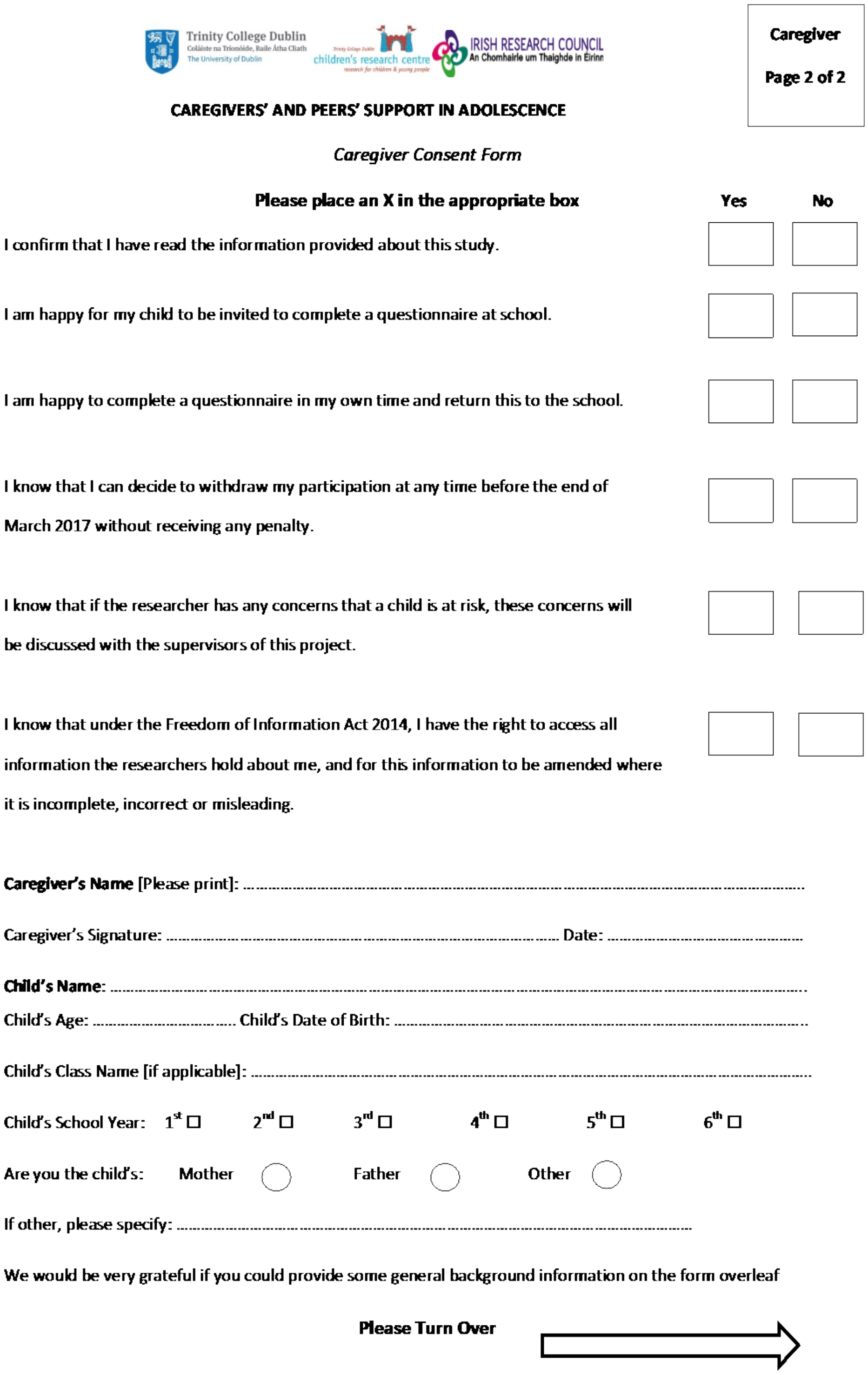
However, if the responses to any questionnaire make us concerned that you or any others are at risk, the researchers will have to discuss these concerns.

Under the Freedom of Information Act 2014, you have the right to access all information we hold about you, and for this information to be amended if it is incomplete, incorrect or misleading.

If you have any questions or require any further information, please feel free to contact:

Sadhbh Byrne on 01 896 8494 or email: byrnes30@tcd.ie
Dr Lorraine Swords on 01 896 3638 or email: swordsl@tcd.ie
Dr Elizabeth Nixon on 01 896 2867 or email: enixon@tcd.ie
School of Psychology, Áras an Phiarsaigh, Trinity College, Dublin 2.

Appendix E Caregiver Consent Form



Caregiver

Page 2 of 2

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

children's research centre

IRISH RESEARCH COUNCIL
An Chomhairle um Thaighde in Éirinn

CAREGIVERS' AND PEERS' SUPPORT IN ADOLESCENCE

Caregiver Consent Form

Please place an X in the appropriate box	**Yes**	**No**
I confirm that I have read the information provided about this study.	☐	☐
I am happy for my child to be invited to complete a questionnaire at school.	☐	☐
I am happy to complete a questionnaire in my own time and return this to the school.	☐	☐
I know that I can decide to withdraw my participation at any time before the end of March 2017 without receiving any penalty.	☐	☐
I know that if the researcher has any concerns that a child is at risk, these concerns will be discussed with the supervisors of this project.	☐	☐
I know that under the Freedom of Information Act 2014, I have the right to access all information the researchers hold about me, and for this information to be amended where it is incomplete, incorrect or misleading.	☐	☐

Caregiver's Name [Please print]: ……………………………………………………………………………………

Caregiver's Signature: ……………………………………………………………… Date: ……………………………

Child's Name: ……………………………………………………………………………………………………

Child's Age: ………………………… Child's Date of Birth: …………………………………………………………

Child's Class Name [if applicable]: ………………………………………………………………………………

Child's School Year: 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐

Are you the child's: Mother ○ Father ○ Other ○

If other, please specify: ………………………………………………………………………………

We would be very grateful if you could provide some general background information on the form overleaf

Please Turn Over ⇨

To avoid asking young people about their own family backgrounds, we would be very grateful if you could fill in the details on your child's family below. This information is **confidential** and **will only** be used to build an overall profile of the study population and the overall family contexts of the children in the study. Individual answers will not be used under any circumstances. These answers will help us understand how different factors influence a child's life.

Ethnic & Cultural Background

Were you born in Ireland? Yes ○ No ○

If no, in which country were you born? ……………………………………………………………………………

Please indicate your ethnic or cultural background:

☐ White Irish
☐ Irish Traveller
☐ Any other White background
☐ Black Irish
☐ African
☐ Any other Black background
☐ Chinese
☐ Any other Asian background

Other, including mixed background (please specify): …………………………………………………………………………

Socio-Demographic Information

What is the highest level of education the child's mother or female guardian has completed to date?

☐ Primary or less

☐ Intermediate/Group/Junior Certificate or equivalent

☐ Leaving Certificate or equivalent

☐ Diploma/Certificate

☐ Primary/Bachelor's Degree

☐ Postgraduate/Higher Degree

Other not listed [please specify]: ………………………………………………………………………………………

Thank you for your time. Please return this form to school.

If you would like any more information, please contact:

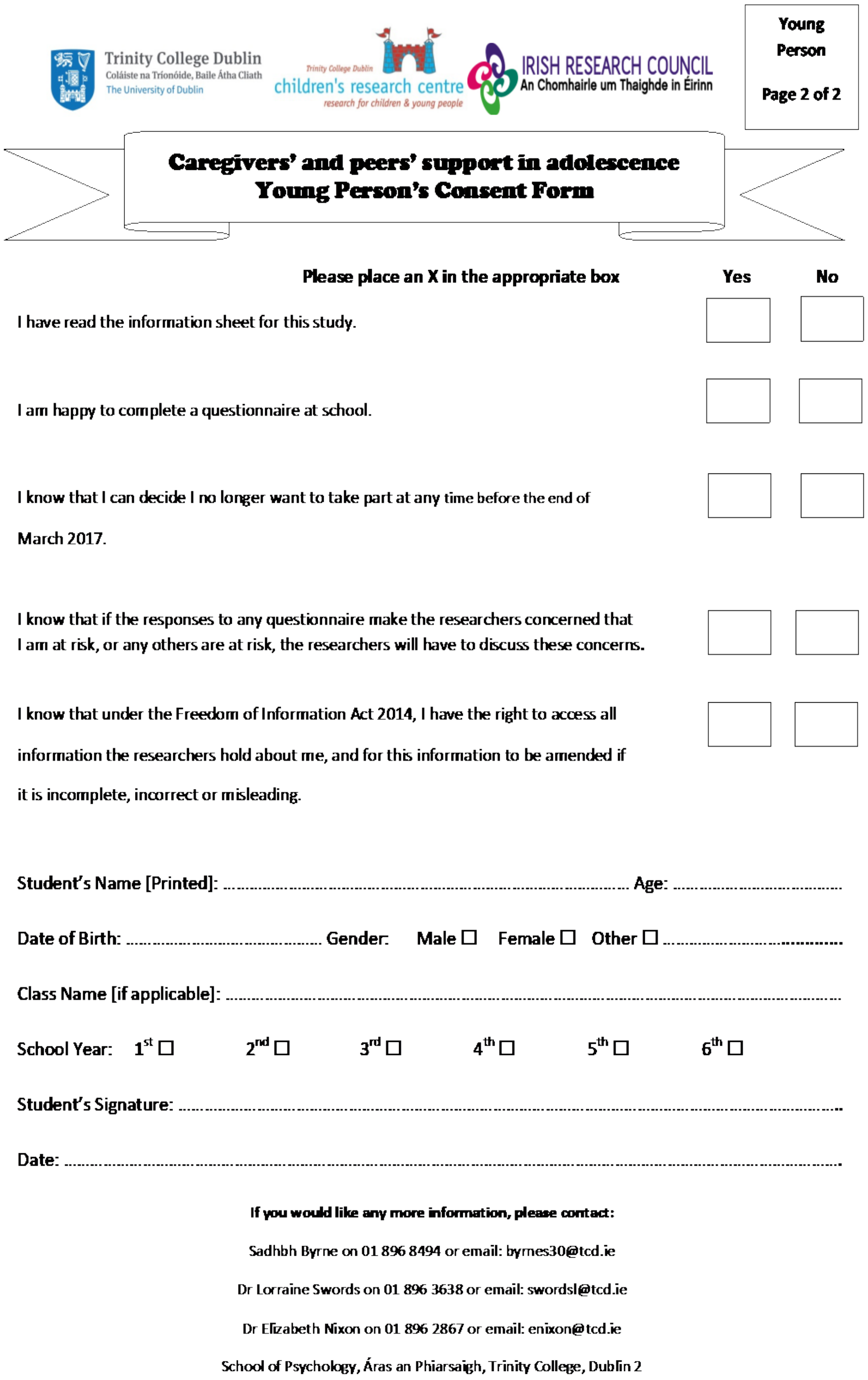
Sadhbh Byrne on 01 896 8494 or email: byrnes30@tcd.ie

Dr Lorraine Swords on 01 896 3638 or email: swordsl@tcd.ie

Dr Elizabeth Nixon on 01 896 2867 or email: enixon@tcd.ie

School of Psychology, Áras an Phiarsaigh, Trinity College, Dublin 2

Appendix F Adolescent Consent Form



Young
Person

Page 2 of 2

Caregivers' and peers' support in adolescence
Young Person's Consent Form

Please place an X in the appropriate box	Yes	No
I have read the information sheet for this study.	☐	☐
I am happy to complete a questionnaire at school.	☐	☐
I know that I can decide I no longer want to take part at any time before the end of March 2017.	☐	☐
I know that if the responses to any questionnaire make the researchers concerned that I am at risk, or any others are at risk, the researchers will have to discuss these concerns.	☐	☐
I know that under the Freedom of Information Act 2014, I have the right to access all information the researchers hold about me, and for this information to be amended if it is incomplete, incorrect or misleading.	☐	☐

Student's Name [Printed]: .... **Age:** ....

Date of Birth: .... **Gender:** **Male** ☐ **Female** ☐ **Other** ☐ ....

Class Name [if applicable]: ....

School Year: 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐

Student's Signature: ....

Date: ....

If you would like any more information, please contact:

Sadhbh Byrne on 01 896 8494 or email: byrnes30@tcd.ie

Dr Lorraine Swords on 01 896 3638 or email: swordsl@tcd.ie

Dr Elizabeth Nixon on 01 896 2867 or email: enixon@tcd.ie

School of Psychology, Áras an Phiarsaigh, Trinity College, Dublin 2

Appendix G Version of questionnaire for adolescent participants

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

IRISH RESEARCH COUNCIL
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Caregivers' and Peers' Support in Adolescence

Young Person's Questionnaire Booklet

Please fill out this information:

Your Name: ……………………………………………………………………………………

Your Date of Birth: ………………………………………………………………………………

Your Gender: Male ☐

Female ☐

Other ☐ ………………………………………………………

Please answer the following questions as honestly as possible.

Thank you so much for your help with this study!

Code: ………………………………………………

(for researcher's purposes only)

SECTION A

Please **circle the number** that corresponds with how you feel about each statement, using the scale detailed below:

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
1. My friends' emotions don't affect me much	1	2	3	4	5
2. After being with a friend who is sad about something, I usually feel sad	1	2	3	4	5
3. I can understand my friend's happiness when she/he does well at something	1	2	3	4	5
4. I get frightened when I watch characters in a good scary movie	1	2	3	4	5
5. I get caught up in other people's feelings easily	1	2	3	4	5
6. I find it hard to know when my friends are frightened	1	2	3	4	5
7. I don't become sad when I see other people crying	1	2	3	4	5
8. Other people's feelings don't bother me at all	1	2	3	4	5
9. When someone is feeling 'down', I can usually understand how they feel	1	2	3	4	5
10. I can usually work out when my friends are scared	1	2	3	4	5
11. I often become sad when watching sad things on TV or in films	1	2	3	4	5
12. I can often understand how people are feeling even before they tell me	1	2	3	4	5
13. Seeing a person who has been angered has no effect on my feelings	1	2	3	4	5
14. I can usually work out when people are cheerful	1	2	3	4	5
15. I tend to feel scared when I am with friends who are afraid	1	2	3	4	5
16. I can usually realise quickly when a friend is angry	1	2	3	4	5
17. I often get swept up in my friends' feelings	1	2	3	4	5
18. My friends' unhappiness doesn't make me feel anything	1	2	3	4	5
19. I am not usually aware of my friends' feelings	1	2	3	4	5
20. I have trouble figuring out when my friends are happy	1	2	3	4	5

SECTION B

You are now going to read about a teenager called Michelle, who is **the same age** as you. We are going to ask you to **imagine that Michelle is your friend**. You will be asked to answer some questions about what you think and feel about Michelle. Please take your time to read these questions carefully and to respond as truthfully as possible. We are only interested in your opinion. **There are no right or wrong answers**.

Michelle

Michelle used to enjoy lots of hobbies, such as hanging out with friends and playing football for her local team. Although Michelle sometimes complained about how much time the team had to spend training, she was usually quite good at turning up for practice. A few months ago, Michelle started missing a lot of training sessions and has since stopped coming altogether. Over this time you have noticed a change in her, in that she doesn't seem to be interested in doing things with you and her other friends any more - she no longer makes an effort to hang out with you or talk to you online. You have also noticed that she seems more irritable lately and doesn't smile, or laugh, or appear to find as much enjoyment in things as she used to. Michelle has also started to experience some problems at school. Over the past six weeks or so, Michelle has been constantly late for school and has started to fall behind on her school work. When the head teacher asked Michelle about this, she said that she has been finding it extremely difficult to get to sleep at night and feels tired all the time. Michelle explained that although she would like to do better in school, she just couldn't concentrate on things or think as well as she used to. Michelle said that she just feels 'down' all the time now and doesn't think that she is good at anything anymore.

1. How worried are you about Michelle's overall wellbeing?
    - I would not be at all worried about her wellbeing ☐
    - I would be a little bit worried about her wellbeing ☐
    - I would be quite worried about her wellbeing ☐
    - I would be extremely worried about her wellbeing ☐

2. In five words or less, what do you think is the matter with Michelle?

    ………

3. Please quote all the words/phrases from Michelle's story that suggest to you that she might be experiencing difficulties

    ………

    ………

4. How long do you think it will take for Michelle to feel better again?
    - One or two days ☐
    - One or two weeks ☐
    - One or two months ☐
    - Longer than a few months ☐

5. Do you think Michelle needs help from another person to cope with her problems?
    - Yes ☐
    - No ☐
    - Don't Know ☐

SECTION C

Below is a list of possible responses to Michelle's situation. Please **circle the number** that corresponds with how likely it is that you would do each of these, using the scale detailed below:

	Extremely unlikely	Unlikely	Likely	Extremely likely
1. I would suggest Michelle seek professional help	1	2	3	4
2. I would make an appointment for Michelle to see a professional	1	2	3	4
3. I would talk to Michelle about her feelings	1	2	3	4
4. I would wait to gather more information before saying or doing anything	1	2	3	4
5. I would encourage Michelle to go to a teacher or another member of school staff (e.g. school counsellor)	1	2	3	4
6. I would tell Michelle that her new pattern of behaviour is unacceptable	1	2	3	4
7. I would talk Michelle out of her negative feelings	1	2	3	4
8. I would try to distract Michelle from her problems	1	2	3	4
9. I would encourage Michelle to look on the bright side of things	1	2	3	4
10. I would ask a friend for advice about what to do	1	2	3	4
11. I would offer to accompany Michelle to an appointment with a mental health professional	1	2	3	4
12. I would tell one of my family members about the situation	1	2	3	4
13. I would not say or do anything	1	2	3	4
14. I would tell a teacher or another member of school staff (e.g. school counsellor) about Michelle's situation	1	2	3	4
15. I would give Michelle information on how to make an appointment to see a mental health professional	1	2	3	4
16. I would call a crisis hotline (e.g. Samaritans, Childline) for help and advice	1	2	3	4
17. I would tell Michelle to stop being so dramatic	1	2	3	4
18. I would give Michelle space	1	2	3	4
19. I would tell Michelle's parent or key caregiver about the situation	1	2	3	4
20. I would express my concern about Michelle to others	1	2	3	4
21. I would talk to one of Michelle's friends about my concern for Michelle	1	2	3	4

	Extremely unlikely	Unlikely	Likely	Extremely likely
22. I would encourage Michelle to seek advice from a website or online support forum	1	2	3	4
23. I would encourage Michelle to seek help from a crisis hotline	1	2	3	4
24. I would seek help from a website or online support forum	1	2	3	4
25. I would ignore the subject unless Michelle brought it up first	1	2	3	4
26. I would tell Michelle that I am concerned about her	1	2	3	4
27. I would encourage Michelle to talk to her family	1	2	3	4
28. I would ask Michelle if anything is wrong	1	2	3	4
29. I would ring a professional for help and advice about the situation	1	2	3	4
30. I would contact Michelle's family about my concern	1	2	3	4
31. I would listen to Michelle's problems in an understanding way	1	2	3	4
32. I would talk to Michelle firmly about getting her act together	1	2	3	4
33. I would ask Michelle whether she is feeling suicidal	1	2	3	4
34. I would suggest Michelle has a few drinks to forget about her troubles	1	2	3	4
35. I would encourage Michelle to become more physically active	1	2	3	4
36. I would wait to see if Michelle's symptoms continued before saying or doing anything	1	2	3	4

Is there anything else you might do or say, that isn't included in this list? If so, please explain what else you would do:

………

………

………

………

………

SECTION D

Please **circle the number** that corresponds with how you feel:

1. Other people like me would involve a professional (e.g. GP, psychologist) in Michelle's situation

Strongly Agree	1	2	3	4	5	Strongly Disagree

2. Other people like me would involve another person who isn't a professional (e.g. friend, family member, teacher) in Michelle's situation

Strongly Agree	1	2	3	4	5	Strongly Disagree

3. Other people like me would talk with Michelle one-on-one about her situation

Strongly Agree	1	2	3	4	5	Strongly Disagree

4. Other people like me would not get involved in Michelle's situation

Strongly Agree	1	2	3	4	5	Strongly Disagree

SECTION E

Please **circle the number** that corresponds with whether you think each person or treatment would be 'helpful', 'harmful' or 'make no difference' to Michelle.

	Helpful	Harmful	Make no difference
1. Listen to Michelle's problems in an understanding way	1	2	3
2. Talk to Michelle firmly about getting her act together.	1	2	3
3. Suggest Michelle seek professional help.	1	2	3
4. Make an appointment for Michelle to see a general practitioner (GP)	1	2	3
5. Ask Michelle whether she is feeling suicidal.	1	2	3
6. Suggest Michelle has a few drinks to forget her troubles.	1	2	3
7. Rally friends to cheer Michelle up.	1	2	3
8. Ignore Michelle until she gets over it.	1	2	3
9. Keep Michelle busy to keep her mind off her problems.	1	2	3
10. Encourage Michelle to become more physically active.	1	2	3

SECTION F

Please **circle the number** that best describes your personal opinion.

1. Helping Michelle would be…

Not regrettable	1	2	3	4	5	6	7	Regrettable

2. Helping Michelle would be…

Beneficial	1	2	3	4	5	6	7	Harmful

3. Helping Michelle would be…

Negative	1	2	3	4	5	6	7	Positive

4. Helping Michelle would be…

Bad	1	2	3	4	5	6	7	Good

5. Helping Michelle would be…

Worthless	1	2	3	4	5	6	7	Valuable

6. Helping Michelle would be…

Useful	1	2	3	4	5	6	7	Useless

7. Helping Michelle would be…

Possible	1	2	3	4	5	6	7	Impossible

8. Helping Michelle would be…

Unpleasant	1	2	3	4	5	6	7	Pleasant

9. Helping Michelle would be…

Not upsetting	1	2	3	4	5	6	7	Upsetting

10. Helping Michelle would be…

Not scary	1	2	3	4	5	6	7	Scary

11. Helping Michelle would be…

Stressful	1	2	3	4	5	6	7	Not stressful

SECTION G

Please **circle the number** that best describes your personal opinion

1. How controllable, do you think, is the cause of Michelle's present condition?

Not at all under personal control	1	2	3	4	5	6	7	8	9	Completely under personal control

2. How responsible, do you think, is Michelle for her present condition?

Not at all responsible	1	2	3	4	5	6	7	8	9	Very much responsible

3. I would think that it is Michelle's own fault that she is in the present situation

No, not at all	1	2	3	4	5	6	7	8	9	Yes, absolutely so

4. How much sympathy would you feel for Michelle?

None at all	1	2	3	4	5	6	7	8	9	Very much

5. I would feel pity for Michelle

None at all	1	2	3	4	5	6	7	8	9	Very much

6. How much concern would you feel for Michelle?

None at all	1	2	3	4	5	6	7	8	9	Very much

7. How angry would you feel at Michelle?

Not at all	1	2	3	4	5	6	7	8	9	Very much

8. How irritated would you feel by Michelle?

Not at all	1	2	3	4	5	6	7	8	9	Very much

9. I would feel aggravated by Michelle

Not at all	1	2	3	4	5	6	7	8	9	Very much so

SECTION H

Please **circle the number** that best describes your personal opinion

1. I am confident in my ability to discuss Michelle's situation with her

Strongly disagree	1	2	3	4	5	Strongly agree

2. I have the interpersonal skills necessary to have a serious discussion with Michelle about her situation

Strongly disagree	1	2	3	4	5	Strongly agree

3. I am confident I can express my concern with Michelle as a friend

Strongly disagree	1	2	3	4	5	Strongly agree

4. I am confident I could call a crisis hotline for help and advice

Strongly disagree	1	2	3	4	5	Strongly agree

5. I am resourceful, I would be able to locate someone for Michelle to talk to

Strongly disagree	1	2	3	4	5	Strongly agree

6. I am sure I could help Michelle in some way

Strongly disagree	1	2	3	4	5	Strongly agree

7. I am confident I could be helpful in a situation like Michelle's

Strongly disagree	1	2	3	4	5	Strongly agree

8. I am NOT confident I could talk to a teacher about my concerns

Strongly disagree	1	2	3	4	5	Strongly agree

9. It would be difficult for me to discuss my concern for Michelle

Strongly disagree	1	2	3	4	5	Strongly agree

10. I am sure I would be able to discuss my concern with a professional

Strongly disagree	1	2	3	4	5	Strongly agree

SECTION I

Please **tick the appropriate box**, based on your past experience:

1. In the past year, has anyone in your family or close circle of friends had a problem similar to Michelle's?
   No ☐ **Go straight to Section J**
   Don't Know ☐
   Yes ☐

2. Did just one person have the problem, or more than one?
   Just one ☐
   More than one ☐

If you answered
'More than one':
Because you know more than one person who had a problem similar to Michelle's, for the next few questions, I want you to think about the person you know best.

3. How old was that person at the time?
   0 to 9 years ☐
   10 to 19 years ☐
   20 to 29 years ☐
   30 to 39 years ☐
   40 to 49 years ☐
   50 to 59 years ☐
   60 years or over ☐
   Don't Know ☐

4. What was this person's gender?
   Male ☐ Female ☐ Other ☐

5. Was this person a family member or a friend?
   Family member ☐ Friend ☐

6. In the past year, have you done anything to help this person?
   Yes ☐ No ☐

7. What did you do?
   ....
   ....

SECTION J

Please tick all items that apply to you: ☑

1. I have had a mental illness.
2. I have lived with someone with a mental illness.
3. I have frequent contact with a friend or relative who has a mental illness.
4. It is my main duty to provide service to people with mental illness.
5. I often encounter people with mental illness (at least twice a month).
6. I encounter people with mental illness occasionally.
7. I have observed, in passing, someone who might have a mental illness.
8. I have seen realistic portrayals of people with mental illness in newspapers, magazines, films, or TV programmes.
9. None of the above is true.

•••••••••

You're finished!
Thank you SO MUCH for your participation in this study!

Appendix H Version of questionnaire for caregiver participants

Caregivers' and Peers' Support in Adolescence

Caregiver's Questionnaire Booklet

Please fill out this information:

Your Child's Name: ....

Your Name: ....

Your Date of Birth: ....

Your Gender: Male ☐

Female ☐

Other ☐ ....

Please answer the following questions as honestly as possible.

Thank you so much for your help with this study!

Code: ....

(for researcher's purposes only)

SECTION B

You are now going to read about a teenager called Michelle, who is **the same age** as your adolescent son/daughter. We are going to ask you to **imagine that Michelle is your daughter**. You will be asked to answer some questions about what you think and feel about Michelle. Please take your time to read these questions carefully and to respond as truthfully as possible. We are only interested in your opinion. **There are no right or wrong answers**.

Michelle

Michelle used to enjoy lots of hobbies, such as hanging out with friends and playing football for her local team. Although Michelle sometimes complained about how much time the team had to spend training, she was usually quite good at turning up for practice. A few months ago, Michelle started missing a lot of training sessions and has since stopped coming altogether. Over this time you have noticed a change in her, in that she doesn't seem to be interested in doing things with her friends any more - she no longer makes an effort to hang out with them or talk to them online. You have also noticed that she seems more irritable lately and doesn't smile, or laugh, or appear to find as much enjoyment in things as she used to. Michelle has also started to experience some problems at school. Over the past six weeks or so, Michelle has been constantly late for school and has started to fall behind on her school work. When the head teacher asked Michelle about this, she said that she has been finding it extremely difficult to get to sleep at night and feels tired all the time. Michelle explained that although she would like to do better in school, she just couldn't concentrate on things or think as well as she used to. Michelle said that she just feels 'down' all the time now and doesn't think that she is good at anything anymore.

1. How worried are you about Michelle's overall wellbeing?

   I would not be at all worried about her wellbeing ☐
   I would be a little bit worried about her wellbeing ☐
   I would be quite worried about her wellbeing ☐
   I would be extremely worried about her wellbeing ☐

2. In five words or less, what do you think is the matter with Michelle?

   ………

3. Please quote all the words/phrases from Michelle's story that suggest to you that she might be experiencing difficulties

   ………
   ………

4. How long do you think it will take for Michelle to feel better again?

   One or two days ☐
   One or two weeks ☐
   One or two months ☐
   Longer than a few months ☐

5. Do you think Michelle needs help from another person to cope with her problems?

   Yes ☐
   No ☐
   Don't Know ☐

SECTION C

Below is a list of possible responses to Michelle's situation. Please **circle the number** that corresponds with how likely it is that you would do each of these, using the scale detailed below:

	Extremely unlikely	Unlikely	Likely	Extremely likely
1. I would suggest Michelle seek professional help	1	2	3	4
2. I would make an appointment for Michelle to see a professional	1	2	3	4
3. I would talk to Michelle about her feelings	1	2	3	4
4. I would wait to gather more information before saying or doing anything	1	2	3	4
5. I would encourage Michelle to go to a teacher or another member of school staff (e.g. school counsellor)	1	2	3	4
6. I would tell Michelle that her new pattern of behaviour is unacceptable	1	2	3	4
7. I would talk Michelle out of her negative feelings	1	2	3	4
8. I would try to distract Michelle from her problems	1	2	3	4
9. I would encourage Michelle to look on the bright side of things	1	2	3	4
10. I would ask a friend for advice about what to do	1	2	3	4
11. I would offer to accompany Michelle to an appointment with a mental health professional	1	2	3	4
12. I would tell one of my family members about the situation	1	2	3	4
13. I would not say or do anything	1	2	3	4
14. I would tell a teacher or another member of school staff (e.g. school counsellor) about Michelle's situation	1	2	3	4
15. I would give Michelle information on how to make an appointment to see a mental health professional	1	2	3	4
16. I would call a crisis hotline (e.g. Samaritans, Childline) for help and advice	1	2	3	4
17. I would tell Michelle to stop being so dramatic	1	2	3	4
18. I would give Michelle space	1	2	3	4
19. I would tell Michelle's other parent or key caregiver about the situation	1	2	3	4
20. I would express my concern about Michelle to others	1	2	3	4
21. I would talk to one of Michelle's friends about my concern for Michelle	1	2	3	4

	Extremely unlikely	Unlikely	Likely	Extremely likely
22. I would encourage Michelle to seek advice from a website or online support forum	1	2	3	4
23. I would encourage Michelle to seek help from a crisis hotline	1	2	3	4
24. I would seek help from a website or online support forum	1	2	3	4
25. I would ignore the subject unless Michelle brought it up first	1	2	3	4
26. I would tell Michelle that I am concerned about her	1	2	3	4
27. I would encourage Michelle to talk to her family	1	2	3	4
28. I would ask Michelle if anything is wrong	1	2	3	4
29. I would ring a professional for help and advice about the situation	1	2	3	4
30. I would contact Michelle's extended family about my concern	1	2	3	4
31. I would listen to Michelle's problems in an understanding way	1	2	3	4
32. I would talk to Michelle firmly about getting her act together	1	2	3	4
33. I would ask Michelle whether she is feeling suicidal	1	2	3	4
34. I would suggest Michelle has a few drinks to forget about her troubles	1	2	3	4
35. I would encourage Michelle to become more physically active	1	2	3	4
36. I would wait to see if Michelle's symptoms continued before saying or doing anything	1	2	3	4

Is there anything else you might do or say, that **isn't included in this list**? If so, please explain what else you would do:

....
....
....
....
....

SECTION D

Please **circle the number** that corresponds with how you feel:

1. Other people like me would involve a professional (e.g. GP, psychologist) in Michelle's situation

Strongly Agree	1	2	3	4	5	Strongly Disagree

2. Other people like me would involve another person who isn't a professional (e.g. friend, family member, teacher) in Michelle's situation

Strongly Agree	1	2	3	4	5	Strongly Disagree

3. Other people like me would talk with Michelle one-on-one about her situation

Strongly Agree	1	2	3	4	5	Strongly Disagree

4. Other people like me would not get involved in Michelle's situation

Strongly Agree	1	2	3	4	5	Strongly Disagree

SECTION E

Please circle the number that corresponds with whether you think each person or treatment would be 'helpful', 'harmful' or 'make no difference' to Michelle.

	Helpful	Harmful	Make no difference
1. Listen to Michelle's problems in an understanding way	1	2	3
2. Talk to Michelle firmly about getting her act together.	1	2	3
3. Suggest Michelle seek professional help.	1	2	3
4. Make an appointment for Michelle to see a general practitioner (GP)	1	2	3
5. Ask Michelle whether she is feeling suicidal.	1	2	3
6. Suggest Michelle has a few drinks to forget her troubles.	1	2	3
7. Rally friends to cheer Michelle up.	1	2	3
8. Ignore Michelle until she gets over it.	1	2	3
9. Keep Michelle busy to keep her mind off her problems.	1	2	3
10. Encourage Michelle to become more physically active.	1	2	3

SECTION F

Please **circle the number** that best describes your personal opinion.

1. **Helping Michelle would be…**

Not regrettable	1	2	3	4	5	6	7	**Regrettable**

2. **Helping Michelle would be…**

Beneficial	1	2	3	4	5	6	7	**Harmful**

3. **Helping Michelle would be…**

Negative	1	2	3	4	5	6	7	**Positive**

4. **Helping Michelle would be…**

Bad	1	2	3	4	5	6	7	**Good**

5. **Helping Michelle would be…**

Worthless	1	2	3	4	5	6	7	**Valuable**

6. **Helping Michelle would be…**

Useful	1	2	3	4	5	6	7	**Useless**

7. **Helping Michelle would be…**

Possible	1	2	3	4	5	6	7	**Impossible**

8. **Helping Michelle would be…**

Unpleasant	1	2	3	4	5	6	7	**Pleasant**

9. **Helping Michelle would be…**

Not upsetting	1	2	3	4	5	6	7	**Upsetting**

10. **Helping Michelle would be…**

Not scary	1	2	3	4	5	6	7	**Scary**

11. **Helping Michelle would be…**

Stressful	1	2	3	4	5	6	7	**Not stressful**

SECTION G

Please **circle the number** that best describes your personal opinion

1. How controllable, do you think, is the cause of Michelle's present condition?

Not at all under personal control	1	2	3	4	5	6	7	8	9	Completely under personal control

2. How responsible, do you think, is Michelle for her present condition?

Not at all responsible	1	2	3	4	5	6	7	8	9	Very much responsible

3. I would think that it is Michelle's own fault that she is in the present situation

No, not at all	1	2	3	4	5	6	7	8	9	Yes, absolutely so

4. How much sympathy would you feel for Michelle?

None at all	1	2	3	4	5	6	7	8	9	Very much

5. I would feel pity for Michelle

None at all	1	2	3	4	5	6	7	8	9	Very much

6. How much concern would you feel for Michelle?

None at all	1	2	3	4	5	6	7	8	9	Very much

7. How angry would you feel at Michelle?

Not at all	1	2	3	4	5	6	7	8	9	Very much

8. How irritated would you feel by Michelle?

Not at all	1	2	3	4	5	6	7	8	9	Very much

9. I would feel aggravated by Michelle

Not at all	1	2	3	4	5	6	7	8	9	Very much so

SECTION H

Please **circle the number** that best describes your personal opinion

1. I am confident in my ability to discuss Michelle's situation with her

Strongly disagree	1	2	3	4	5	Strongly agree

2. I have the interpersonal skills necessary to have a serious discussion with Michelle about her situation

Strongly disagree	1	2	3	4	5	Strongly agree

3. I am confident I can express my concern with Michelle as a parent

Strongly disagree	1	2	3	4	5	Strongly agree

4. I am confident I could call a crisis hotline for help and advice

Strongly disagree	1	2	3	4	5	Strongly agree

5. I am resourceful, I would be able to locate someone for Michelle to talk to

Strongly disagree	1	2	3	4	5	Strongly agree

6. I am sure I could help Michelle in some way

Strongly disagree	1	2	3	4	5	Strongly agree

7. I am confident I could be helpful in a situation like Michelle's

Strongly disagree	1	2	3	4	5	Strongly agree

8. I am NOT confident I could talk to a teacher about my concerns

Strongly disagree	1	2	3	4	5	Strongly agree

9. It would be difficult for me to discuss my concern for Michelle

Strongly disagree	1	2	3	4	5	Strongly agree

10. I am sure I would be able to discuss my concern with a professional

Strongly disagree	1	2	3	4	5	Strongly agree

SECTION I

Please **tick the appropriate box**, based on your past experience:

1. In the past year, has anyone in your family or close circle of friends had a problem similar to Michelle's?
   No ☐ **Go straight to Section J**
   Don't Know ☐
   Yes ☐

2. Did just one person have the problem, or more than one?
   Just one ☐
   More than one ☐

If you answered
'More than one':
Because you know more than one person who had a problem similar to Michelle's, for the next few questions, I want you to think about the person you know best.

3. How old was that person at the time?
   0 to 9 years ☐
   10 to 19 years ☐
   20 to 29 years ☐
   30 to 39 years ☐
   40 to 49 years ☐
   50 to 59 years ☐
   60 years or over ☐
   Don't Know ☐

4. What was this person's gender?
   Male ☐ Female ☐ Other ☐

5. Was this person a family member or a friend?
   Family member ☐ Friend ☐

6. In the past year, have you done anything to help this person?
   Yes ☐ No ☐

7. What did you do?
   ……………………………………………………………………………………………………
   ……………………………………………………………………………………………………

SECTION J

Please tick all items that apply to you: ☑

1.	I have had a mental illness.
2.	I have lived with someone with a mental illness.
3.	I have frequent contact with a friend or relative who has a mental illness.
4.	It is my main duty to provide service to people with mental illness.
5.	I often encounter people with mental illness (at least twice a month).
6.	I encounter people with mental illness occasionally.
7.	I have observed, in passing, someone who might have a mental illness.
8.	I have seen realistic portrayals of people with mental illness in newspapers, magazines, films, or TV programmes.
9.	None of the above is true.

****

You're finished!
Thank you SO MUCH for your participation in this study!

Appendix I Debriefing sheet for adolescent participants

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin
Trinity College Dublin
children's research centre
research for children & young people
IRISH RESEARCH COUNCIL
An Chomhairle um Thaighde in Éirinn

CAREGIVERS' AND PEERS' SUPPORT IN ADOLESCENCE

Debriefing Sheet for Young People

Thank you very much for your participation

Thank you for taking part in this study. You read a story that described a young person, who displayed significant symptoms and signs that indicate that they have depression. The aim of this study is to understand how young people might support a friend with mental health problems. This is important, as other research has shown that young people often turn to their peers when they have mental health problems.

What will happen to the information?

The information provided by you and other students may be used to write a report about the types of support young people offer to their friends. If you would like to know what I discover, you can email me at byrnes30@tcd.ie .

But don't worry; we will not use your name, as all information provided is private. However, if the responses to any questionnaire make us concerned that you or any others are at risk, the researchers will have to discuss these concerns with someone who can help.

If you would like to talk:

If you have been affected in any way by what you just read or thought about, your school counsellor is available to listen and talk it through with you. The school counsellor is based in Room ________ and can also be contacted by ringing ____________________ or emailing _________________________.

You can also contact the Samaritans, who provide confidential emotional support, and are available 24 hours a day at **1850 60 90 90**. If you would like support specifically for depression, you can also contact Aware at **1890 303 302** or supportmail@aware.ie

If you would like some more information about youth mental health, check out Headstrong – The National Centre for Youth Mental Health at their website: www.headstrong.ie or call 01 472 7010 or email info@headstrong.ie

If you have any queries or require any further information, please feel free to contact:

Sadhbh Byrne on 01 896 4835 or email: byrnes30@tcd.ie

Dr Lorraine Swords on 01 896 3638 or email: swordsl@tcd.ie

Dr Elizabeth Nixon on 01 896 2867 or email: enixon@tcd.ie

School of Psychology, Áras an Phiarsaigh, Trinity College, Dublin 2.

Appendix J Pilot study questionnaire for adolescent participants

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

IRISH RESEARCH COUNCIL
An Chomhairle um Thaighde in Éirinn

Trinity College Dublin
children's research centre
research for children & young people

Young Person's Questionnaire Booklet

Participant Name: ....

Participant Date of Birth: ....

Participant Gender: Male ☐

Female ☐

Other ☐

Please answer the following questions as honestly as possible.

Thank you for your help with this study!

Code: ....

(for researcher's purposes only)

Code: ……………………………………………………

(for researcher's purposes only)

Basic Empathy Scale (Jolliffe & Farrington, 2006)

Please **circle the number** that corresponds with how you feel about each statement, using the scale detailed below:

1	Strongly Disagree
2	Disagree
3	Neither Agree nor Disagree
4	Agree
5	Strongly Agree

1. My friend's emotions don't affect me much	1	2	3	4	5
2. After being with a friend who is sad about something, I usually feel sad	1	2	3	4	5
3. I can understand my friend's happiness when she/he does well at something	1	2	3	4	5
4. I get frightened when I watch characters in a good scary movie	1	2	3	4	5
5. I get caught up in other people's feelings easily	1	2	3	4	5
6. I find it hard to know when my friends are frightened	1	2	3	4	5
7. I don't become sad when I see other people crying	1	2	3	4	5
8. Other people's feelings don't bother me at all	1	2	3	4	5
9. When someone is feeling 'down' I can usually understand how they feel	1	2	3	4	5
10. I can usually work out when my friends are scared	1	2	3	4	5
11. I often become sad when watching sad things on TV or in films	1	2	3	4	5
12. I can often understand how people are feeling even before they tell me	1	2	3	4	5
13. Seeing a person who has been angered has no effect on my feelings	1	2	3	4	5
14. I can usually work out when people are cheerful	1	2	3	4	5
15. I tend to feel scared when I am with friends who are afraid	1	2	3	4	5
16. I can usually realise quickly when a friend is angry	1	2	3	4	5

17. I often get swept up in my friends' feelings	1	2	3	4	5
18. My friend's unhappiness doesn't make me feel anything	1	2	3	4	5
19. I am not usually aware of my friends' feelings	1	2	3	4	5
20. I have trouble figuring out when my friends are happy	1	2	3	4	5

****

You are now going to read about a teenager called Michelle. You will be asked to answer some questions about what you think and feel about Michelle. Please take your time to read these questions carefully and to respond as truthfully as possible. We are only interested in your opinion. There are no right or wrong answers.

Michelle

Michelle is your friend. She is in the same year as you. She used to enjoy lots of hobbies, such as hanging out with friends and playing football for her local team. Although Michelle sometimes complained about how much time the team had to spend training, she was usually quite good at turning up for practice. A few months ago, Michelle started missing a lot of training sessions and has since stopped coming altogether. Over this time you have noticed a change in her, in that she doesn't seem to be interested in doing things with you and your other friends any more - she no longer makes an effort to hang out or talk online. You have also noticed that she seems more irritable lately and doesn't smile, or laugh, or appear to find as much enjoyment in things as she used to. Michelle has also started to experience some problems at school. Over the past six weeks or so, Michelle has been constantly late for school and has started to fall behind on her school work. When the head teacher asked Michelle about this, she said that she has been finding it extremely difficult to get to sleep at night and feels tired all the time. Michelle explained that although she would like to do better in school, she just couldn't concentrate on things or think as well as she used to. Michelle said that she just feels 'down' all the time now and doesn't think that she is good at anything anymore.

Friend in Need Questionnaire (Burns & Rapee, 2006)

21. How worried are you about Michelle's overall wellbeing?
    - I would not be at all worried about her wellbeing ☐
    - I would be a little bit worried about her wellbeing ☐
    - I would be quite worried about her wellbeing ☐
    - I would be extremely worried about her wellbeing ☐

22. In five words or less, what do you think is the matter with Michelle?

………

23. Please quote all the words/phrases from Michelle's story that suggest to you that she might be experiencing difficulties

………

………

………

24. How long do you think it will take for Michelle to feel better again?

One or two days ☐

One or two weeks ☐

One or two months ☐

Longer than a few months ☐

25. Do you think Michelle needs help from another person to cope with her problems?

No ☐

Don't Know ☐

Yes ☐

****

Intentions to Provide Mental Health Support Scale (original)

Below is a list of possible responses to Michelle's situation. Please **circle the number** that corresponds with how likely it is that you would do each of these, using the scale detailed below:

1	Extremely unlikely
2	Unlikely
4	Likely
5	Extremely likely

Note: When we refer to 'professional' help, we mean a general practitioner (GP), psychiatrist, psychologist, or similar other.

26. I would suggest Michelle seek professional help	1	2	3	4
27. I would make an appointment for her to see a professional	1	2	3	4
28. I would talk to Michelle about her feelings	1	2	3	4
29. I would wait to gather more information before saying or doing anything	1	2	3	4
30. I would encourage Michelle to go to a teacher or another member of school staff (e.g. school counsellor)	1	2	3	4
31. I would tell Michelle that her new pattern of behaviour is unacceptable	1	2	3	4
32. I would talk Michelle out of her negative feelings	1	2	3	4
33. I would try to distract Michelle from her problems	1	2	3	4
34. I would encourage Michelle to look on the bright side of things	1	2	3	4
35. I would ask a friend for advice about what to do	1	2	3	4
36. I would offer to accompany Michelle to an appointment with a mental health professional	1	2	3	4
37. I would tell one of my family members about the situation	1	2	3	4
38. I would not say or do anything	1	2	3	4
39. I would tell a teacher or another member of school staff (e.g. school counsellor) about Michelle's situation	1	2	3	4
40. I would give Michelle information on how to make an appointment to see a mental health professional	1	2	3	4
41. I would call a crisis hotline (e.g. Samaritans, Childline) for help and advice	1	2	3	4
42. I would tell Michelle to stop being so dramatic	1	2	3	4
43. I would give Michelle space	1	2	3	4
44. I would tell one of Michelle's family members about the situation	1	2	3	4
45. I would express my concern about Michelle to others	1	2	3	4
46. I would talk to a mutual friend about my concern for Michelle	1	2	3	4
47. I would encourage Michelle to seek advice from a website or online support forum	1	2	3	4
48. I would encourage Michelle to seek help from a crisis hotline	1	2	3	4
49. I would seek help from a website or online support forum	1	2	3	4
50. I would ignore the subject unless Michelle brought it up first	1	2	3	4

51. I would tell Michelle that I am concerned about her	1	2	3	4
52. I would encourage Michelle to talk to her family	1	2	3	4
53. I would ask Michelle if anything is wrong	1	2	3	4
54. I would ring a professional for help and advice about the situation	1	2	3	4
55. I would contact Michelle's family about my concern	1	2	3	4
56. I would listen to Michelle's problems in an understanding way	1	2	3	4
57. I would talk to Michelle firmly about getting her act together	1	2	3	4
58. I would ask Michelle whether she is feeling suicidal	1	2	3	4
59. I would suggest Michelle has a few drinks to forget about her troubles	1	2	3	4
60. I would encourage Michelle to become more physically active	1	2	3	4
61. I would wait to see if Michelle's symptoms continued before saying or doing anything	1	2	3	4

Is there anything else you might do or say, that isn't included in this list? If so, please explain what else you would do:

....
....
....

****

Original Subjective Norms questions

62. Other young people like me would involve a professional (e.g. GP, psychologist) in Michelle's situation

Strongly Agree 1 2 3 4 5 Strongly Disagree

63. Other young people like me would involve another person who isn't a professional (e.g. friend, family member, teacher) in Michelle's situation

Strongly Agree 1 2 3 4 5 Strongly Disagree

64. Other young people like me would talk with Michelle one-on-one about her situation

Strongly Agree 1 2 3 4 5 Strongly Disagree

65. Other young people like me would not get involved in Michelle's situation

Strongly Agree	1	2	3	4	5	Strongly Disagree

****

Beliefs about Appropriate Help – as used by Jorm, Wright, & Morgan (2007); Jorm & Wright (2008); Cotton et al. (2006); Wright et al. (2005); Wright, Jorm, Harris, & McGorry (2007)

Please tick whether you think each person or treatment would be 'helpful', 'harmful' or 'make no difference' to Michelle.

66. Listen to Michelle's problems in an understanding way.

Helpful ☐

Harmful ☐

Make no difference ☐

67. Talk to Michelle firmly about getting her act together.

Helpful ☐

Harmful ☐

Make no difference ☐

68. Suggest Michelle seek professional help.

Helpful ☐

Harmful ☐

Make no difference ☐

69. Make an appointment for Michelle to see a general practitioner (GP).

Helpful ☐

Harmful ☐

Make no difference ☐

70. Ask Michelle whether she is feeling suicidal.

Helpful ☐

Harmful ☐

Make no difference ☐

71. Suggest Michelle has a few drinks to forget her troubles.

Helpful ☐

Harmful ☐

Make no difference ☐

72. Rally friends to cheer Michelle up.

Helpful ☐

Harmful ☐

Make no difference ☐

73. Ignore Michelle until she gets over it.

Helpful ☐

Harmful ☐

Make no difference ☐

74. Keep Michelle busy to keep her mind off problems.

Helpful ☐

Harmful ☐

Make no difference ☐

75. Encourage Michelle to become more physically active.

Helpful ☐

Harmful ☐

Make no difference ☐

****

Attitudes subscale of the Willingness to Intervene Against Suicide Questionnaire (Aldrich, Harrington, & Cerel, 2014) – amended

Please circle the number that best describes your personal opinion.

76. Helping Michelle would be…

Not regrettable 1 2 3 4 5 6 7 Regrettable

77. Helping Michelle would be…

Beneficial 1 2 3 4 5 6 7 Harmful

78. Helping Michelle would be…

Negative 1 2 3 4 5 6 7 Positive

79. Helping Michelle would be…

Bad 1 2 3 4 5 6 7 Good

80. Helping Michelle would be…

Worthless 1 2 3 4 5 6 7 Valuable

81. Helping Michelle would be…

Useful 1 2 3 4 5 6 7 Useless

82. Helping Michelle would be…

Possible 1 2 3 4 5 6 7 Impossible

83. Helping Michelle would be…

Unpleasant 1 2 3 4 5 6 7 Pleasant

84. Helping Michelle would be…

Not upsetting 1 2 3 4 5 6 7 Upsetting

85. Helping Michelle would be…

Not scary 1 2 3 4 5 6 7 Scary

86. Helping Michelle would be…

Stressful 1 2 3 4 5 6 7 Not stressful

****

Reisenzein (1986) Indicator Questions for Perceived Controllability

87. How controllable, do you think, is the cause of Michelle’s present condition?

Not at all under personal control 1 2 3 4 5 6 7 8 9
Completely under personal control

88. How responsible, do you think, is Michelle for her present condition?

Not at all responsible 1 2 3 4 5 6 7 8 9
Very much responsible

89. I would think that it is Michelle’s own fault that she is in the present situation

No, not at all 1 2 3 4 5 6 7 8 9 Yes, absolutely so

90. How much sympathy would you feel for Michelle?

None at all 1 2 3 4 5 6 7 8 9 Very much

91. I would feel pity for Michelle

None at all 1 2 3 4 5 6 7 8 9 Very much

92. How much concern would you feel for Michelle?

None at all 1 2 3 4 5 6 7 8 9 Very much

93. How angry would you feel at Michelle?

Not at all 1 2 3 4 5 6 7 8 9 Very much

94. How irritated would you feel by Michelle?

Not at all 1 2 3 4 5 6 7 8 9 Very much

95. I would feel aggravated by Michelle

Not at all 1 2 3 4 5 6 7 8 9 Very much so

****

Perceived Behavioural Control subscale of the Willingness to Intervene Against Suicide Questionnaire (Aldrich, Harrington, & Cerel, 2014) – amended

96. I am confident in my ability to discuss Michelle's situation with her

1 2 3 4 5

Strongly disagree Strongly agree

97. I have the interpersonal skills necessary to have a serious discussion with Michelle about her situation

1 2 3 4 5

Strongly disagree Strongly agree

98. I am confident I can express my concern with Michelle as a friend

1 2 3 4 5

Strongly disagree Strongly agree

99. I am confident I could call a crisis hotline for help and advice

1 2 3 4 5

Strongly disagree Strongly agree

100. I am resourceful I would be able to locate someone for Michelle to talk to

1 2 3 4 5

Strongly disagree Strongly agree

101. I am sure I could help Michelle in some way

1 2 3 4 5

Strongly disagree Strongly agree

102. I am confident I could be helpful in a situation like Michelle's

1 2 3 4 5

Strongly disagree Strongly agree

103. I am NOT confident I could talk to a class rep or prefect about my concerns

1 2 3 4 5

Strongly disagree Strongly agree

104. It would be difficult for me to discuss my concern for Michelle

1 2 3 4 5

Strongly disagree Strongly agree

105. I am sure I would be able to discuss my concern with a professional

1 2 3 4 5

Strongly disagree Strongly agree

****

Yap, Wright, & Jorm (2011) – questionnaire measuring previous experience in providing mental health support

106. In the past year, has anyone in your family or close circle of friends had a problem similar to Michelle's?

No ☐
Don't Know ☐
Yes ☐

107. Did just one person have the problem, or more than one?

Just one ☐

More than one ☐ Because you know more than one person who had a problem similar to Michelle's, for the next few questions, I want you to think about the person you know best.

108. How old was that person at the time?

0 to 9 years ☐

10 to 19 years ☐

20 to 29 years ☐

30 to 39 years ☐

40 to 49 years ☐

50 to 59 years ☐

60 years or over ☐

Don’t Know ☐

109. What was this person’s gender?

Male ☐

Female ☐

Other ☐

110. Was this person a family member or a friend?

Family member ☐

Friend ☐

111. In the past year, did you do anything to help this person?

Yes ☐

No ☐

112. What did you do?

……

……

……

****

You are now going to read about a teenager called Nicola. You will be asked to answer some questions about what you think and feel about Nicola. Please take your time to read these questions carefully and to respond as truthfully as possible. We are only interested in your opinion. There are no right or wrong answers.

Nicola is in the same year as you. She likes socialising with her friends and spends a lot of her spare time hanging around with them and chatting to them online. Nicola tends to get along well with most of her classmates at school and there are one or two people in particular that she gets on really well with. However, there are still a couple of people in Nicola's year that she doesn't especially like or click well with. Overall, Nicola usually gets on well in school. Sometimes she gets into trouble with her teachers for talking in class but, in general, Nicola's teachers don't have any real problems with her. Out of all of the teachers in the school, Nicola said that she likes her English teacher the best, but that she would like her even more if she didn't give the class quite as much homework. Nicola also has several hobbies. She likes sport and is a member of the school's basketball team. Nicola is also trying to learn to play the guitar and has been taking guitar lessons for the past few months. Nicola really enjoys playing basketball for the school, but she wishes that the team were slightly better than they are now. Nicola also used to really enjoy learning to play the guitar as well, but she has recently started to think that the lessons take up too much of her free time and so she has decided to give them up.

Friend in Need Questionnaire (Burns & Rapee, 2006)

1. How worried are you about Nicola's overall wellbeing?
    - I would not be at all worried about her wellbeing ☐
    - I would be a little bit worried about her wellbeing ☐
    - I would be quite worried about her wellbeing ☐
    - I would be extremely worried about her wellbeing ☐

2. In five words or less, what do you think is the matter with Nicola?

    ……

3. Please quote all the words/phrases from Nicola's story that suggest to you that she might be experiencing difficulties

    ……
    ……
    ……

4. How long do you think it will take for Nicola to feel better again?

    One or two days ☐

One or two weeks ☐

One or two months ☐

Longer than a few months ☐

5. Do you think Nicola needs help from another person to cope with her problems?

No ☐

Don’t Know ☐

Yes ☐

****

Intentions to Provide Mental Health Support Scale (original)

Below is a list of possible responses to Nicola’s situation. Please **circle the number** that corresponds with how likely it is that you would do each of these, using the scale detailed below:

1	Extremely unlikely
2	Unlikely
4	Likely
5	Extremely likely

Note: When we refer to ‘professional’ help, we mean a general practitioner (GP), psychiatrist, psychologist, or similar other.

6. I would suggest Nicola seek professional help	1	2	3	4
7. I would make an appointment for her to see a professional	1	2	3	4
8. I would talk to Nicola about her feelings	1	2	3	4
9. I would wait to gather more information before saying or doing anything	1	2	3	4
10. I would encourage Nicola to go to a teacher or another member of school staff (e.g. school counsellor)	1	2	3	4
11. I would tell Nicola that her new pattern of behaviour is unacceptable	1	2	3	4
12. I would talk Nicola out of her negative feelings	1	2	3	4
13. I would try to distract Nicola from her problems	1	2	3	4

14. I would encourage Nicola to look on the bright side of things	1	2	3	4
15. I would ask a friend for advice about what to do	1	2	3	4
16. I would offer to accompany Nicola to an appointment with a mental health professional	1	2	3	4
17. I would tell one of my family members about the situation	1	2	3	4
18. I would not say or do anything	1	2	3	4
19. I would tell a teacher or another member of school staff (e.g. school counsellor) about Nicola's situation	1	2	3	4
20. I would give Nicola information on how to make an appointment to see a mental health professional	1	2	3	4
21. I would call a crisis hotline (e.g. Samaritans, Childline) for help and advice	1	2	3	4
22. I would tell Nicola to stop being so dramatic	1	2	3	4
23. I would give Nicola space	1	2	3	4
24. I would tell one of Nicola's family members about the situation	1	2	3	4
25. I would express my concern about Nicola to others	1	2	3	4
26. I would talk to a mutual friend about my concern for Nicola	1	2	3	4
27. I would encourage Nicola to seek advice from a website or online support forum	1	2	3	4
28. I would encourage Nicola to seek help from a crisis hotline	1	2	3	4
29. I would seek help from a website or online support forum	1	2	3	4
30. I would ignore the subject unless Nicola brought it up first	1	2	3	4
31. I would tell Nicola that I am concerned about her	1	2	3	4
32. I would encourage Nicola to talk to her family	1	2	3	4
33. I would ask Nicola if anything is wrong	1	2	3	4
34. I would ring a professional for help and advice about the situation	1	2	3	4
35. I would contact Nicola's family about my concern	1	2	3	4
36. I would listen to Nicola's problems in an understanding way	1	2	3	4
37. I would talk to Nicola firmly about getting her act together	1	2	3	4
38. I would ask Nicola whether she is feeling suicidal	1	2	3	4

39. I would suggest Nicola has a few drinks to forget about her troubles	1	2	3	4
40. I would encourage Nicola to become more physically active	1	2	3	4
41. I would wait to see if Nicola's symptoms continued before saying or doing anything	1	2	3	4

Is there anything else you might do or say, that isn't included in this list? If so, please explain what else you would do:

……

……

……

****

Original Subjective Norms questions

42. Other young people like me would involve a professional (e.g. GP, psychologist) in Nicola's situation

Strongly Agree 1 2 3 4 5 Strongly Disagree

43. Other young people like me would involve another person who isn't a professional (e.g. friend, family member, teacher) in Nicola's situation

Strongly Agree 1 2 3 4 5 Strongly Disagree

44. Other young people like me would talk with Nicola one-on-one about her situation

Strongly Agree 1 2 3 4 5 Strongly Disagree

45. Other young people like me would not get involved in Nicola's situation

Strongly Agree 1 2 3 4 5 Strongly Disagree

****

Beliefs about Appropriate Help – as used by Jorm, Wright, & Morgan (2007); Jorm & Wright (2008); Cotton et al. (2006); Wright et al. (2005); Wright, Jorm, Harris, & McGorry (2007)

Please tick whether you think each person or treatment would be 'helpful', 'harmful' or 'make no difference' to Nicola.

46. Listen to Nicola's problems in an understanding way.

Helpful ☐

Harmful ☐

Make no difference ☐

47. Talk to Nicola firmly about getting her act together.

Helpful ☐

Harmful ☐

Make no difference ☐

48. Suggest Nicola seek professional help.

Helpful ☐

Harmful ☐

Make no difference ☐

49. Make an appointment for Nicola to see a general practitioner (GP).

Helpful ☐

Harmful ☐

Make no difference ☐

50. Ask Nicola whether she is feeling suicidal.

Helpful ☐

Harmful ☐

Make no difference ☐

51. Suggest Nicola has a few drinks to forget her troubles.

Helpful ☐

Harmful ☐

Make no difference ☐

52. Rally friends to cheer Nicola up.

Helpful ☐

Harmful ☐

Make no difference ☐

53. Ignore Nicola until she gets over it.

Helpful ☐

Harmful ☐

Make no difference ☐

54. Keep Nicola busy to keep her mind off problems.

Helpful ☐

Harmful ☐

Make no difference ☐

55. Encourage Nicola to become more physically active.

Helpful ☐

Harmful ☐

Make no difference ☐

****

Attitudes subscale of the Willingness to Intervene Against Suicide Questionnaire (Aldrich, Harrington, & Cerel, 2014) – amended

Please circle the number that best describes your personal opinion.

56. Helping Nicola would be…

Not regrettable 1 2 3 4 5 6 7 Regrettable

57. Helping Nicola would be…

Beneficial 1 2 3 4 5 6 7 Harmful

58. Helping Nicola would be…

Negative 1 2 3 4 5 6 7 Positive

59. Helping Nicola would be…

Bad 1 2 3 4 5 6 7 Good

60. Helping Nicola would be…

Worthless 1 2 3 4 5 6 7 Valuable

61. Helping Nicola would be…

Useful 1 2 3 4 5 6 7 Useless

62. Helping Nicola would be…

Possible 1 2 3 4 5 6 7 Impossible

63. Helping Nicola would be…

Unpleasant 1 2 3 4 5 6 7 Pleasant

64. Helping Nicola would be…

Not upsetting 1 2 3 4 5 6 7 Upsetting

65. Helping Nicola would be…

Not scary 1 2 3 4 5 6 7 Scary

66. Helping Nicola would be…

Stressful 1 2 3 4 5 6 7 Not stressful

****

Reisenzein (1986) Indicator Questions for Perceived Controllability

67. How controllable, do you think, is the cause of Nicola's present condition?

Not at all under personal control 1 2 3 4 5 6 7 8 9
Completely under personal control

68. How responsible, do you think, is Nicola for her present condition?

Not at all responsible 1 2 3 4 5 6 7 8 9 Very much responsible

69. I would think that it is Nicola's own fault that she is in the present situation

No, not at all 1 2 3 4 5 6 7 8 9 Yes, absolutely so

70. How much sympathy would you feel for Nicola?

None at all 1 2 3 4 5 6 7 8 9 Very much

71. I would feel pity for Nicola

None at all 1 2 3 4 5 6 7 8 9 Very much

72. How much concern would you feel for Nicola?

None at all 1 2 3 4 5 6 7 8 9 Very much

73. How angry would you feel at Nicola?

Not at all 1 2 3 4 5 6 7 8 9 Very much

74. How irritated would you feel by Nicola?

Not at all 1 2 3 4 5 6 7 8 9 Very much

75. I would feel aggravated by Nicola

Not at all 1 2 3 4 5 6 7 8 9 Very much so

****

Perceived Behavioural Control subscale of the Willingness to Intervene Against Suicide Questionnaire (Aldrich, Harrington, & Cerel, 2014) – amended

76. I am confident in my ability to discuss Nicola's situation with her

1	2	3	4	5
Strongly disagree				Strongly agree

77. I have the interpersonal skills necessary to have a serious discussion with Nicola about her situation

1	2	3	4	5
Strongly disagree				Strongly agree

78. I am confident I can express my concern with Nicola as a friend

1	2	3	4	5
Strongly disagree				Strongly agree

79. I am confident I could call a crisis hotline for help and advice

1	2	3	4	5
Strongly disagree				Strongly agree

80. I am resourceful I would be able to locate someone for Nicola to talk to

1	2	3	4	5
Strongly disagree				Strongly agree

81. I am sure I could help Nicola in some way

1	2	3	4	5
Strongly disagree				Strongly agree

82. I am confident I could be helpful in a situation like Nicola's

1	2	3	4	5
Strongly disagree				Strongly agree

83. I am NOT confident I could talk to a class rep or prefect about my concerns

1	2	3	4	5
Strongly disagree				Strongly agree

84. It would be difficult for me to discuss my concern for Nicola

1 2 3 4 5

Strongly disagree Strongly agree

85. I am sure I would be able to discuss my concern with a professional

1 2 3 4 5

Strongly disagree Strongly agree

****

Yap, Wright, & Jorm (2011) – questionnaire measuring previous experience in providing mental health support

86. In the past year, has anyone in your family or close circle of friends had a problem similar to Nicola's?

No ☐
Don't Know ☐
Yes ☐

87. Did just one person have the problem, or more than one?

Just one ☐

More than one ☐ Because you know more than one person who had a problem similar to Nicola's, for the next few questions, I want you to think about the person you know best.

88. How old was that person at the time?

0 to 9 years ☐
10 to 19 years ☐
20 to 29 years ☐
30 to 39 years ☐
40 to 49 years ☐
50 to 59 years ☐
60 years or over ☐
Don't Know ☐

89. What was this person's gender?

Male ☐

Female ☐

Other ☐

90. Was this person a family member or a friend?

Family member ☐

Friend ☐

91. In the past year, did you do anything to help this person?

Yes ☐

No ☐

92. What did you do?

……
……
……

****

Revised Level of Contact Report (Tsang et al., 2003)

Please tick all items that apply to you: ☑

1. I have had a mental illness.	
2. I have lived with someone with a mental illness.	
3. I have frequent contact with a friend or relative who has a mental illness.	
4. It is my main duty to provide service to people with mental illness.	
5. I often encounter people with mental illness (at least twice a month).	
6. I encounter people with mental illness occasionally.	
7. I have observed, in passing, someone who might have a mental illness.	
8. I have seen realistic portrayals of people with mental illness in newspapers, magazines, films, or TV programmes.	
9. None of the above is true.	

Thank you very much for your participation in this study!

Appendix K Pilot study questionnaire for caregiver participants

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

IRISH RESEARCH COUNCIL
An Chomhairle um Thaighde in Éirinn

Trinity College Dublin
children's research centre
research for children & young people

Caregiver's Questionnaire Booklet

Participant Name: ……………………………………………………………………………………………….

Participant Date of Birth: ………………………………………………………………………………………

Participant Gender: Male ☐

Female ☐

Other ☐

Please answer the following questions as honestly as possible.

Thank you for your help with this study!

Code: ……………………………………………………

(for researcher's purposes only)

Code: ……………………………………………………

(for researcher's purposes only)

Basic Empathy Scale (Jolliffe & Farrington, 2006)

Please **circle the number** that corresponds with how you feel about each statement, using the scale detailed below:

1	Strongly Disagree
2	Disagree
3	Neither Agree nor Disagree
4	Agree
5	Strongly Agree

1. My friend's emotions don't affect me much	1	2	3	4	5
2. After being with a friend who is sad about something, I usually feel sad	1	2	3	4	5
3. I can understand my friend's happiness when she/he does well at something	1	2	3	4	5
4. I get frightened when I watch characters in a good scary movie	1	2	3	4	5
5. I get caught up in other people's feelings easily	1	2	3	4	5
6. I find it hard to know when my friends are frightened	1	2	3	4	5
7. I don't become sad when I see other people crying	1	2	3	4	5
8. Other people's feelings don't bother me at all	1	2	3	4	5
9. When someone is feeling 'down' I can usually understand how they feel	1	2	3	4	5
10. I can usually work out when my friends are scared	1	2	3	4	5
11. I often become sad when watching sad things on TV or in films	1	2	3	4	5
12. I can often understand how people are feeling even before they tell me	1	2	3	4	5
13. Seeing a person who has been angered has no effect on my feelings	1	2	3	4	5
14. I can usually work out when people are cheerful	1	2	3	4	5
15. I tend to feel scared when I am with friends who are afraid	1	2	3	4	5

16. I can usually realise quickly when a friend is angry	1	2	3	4	5
17. I often get swept up in my friends' feelings	1	2	3	4	5
18. My friend's unhappiness doesn't make me feel anything	1	2	3	4	5
19. I am not usually aware of my friends' feelings	1	2	3	4	5
20. I have trouble figuring out when my friends are happy	1	2	3	4	5

****

You are now going to read about a teenager called Michelle. Michelle is the same age as your son/daughter. You will be asked to answer some questions about what you think and feel about Michelle. Please take your time to read these questions carefully and to respond as truthfully as possible. We are only interested in your opinion. There are no right or wrong answers.

Michelle

Michelle is your daughter. She used to enjoy lots of hobbies, such as hanging out with friends and playing football for her local team. Although Michelle sometimes complained about how much time the team had to spend training, she was usually quite good at turning up for practice. A few months ago, Michelle started missing a lot of training sessions and has since stopped coming altogether. Over this time you have noticed a change in her, in that she doesn't seem to be interested in doing things with her friends any more - she no longer makes an effort to hang out with them or talk to them online. You have also noticed that she seems more irritable lately and doesn't smile, or laugh, or appear to find as much enjoyment in things as she used to. Michelle has also started to experience some problems at school. Over the past six weeks or so, Michelle has been constantly late for school and has started to fall behind on her school work. When the head teacher asked Michelle about this, she said that she has been finding it extremely difficult to get to sleep at night and feels tired all the time. Michelle explained that although she would like to do better in school, she just couldn't concentrate on things or think as well as she used to. Michelle said that she just feels 'down' all the time now and doesn't think that she is good at anything anymore.

Friend in Need Questionnaire (Burns & Rapee, 2006)

21. How worried are you about Michelle's overall wellbeing?
    - I would not be at all worried about her wellbeing ☐
    - I would be a little bit worried about her wellbeing ☐
    - I would be quite worried about her wellbeing ☐
    - I would be extremely worried about her wellbeing ☐

22. In five words or less, what do you think is the matter with Michelle?

....

Please quote all the words/phrases from Michelle's story that suggest to you that she might be experiencing difficulties

....
....
....

23. How long do you think it will take for Michelle to feel better again?

One or two days ☐
One or two weeks ☐
One or two months ☐
Longer than a few months ☐

24. Do you think Michelle needs help from another person to cope with her problems?

No ☐
Don't Know ☐
Yes ☐

****

Intentions to Provide Mental Health Support Scale (original)

Below is a list of possible responses to Michelle's situation. Please **circle the number** that corresponds with how likely it is that you would do each of these, using the scale detailed below:

1	Extremely unlikely
2	Unlikely
4	Likely
5	Extremely likely

25. I would suggest Michelle seek professional help	1	2	3	4
26. I would make an appointment for her to see a professional	1	2	3	4
27. I would talk to Michelle about her feelings	1	2	3	4

28. I would wait to gather more information before saying or doing anything	1	2	3	4
29. I would encourage Michelle to go to a teacher or another member of school staff (e.g. school counsellor)	1	2	3	4
30. I would tell Michelle that her new pattern of behaviour is unacceptable	1	2	3	4
31. I would talk Michelle out of her negative feelings	1	2	3	4
32. I would try to distract Michelle from her problems	1	2	3	4
33. I would encourage Michelle to look on the bright side of things	1	2	3	4
34. I would ask a friend for advice about what to do	1	2	3	4
35. I would offer to accompany Michelle to an appointment with a mental health professional	1	2	3	4
36. I would tell one of my family members about the situation	1	2	3	4
37. I would not say or do anything	1	2	3	4
38. I would tell a teacher or another member of school staff (e.g. school counsellor) about Michelle's situation	1	2	3	4
39. I would give Michelle information on how to make an appointment to see a mental health professional	1	2	3	4
40. I would call a crisis hotline (e.g. Samaritans, Childline) for help and advice	1	2	3	4
41. I would tell Michelle to stop being so dramatic	1	2	3	4
42. I would give Michelle space	1	2	3	4
43. I would tell Michelle's other parent or key caregiver about the situation	1	2	3	4
44. I would express my concern about Michelle to others	1	2	3	4
45. I would talk to one of Michelle's friends about my concern for Michelle	1	2	3	4
46. I would encourage Michelle to seek advice from a website or online support forum	1	2	3	4
47. I would encourage Michelle to seek help from a crisis hotline	1	2	3	4
48. I would seek help from a website or online support forum	1	2	3	4
49. I would ignore the subject unless Michelle brought it up first	1	2	3	4
50. I would tell Michelle that I am concerned about her	1	2	3	4
51. I would encourage Michelle to talk to her family	1	2	3	4
52. I would ask Michelle if anything is wrong	1	2	3	4

53. I would ring a professional for help and advice about the situation	1	2	3	4
54. I would contact Michelle's extended family about my concern	1	2	3	4
55. I would listen to Michelle's problems in an understanding way	1	2	3	4
56. I would talk to Michelle firmly about getting her act together	1	2	3	4
57. I would ask Michelle whether she is feeling suicidal	1	2	3	4
58. I would suggest Michelle has a few drinks to forget about her troubles	1	2	3	4
59. I would encourage Michelle to become more physically active	1	2	3	4
60. I would wait to see if Michelle's symptoms continued before saying or doing anything	1	2	3	4

Is there anything else you might do or say, that isn't included in this list? If so, please explain what else you would do:

……
……
……

****

Original Subjective Norms questions

61. Other parents like me would involve a professional (e.g. GP, psychologist) in Michelle's situation

Strongly Agree 1 2 3 4 5 Strongly Disagree

62. Other parents like me would involve another person who isn't a professional (e.g. friend, family member, teacher) in Michelle's situation

Strongly Agree 1 2 3 4 5 Strongly Disagree

63. Other parents like me would talk with Michelle one-on-one about her situation

Strongly Agree 1 2 3 4 5 Strongly Disagree

64. Other parents like me would not get involved in Michelle's situation

Strongly Agree 1 2 3 4 5 Strongly Disagree

****

Beliefs about Appropriate Help – as used by Jorm, Wright, & Morgan (2007); Jorm & Wright (2008); Cotton et al. (2006); Wright et al. (2005); Wright, Jorm, Harris, & McGorry (2007)

Please tick whether you think each person or treatment would be 'helpful', 'harmful' or 'make no difference' to Michelle.

65. Listen to Michelle's problems in an understanding way.

Helpful ☐
Harmful ☐
Make no difference ☐

66. Talk to Michelle firmly about getting her act together.

Helpful ☐
Harmful ☐
Make no difference ☐

67. Suggest Michelle seek professional help.

Helpful ☐
Harmful ☐
Make no difference ☐

68. Make an appointment for Michelle to see a general practitioner (GP).

Helpful ☐
Harmful ☐
Make no difference ☐

69. Ask Michelle whether she is feeling suicidal.

Helpful ☐
Harmful ☐
Make no difference ☐

70. Suggest Michelle has a few drinks to forget her troubles.

Helpful ☐

Harmful ☐

Make no difference ☐

71. Rally friends to cheer Michelle up.

Helpful ☐

Harmful ☐

Make no difference ☐

72. Ignore Michelle until she gets over it.

Helpful ☐

Harmful ☐

Make no difference ☐

73. Keep Michelle busy to keep her mind off problems.

Helpful ☐

Harmful ☐

Make no difference ☐

74. Encourage Michelle to become more physically active.

Helpful ☐

Harmful ☐

Make no difference ☐

****

Attitudes subscale of the Willingness to Intervene Against Suicide Questionnaire (Aldrich, Harrington, & Cerel, 2014) – amended

Please circle the number that best describes your personal opinion.

75. Helping Michelle would be…

Not regrettable 1 2 3 4 5 6 7 Regrettable

76. Helping Michelle would be…

Beneficial 1 2 3 4 5 6 7 Harmful

77. Helping Michelle would be…

Negative 1 2 3 4 5 6 7 Positive

78. Helping Michelle would be…

Bad 1 2 3 4 5 6 7 Good

79. Helping Michelle would be…

Worthless 1 2 3 4 5 6 7 Valuable

80. Helping Michelle would be…

Useful 1 2 3 4 5 6 7 Useless

81. Helping Michelle would be…

Possible 1 2 3 4 5 6 7 Impossible

82. Helping Michelle would be…

Unpleasant 1 2 3 4 5 6 7 Pleasant

83. Helping Michelle would be…

Not upsetting 1 2 3 4 5 6 7 Upsetting

84. Helping Michelle would be…

Not scary 1 2 3 4 5 6 7 Scary

85. Helping Michelle would be…

Stressful 1 2 3 4 5 6 7 Not stressful

****

Reisenzein (1986) Indicator Questions for Perceived Controllability

86. How controllable, do you think, is the cause of Michelle's present condition?

Not at all under personal control 1 2 3 4 5 6 7 8 9 Completely under personal control

87. How responsible, do you think, is Michelle for her present condition?

Not at all responsible 1 2 3 4 5 6 7 8 9 Very much responsible

88. I would think that it is Michelle's own fault that she is in the present situation

No, not at all 1 2 3 4 5 6 7 8 9 Yes, absolutely so

89. How much sympathy would you feel for Michelle?

None at all 1 2 3 4 5 6 7 8 9 Very much

90. I would feel pity for Michelle

None at all 1 2 3 4 5 6 7 8 9 Very much

91. How much concern would you feel for Michelle?

None at all 1 2 3 4 5 6 7 8 9 Very much

92. How angry would you feel at Michelle?

Not at all 1 2 3 4 5 6 7 8 9 Very much

93. How irritated would you feel by Michelle?

Not at all 1 2 3 4 5 6 7 8 9 Very much

94. I would feel aggravated by Michelle

Not at all 1 2 3 4 5 6 7 8 9 Very much so

****

Perceived Behavioural Control subscale of the Willingness to Intervene Against Suicide Questionnaire (Aldrich, Harrington, & Cerel, 2014) – amended

95. I am confident in my ability to discuss Michelle's situation with her

1 2 3 4 5

Strongly disagree Strongly agree

96. I have the interpersonal skills necessary to have a serious discussion with Michelle about her situation

1 2 3 4 5

Strongly disagree Strongly agree

97. I am confident I can express my concern with Michelle as a parent

1 2 3 4 5

Strongly disagree Strongly agree

98. I am confident I could call a crisis hotline for help and advice

1 2 3 4 5

Strongly disagree Strongly agree

99. I am resourceful I would be able to locate someone for Michelle to talk to

1 2 3 4 5

Strongly disagree Strongly agree

100. I am sure I could help Michelle in some way

1 2 3 4 5

Strongly disagree Strongly agree

101. I am confident I could be helpful in a situation like Michelle's

1 2 3 4 5

Strongly disagree Strongly agree

102. I am NOT confident I could talk to a teacher about my concerns

1 2 3 4 5

Strongly disagree Strongly agree

103. It would be difficult for me to discuss my concern for Michelle

1 2 3 4 5

Strongly disagree Strongly agree

104. I am sure I would be able to discuss my concern with a professional

1 2 3 4 5

Strongly disagree Strongly agree

****

Yap, Wright, & Jorm (2011) – questionnaire measuring previous experience in providing mental health support

105. In the past year, has anyone in your family or close circle of friends had a problem similar to Michelle's?

No ☐
Don't Know ☐
Yes ☐

106. Did just one person have the problem, or more than one?

Just one ☐
More than one ☐ Because you know more than one person who had a problem similar to Michelle's, for the next few questions, I want you to think about the person you know best.

107. How old was that person at the time?

0 to 9 years ☐

10 to 19 years ☐

20 to 29 years ☐

30 to 39 years ☐

40 to 49 years ☐

50 to 59 years ☐

60 years or over ☐

Don't Know ☐

108. What was this person's gender?

Male ☐

Female ☐

Other ☐

109. Was this person a family member or a friend?

Family member ☐

Friend ☐

110. In the past year, have you done anything to help this person?

Yes ☐

No ☐

111. What did you do?

………

………

………

****

You are now going to read about a teenager called Nicola. Nicola is the same age as your son/daughter. You will be asked to answer some questions about what you think and feel about Nicola. Please take your time to read these questions carefully and to respond as truthfully as possible. We are only interested in your opinion. There are no right or wrong answers.

Nicola is your daughter. She likes socialising with her friends and spends a lot of her spare time hanging around with them and chatting to them online. Nicola tends to get along well with most of her classmates at school and there are one or two people in particular that she gets on really well with. However, there are still a couple of people in Nicola's year that she doesn't especially like or click well with. Overall, Nicola usually gets on well in school. Sometimes she gets into trouble with her teachers for talking in class but, in general, Nicola's teachers don't have any real problems with her. Out of all of the teachers in the school, Nicola said that she likes her English teacher the best, but that she would like her even more if she didn't give the class quite as much homework. Nicola also has several hobbies. She likes sport and is a member of the school's basketball team. Nicola is also trying to learn to play the guitar and has been taking guitar lessons for the past few months. Nicola really enjoys playing basketball for the school, but she wishes that the team were slightly better than they are now. Nicola also used to really enjoy learning to play the guitar as well, but she has recently started to think that the lessons take up too much of her free time and so she has decided to give them up.

Friend in Need Questionnaire (Burns & Rapee, 2006)

1. How worried are you about Nicola's overall wellbeing?

   I would not be at all worried about her wellbeing ☐
   I would be a little bit worried about her wellbeing ☐
   I would be quite worried about her wellbeing ☐
   I would be extremely worried about her wellbeing ☐

2. In five words or less, what do you think is the matter with Nicola?

   ……

   Please quote all the words/phrases from Nicola's story that suggest to you that she might be experiencing difficulties

   ……
   ……
   ……

3. How long do you think it will take for Nicola to feel better again?

   One or two days ☐

One or two weeks ☐

One or two months ☐

Longer than a few months ☐

4. Do you think Nicola needs help from another person to cope with her problems?

No ☐

Don't Know ☐

Yes ☐

****

Intentions to Provide Mental Health Support Scale (original)

Below is a list of possible responses to Nicola's situation. Please **circle the number** that corresponds with how likely it is that you would do each of these, using the scale detailed below:

1	Extremely unlikely
2	Unlikely
4	Likely
5	Extremely likely

5. I would suggest Nicola seek professional help	1	2	3	4
6. I would make an appointment for her to see a professional	1	2	3	4
7. I would talk to Nicola about her feelings	1	2	3	4
8. I would wait to gather more information before saying or doing anything	1	2	3	4
9. I would encourage Nicola to go to a teacher or another member of school staff (e.g. school counsellor)	1	2	3	4
10. I would tell Nicola that her new pattern of behaviour is unacceptable	1	2	3	4
11. I would talk Nicola out of her negative feelings	1	2	3	4
12. I would try to distract Nicola from her problems	1	2	3	4
13. I would encourage Nicola to look on the bright side of things	1	2	3	4
14. I would ask a friend for advice about what to do	1	2	3	4
15. I would offer to accompany Nicola to an appointment with a mental health professional	1	2	3	4

16. I would tell one of my family members about the situation	1	2	3	4
17. I would not say or do anything	1	2	3	4
18. I would tell a teacher or another member of school staff (e.g. school counsellor) about Nicola's situation	1	2	3	4
19. I would give Nicola information on how to make an appointment to see a mental health professional	1	2	3	4
20. I would call a crisis hotline (e.g. Samaritans, Childline) for help and advice	1	2	3	4
21. I would tell Nicola to stop being so dramatic	1	2	3	4
22. I would give Nicola space	1	2	3	4
23. I would tell Nicola's other parent/key caregiver about the situation	1	2	3	4
24. I would express my concern about Nicola to others	1	2	3	4
25. I would talk to one of Nicola's friends about my concern for Nicola	1	2	3	4
26. I would encourage Nicola to seek advice from a website or online support forum	1	2	3	4
27. I would encourage Nicola to seek help from a crisis hotline	1	2	3	4
28. I would seek help from a website or online support forum	1	2	3	4
29. I would ignore the subject unless Nicola brought it up first	1	2	3	4
30. I would tell Nicola that I am concerned about her	1	2	3	4
31. I would encourage Nicola to talk to her family	1	2	3	4
32. I would ask Nicola if anything is wrong	1	2	3	4
33. I would ring a professional for help and advice about the situation	1	2	3	4
34. I would contact Nicola's extended family about my concern	1	2	3	4
35. I would listen to Nicola's problems in an understanding way	1	2	3	4
36. I would talk to Nicola firmly about getting her act together	1	2	3	4
37. I would ask Nicola whether she is feeling suicidal	1	2	3	4
38. I would suggest Nicola has a few drinks to forget about her troubles	1	2	3	4
39. I would encourage Nicola to become more physically active	1	2	3	4
40. I would wait to see if Nicola's symptoms continued before saying or doing anything	1	2	3	4

Is there anything else you might do or say, that isn't included in this list? If so, please explain what else you would do:

....

....

....

****

Original Subjective Norms questions

41. Other parents like me would involve a professional (e.g. GP, psychologist) in Nicola's situation

Strongly Agree 1 2 3 4 5 Strongly Disagree

42. Other parents like me would involve another person who isn't a professional (e.g. friend, family member, teacher) in Nicola's situation

Strongly Agree 1 2 3 4 5 Strongly Disagree

43. Other parents like me would talk with Nicola one-on-one about her situation

Strongly Agree 1 2 3 4 5 Strongly Disagree

44. Other parents like me would not get involved in Nicola's situation

Strongly Agree 1 2 3 4 5 Strongly Disagree

****

Beliefs about Appropriate Help – as used by Jorm, Wright, & Morgan (2007); Jorm & Wright (2008); Cotton et al. (2006); Wright et al. (2005); Wright, Jorm, Harris, & McGorry (2007)

Please tick whether you think each person or treatment would be 'helpful', 'harmful' or 'make no difference' to Nicola.

45. Listen to Nicola's problems in an understanding way.

Helpful ☐

Harmful ☐

Make no difference ☐

46. Talk to Nicola firmly about getting her act together.

Helpful ☐

Harmful ☐

Make no difference ☐

47. Suggest Nicola seek professional help.

Helpful ☐

Harmful ☐

Make no difference ☐

48. Make an appointment for Nicola to see a general practitioner (GP).

Helpful ☐

Harmful ☐

Make no difference ☐

49. Ask Nicola whether she is feeling suicidal.

Helpful ☐

Harmful ☐

Make no difference ☐

50. Suggest Nicola has a few drinks to forget her troubles.

Helpful ☐

Harmful ☐

Make no difference ☐

51. Rally friends to cheer Nicola up.

Helpful ☐

Harmful ☐

Make no difference ☐

52. Ignore Nicola until she gets over it.

Helpful ☐

Harmful ☐

Make no difference ☐

53. Keep Nicola busy to keep her mind off problems.

Helpful ☐

Harmful ☐

Make no difference ☐

54. Encourage Nicola to become more physically active.

Helpful ☐

Harmful ☐

Make no difference ☐

****

Attitudes subscale of the Willingness to Intervene Against Suicide Questionnaire (Aldrich, Harrington, & Cerel, 2014) – amended

Please circle the number that best describes your personal opinion.

55. Helping Nicola would be…

Not regrettable 1 2 3 4 5 6 7 Regrettable

56. Helping Nicola would be…

Beneficial 1 2 3 4 5 6 7 Harmful

57. Helping Nicola would be…

Negative 1 2 3 4 5 6 7 Positive

58. Helping Nicola would be…

Bad 1 2 3 4 5 6 7 Good

59. Helping Nicola would be…

Worthless 1 2 3 4 5 6 7 Valuable

60. Helping Nicola would be…

Useful 1 2 3 4 5 6 7 Useless

61. Helping Nicola would be…

Possible 1 2 3 4 5 6 7 Impossible

62. Helping Nicola would be…

Unpleasant 1 2 3 4 5 6 7 Pleasant

63. Helping Nicola would be…

Not upsetting 1 2 3 4 5 6 7 Upsetting

64. Helping Nicola would be…

Not scary 1 2 3 4 5 6 7 Scary

65. Helping Nicola would be…

Stressful 1 2 3 4 5 6 7 Not stressful

****

Reisenzein (1986) Indicator Questions for Perceived Controllability

66. How controllable, do you think, is the cause of Nicola's present condition?

Not at all under personal control 1 2 3 4 5 6 7 8 9 Completely under personal control

67. How responsible, do you think, is Nicola for her present condition?

Not at all responsible 1 2 3 4 5 6 7 8 9 Very much
responsible

68. I would think that it is Nicola's own fault that she is in the present situation

No, not at all 1 2 3 4 5 6 7 8 9 Yes, absolutely so

69. How much sympathy would you feel for Nicola?

None at all 1 2 3 4 5 6 7 8 9 Very much

70. I would feel pity for Nicola

None at all 1 2 3 4 5 6 7 8 9 Very much

71. How much concern would you feel for Nicola?

None at all 1 2 3 4 5 6 7 8 9 Very much

72. How angry would you feel at Nicola?

Not at all 1 2 3 4 5 6 7 8 9 Very much

73. How irritated would you feel by Nicola?

Not at all 1 2 3 4 5 6 7 8 9 Very much

74. I would feel aggravated by Nicola

Not at all 1 2 3 4 5 6 7 8 9 Very much so

****

Perceived Behavioural Control subscale of the Willingness to Intervene Against Suicide Questionnaire (Aldrich, Harrington, & Cerel, 2014) – amended

75. I am confident in my ability to discuss Nicola's situation with her

1 2 3 4 5

Strongly disagree Strongly agree

76. I have the interpersonal skills necessary to have a serious discussion with Nicola about her situation

1 2 3 4 5

Strongly disagree Strongly agree

77. I am confident I can express my concern with Nicola as a parent

1 2 3 4 5

Strongly disagree Strongly agree

78. I am confident I could call a crisis hotline for help and advice

1 2 3 4 5

Strongly disagree Strongly agree

79. I am resourceful I would be able to locate someone for Nicola to talk to

1 2 3 4 5

Strongly disagree Strongly agree

80. I am sure I could help Nicola in some way

1 2 3 4 5

Strongly disagree Strongly agree

81. I am confident I could be helpful in a situation like Nicola's

1 2 3 4 5

Strongly disagree Strongly agree

82. I am NOT confident I could talk to a teacher about my concerns

1 2 3 4 5

Strongly disagree Strongly agree

83. It would be difficult for me to discuss my concern for Nicola

1 2 3 4 5

Strongly disagree Strongly agree

84. I am sure I would be able to discuss my concern with a professional

1	2	3	4	5
Strongly disagree				Strongly agree

****

Yap, Wright, & Jorm (2011) – questionnaire measuring previous experience in providing mental health support

85. In the past year, has anyone in your family or close circle of friends had a problem similar to Nicola's?

No	☐
Don't Know	☐
Yes	☐

86. Did just one person have the problem, or more than one?

Just one	☐
More than one	☐ Because you know more than one person who had a problem similar to Nicola's, for the next few questions, I want you to think about the person you know best.

87. How old was that person at the time?

0 to 9 years	☐
10 to 19 years	☐
20 to 29 years	☐
30 to 39 years	☐
40 to 49 years	☐
50 to 59 years	☐
60 years or over	☐
Don't Know	☐

88. What was this person's gender?

Male	☐
Female	☐
Other	☐

89. Was this person a family member or a friend?

Family member ☐

Friend ☐

90. In the past year, have you done anything to help this person?

Yes ☐

No ☐

91. What did you do?

………

………

………

****

Revised Level of Contact Report (Tsang et al., 2003)

Please tick all items that apply to you: ☑

92. I have had a mental illness.	
93. I have lived with someone with a mental illness.	
94. I have frequent contact with a friend or relative who has a mental illness.	
95. It is my main duty to provide service to people with mental illness.	
96. I often encounter people with mental illness (at least twice a month).	
97. I encounter people with mental illness occasionally.	
98. I have observed, in passing, someone who might have a mental illness.	
99. I have seen realistic portrayals of people with mental illness in newspapers, magazines, films, or TV programmes.	
100. None of the above is true.	

****

Thank you for your participation in this study!

Appendix L The Modes of Intended Mental Health Support (MIMHS) scale and response options

Below is a list of possible responses to Michelle's situation. Please **circle the number** that corresponds with how likely it is that you would do each of these, using the scale detailed below:

	Extremely unlikely	**Unlikely**	**Likely**	**Extremely likely**
1. I would suggest Michelle seek professional help	1	2	3	4
2. I would make an appointment for Michelle to see a professional	1	2	3	4
3. I would talk to Michelle about her feelings	1	2	3	4
4. I would wait to gather more information before saying or doing anything	1	2	3	4
5. I would encourage Michelle to go to a teacher or another member of school staff (e.g. school counsellor)	1	2	3	4
6. I would tell Michelle that her new pattern of behaviour is unacceptable	1	2	3	4
7. I would talk Michelle out of her negative feelings	1	2	3	4
8. I would try to distract Michelle from her problems	1	2	3	4
9. I would encourage Michelle to look on the bright side of things	1	2	3	4
10. I would ask a friend for advice about what to do	1	2	3	4
11. I would offer to accompany Michelle to an appointment with a mental health professional	1	2	3	4
12. I would tell one of my family members about the situation	1	2	3	4

	Extremely unlikely	**Unlikely**	**Likely**	**Extremely likely**
13. I would not say or do anything	1	2	3	4
14. I would tell a teacher or another member of school staff (e.g. school counsellor) about Michelle's situation	1	2	3	4
15. I would give Michelle information on how to make an appointment to see a mental health professional	1	2	3	4
16. I would call a crisis hotline (e.g. Samaritans, Childline) for help and advice	1	2	3	4
17. I would tell Michelle to stop being so dramatic	1	2	3	4
18. I would give Michelle space	1	2	3	4
19. I would tell Michelle's parent or key caregiver about the situation	1	2	3	4
20. I would express my concern about Michelle to others	1	2	3	4
21. I would talk to one of Michelle's friends about my concern for Michelle	1	2	3	4
22. I would encourage Michelle to seek advice from a website or online support forum	1	2	3	4
23. I would encourage Michelle to seek help from a crisis hotline	1	2	3	4
24. I would seek help from a website or online support forum	1	2	3	4
25. I would ignore the subject unless Michelle brought it up first	1	2	3	4
26. I would tell Michelle that I am concerned about her	1	2	3	4
27. I would encourage Michelle to talk to her family	1	2	3	4
28. I would ask Michelle if anything is wrong	1	2	3	4

	Extremely unlikely	**Unlikely**	**Likely**	**Extremely likely**
29. I would ring a professional for help and advice about the situation	1	2	3	4
30. I would contact Michelle's family about my concern	1	2	3	4
31. I would listen to Michelle's problems in an understanding way	1	2	3	4
32. I would talk to Michelle firmly about getting her act together	1	2	3	4
33. I would ask Michelle whether she is feeling suicidal	1	2	3	4
34. I would suggest Michelle has a few drinks to forget about her troubles	1	2	3	4
35. I would encourage Michelle to become more physically active	1	2	3	4
36. I would wait to see if Michelle's symptoms continued before saying or doing anything	1	2	3	4