Support? What support? An exploratory study of young people’s experiences of living with depression during their student years

A thesis submitted to the University of Manchester for the degree of Doctorate in Educational and Child Psychology in the Faculty of Humanities

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Dorota I Martin

School of Environment, Education and Development (SEED)
Table of Contents

LIST OF FIGURES .............................................................................................................. 5
LIST OF TABLES .................................................................................................................. 6
ABSTRACT ............................................................................................................................. 7
DECLARATION ....................................................................................................................... 8
COPYRIGHT STATEMENT ..................................................................................................... 9
ACKNOWLEDGEMENTS ..................................................................................................... 10
INTRODUCTION .................................................................................................................... 11
  BACKGROUND INFORMATION ........................................................................................... 11
  OVERALL THESIS STRATEGY .......................................................................................... 12
  ONTOLOGY (NATURE OF REALITY), EPISTEMOLOGY (NATURE OF KNOWLEDGE), AND
  AXIOLOGY (VALUES ASSOCIATED WITH RESEARCH AND THEORIES) .................................. 16
  REFERENCES ....................................................................................................................... 17

PAPER 1 .................................................................................................................................. 19

WHAT NARRATIVES DO YOUNG PEOPLE USE TO COMMUNICATE
DEPRESSION? A SYSTEMATIC REVIEW OF THE LITERATURE .................. 19

  ABSTRACT............................................................................................................................ 20
  INTRODUCTION.................................................................................................................... 21
  The role of educators in supporting the mental health of young people......................... 21
  Depression amongst young people ................................................................................. 22
  Communicating depression ............................................................................................... 23
  METHOD............................................................................................................................... 24
  Data sources and search strategy ..................................................................................... 24
  Inclusion and exclusion criteria ....................................................................................... 25
  RESULTS............................................................................................................................... 25
  Quality assessment ........................................................................................................... 31
  Overview of studies included ........................................................................................... 32
  Sample................................................................................................................................. 32
  Data collection and measures .......................................................................................... 33
  FINDINGS............................................................................................................................... 33
  DISCUSSION.......................................................................................................................... 41
  Limitations of the review.................................................................................................. 44
  Conclusion and implications for future research ............................................................. 45
  REFERENCES......................................................................................................................... 47

PAPER 2 .................................................................................................................................. 53

‘IT ALL FELL DOWN TO CHANCE’ – LIVED EXPERIENCES OF
DEPRESSION DURING SCHOOLING .................................................................. 53

  ABSTRACT............................................................................................................................ 54
  INTRODUCTION.................................................................................................................... 55
  Depression.............................................................................................................................. 55
Mental health in schools and help-seeking ................................................................. 56
METHOD .......................................................................................................................... 58
Participants ..................................................................................................................... 58
Ethical considerations and inclusion criteria ............................................................. 58
Data gathering and analysis .......................................................................................... 59
FINDINGS ........................................................................................................................ 61
“The weariness of the world was upon me” ................................................................. 61
“It all fell down to chance” ......................................................................................... 70
DISCUSSION .................................................................................................................. 75
Limitations of the study .................................................................................................. 78
Conclusion and implications for practice ....................................................................... 78
REFERENCES ................................................................................................................. 79

PAPER 3 ......................................................................................................................... 82

THE DISSEMINATION OF EVIDENCE TO PROFESSIONAL PRACTICE 82

INTRODUCTION ........................................................................................................... 83
SECTION A: OVERVIEW OF EVIDENCE-BASED PRACTICE (EBP) AND PRACTICE-BASED
RESEARCH ..................................................................................................................... 83
SECTION B: THE EFFECTIVE DISSEMINATION OF RESEARCH: OUTCOMES AND IMPACT .... 86
SECTION C: THE IMPLICATIONS OF THE CURRENT RESEARCH ..................................... 90
SECTION D: PROMOTING AND EVALUATING THE DISSEMINATION AND IMPACT OF THE
CURRENT RESEARCH ..................................................................................................... 95
CONCLUSIONS ............................................................................................................... 98
REFERENCES ................................................................................................................. 100

LIST OF APPENDICES .................................................................................................. 108

APPENDIX A .................................................................................................................... 108
Appendix A1: Emotional and Behavioural Difficulties author guidelines ...................... 109
Appendix A2: Journal of Youth Studies author guidelines .............................................. 113
APPENDIX B ................................................................................................................... 117
Appendix B1: Methodological quality (qualitative investigation research) .................... 118
Appendix B2: Methodological quality (quantitative investigation research) .................. 119
Appendix B3: Methodological appropriateness ............................................................... 120
Appendix B4: Focus of study – relevance to review questions ....................................... 121
Appendix B5: Overall weight of evidence ratings .......................................................... 122
APPENDIX C ................................................................................................................... 123
Appendix C1: Ethical approval and ethics forms ............................................................. 124
Appendix C2: Invitation to participate in the study poster .............................................. 125
Appendix C3: Request for permission to carry out the research in Higher Education166
Appendix C4: Preliminary questions to establish participants’ eligibility ....................... 170
Appendix C5: Participant information sheet .................................................................. 172
Appendix C6: Participant consent form ......................................................................... 176
Appendix C7: Distress protocol for participant ................................................................ 177
Appendix C8: Distress protocol for the researcher ......................................................... 178
Appendix C9: Interview guide and Participant debrief sheet with sources of support 180
APPENDIX D ................................................................................................................... 183
Appendix D1: Stages of analysis in IPA ......................................................................... 184

3
Appendix D2: Representation of stages of analysis process of an interview .......... 185
Appendix D3: Example of higher-order (superordinate) themes from one participant – stage four of the analysis ................................................................. 189
Appendix D4: Examples of interrogative themes applied to each interview (an example from one participant) ........................................................................... 191
Appendix D5: Representation of stages of analysis across interviews .................. 193
Appendix D6: Representation of final themes with subthemes ............................ 195
Appendix D7: Master table – example of one master theme with subthemes .......... 196
Appendix D8: Final interrogative themes examples across all interviews .......... 205

APPENDIX E: SLIDES FROM PILOT STUDY FINDINGS PRESENTATION ................. 210

Word count: 26,983
List of Figures

Figure 1. PRISMA framework (Moher et al. 2009) .......................................................26
Figure 2. Proposed framework for practice, considering actions to be taken at
  individual, and organisational level ...............................................................46
Figure 3. Stages of IPA analysis. Adapted from Smith, Flowers, and Larkin (2009) ...60
Figure 4. Findings: master themes (big circles) with subthemes ...............................63
Figure 5. Traditional hierarchy of research design, adapted from APA (2006) and
  Raines (2008) ....................................................................................................83
Figure 6. Proposed dissemination strategy at national, regional, local, and participant
  level ...............................................................................................................99
List of Tables

Table 1. Study characteristics .................................................................27
Table 2. Overall weight of evidence ratings ............................................32
Table 3. Issues found in the current literature review .................................41
Table 4. Participant information ...............................................................58
Abstract

The University of Manchester

Dorota I Martin

Doctorate in Educational and Child Psychology

Support? What support? An exploratory study of young people’s experiences of living with depression during their student years

2017

The recent changes in legislation and codes of practice expand the role of the educational psychologist to a wider age range: 0-25. Moreover, surveys suggest an increasing number of children and young people experience difficulties with mental health, including depression.

A systematic literature review of what narratives young people use to communicate depression was undertaken in the first paper. Despite an abundance of literature about depression in clinical settings, only eight studies met the inclusion criteria and were incorporated in the synthesis. A number of issues were identified including ways and methods of communicating depression and the impact of normative pressures and gendered experiences. Findings have implications for practitioners working with young people and have been used to develop a tentative framework for effective practice.

The second paper reports on qualitative research, adapting a phenomenological approach. The self-selected participant sample (three university students, aged 19-21) had experiences of living with depression. Each participant was interviewed three times, using focused semi-structured interviews. The data were subsequently transcribed and analysed using a framework of Interpretative Phenomenological Analysis (Smith, Flowers & Larkin, 2009). The themes were grouped into superordinate themes and interpreted in the light of researcher’s own experiences and knowledge. Two reported themes ‘the weariness of the world was upon me’ and ‘it all fell down to chance’ discuss embodied experiences of living with depression and barriers and facilitators to accessing help, which was mostly coincidental.

Finally, the third paper discusses evidence-based practice, ways of achieving impact in research, and dissemination of research at individual, organisational and academic level. Overall, the present research suggests that educational psychologists can play an important role in raising awareness of children and young people living with depression, as well as promoting mental health, wellbeing and resilience in a variety of educational settings and amongst practitioners working with children and young people.
Declaration

I declare that no portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.
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Finally, a very special thanks and love to Patrick for his love, unwavering support, understanding, and belief in me. You kept me and our family together, even in the hardest of times.
Introduction

Background information

This thesis forms a part of the assessment requirement for the University of Manchester Doctorate in Educational and Child Psychology. The researcher is currently a third (and final year) trainee educational psychologist (TEP) and has experience of working with children and young people (CYP) in both educational and community settings. The choice of focus on mental health has been informed by multiple factors, including: previous work experience delivering resilience training to parent/carers, volunteering as a befriender for a local charity, previous basic counselling skills training, current doctoral study, interest in therapeutic approaches, and various casework during the placement in the North West, and West Local Authorities (LAs).

The choice of present topic was also influenced by the new Special Educational Needs and Disability (SEND) Code of Practice (Department for Education (DfE) & Department of Health (DoH), 2014), and the current government agenda on delivering mental health support in schools (DfE, 2015). These expand the role of the educational psychologist (EP) to work with CYP age ranged 0-25, and this requires from EPs finding new ways of working, updating knowledge and understanding how to support mental health needs in educational contexts. This acknowledges the situatedness of the researcher’s role within time, culture, and interrelated socio-political factors.

The current focus on the mental health of children and young people is perhaps not surprising, given that the estimated annual economic cost in the UK of adolescent and child mental illness to society in 2005/2006 ranged from €1500 to €245 921 for an individual child (Clark, O’Malley, Woodham, Barret, & Byford, 2005). This figure was higher for young offenders (aged 13-18) living with depression, at €107 784 (Barrett, Byford, Chitsabesan, & Kenning, 2006). For children and young people this cost was distributed amongst various sectors, of which the largest cost fell into productivity (55.5%), followed closely by the education sector (40.9%) (Suhrcke, Puillas, & Selai, 2008). Needless to say, these estimations are alarming; it seems of vital importance to be able to understand
unique experiences of depression in children and young people to be able to help them.

**Overall thesis strategy**

*Findings from a preliminary study*

The current research also builds upon a qualitative pilot study carried out by the author of this paper in the first year of the doctoral training within two LAs in the United Kingdom (UK) (Martin, 2016, July). In this study I conducted semi-structured, open-ended interviews with two educational professionals, exploring their perceptions and lived experiences of working with post-16 learners with mental health needs. The pilot study found those educational professionals’ experiences of helping post-16 learners were complex; both rewarding and stressful due to the responsibilities and consequences of getting the right help for the students. The help students received from outside agencies was inconsistent due to the long waiting lists and cuts in funding, raising thresholds for referral processes. This also raised issues about support available for the learners once they move to adult services. Issues of young people reporting mental health difficulties particularly resonated with me, as I met many young people (and their carers) who experienced poor mental health throughout my career (in my capacity as a befriender, person-centred planner, translator/interpreter and TEP), listened to their stories of struggles, sadness and hope. These people and their stories of humanity inspired me; and I believe it is crucial to understand others’ experiences to be able to help them, and in the process, learn from each other. For these reasons, I wanted to explore the topic in more detail for my main thesis research. However, the pilot study had some limitations, most significantly that one interview with each participant did not allow for more in-depth exploration of the topic or clarifying queries.

The findings from the pilot study were disseminated to: the participants in written form, Educational Psychology Service (EPS) teams in different localities (via written form and oral/PowerPoint presentations at team meetings), the University of Manchester Interpretative Phenomenological Analysis (IPA) Research Interest Group through an oral presentation, and at a multi-disciplinary 5th Conference on Applied Qualitative Research via PowerPoint presentation (Martin, 2016, July).
Thesis strategy

This thesis is presented in three separate papers. Paper 1 provides a systematic literature review on the topic of how young people communicate depression and a narrative synthesis of the findings from eight located papers. The findings present a number of issues associated with communicating depression, including methods and processes of communication; and normative pressures encountered by young people that serve as barriers to communication. The discussion of the findings acknowledges the limitations of the review and includes a proposed framework for practice for education professionals, taking into account how to apply these issues at an individual and universal/organisational level.

Paper 2 presents an empirical research project, linking the importance of understanding young people’s lived experiences of depression and perceived facilitators and barriers to accessing help during their student years. The term ‘student years’ encompasses educational, schooling, and university settings. The current research adopted a hermeneutic phenomenological approach and more specifically, IPA (Langridge, 2007; Smith, Flowers, & Larkin, 2009; Smith & Osborn, 2003). I used this qualitative approach previously in my undergraduate research, exploring parent carers’ lived experiences of person-centred planning for their children. This enabled me to find out more about IPA and confirm that the approach resonates with my own beliefs that any attempt to explore individuals’ experiences is inextricably linked with ‘being-in-the-world’ and how these experiences (phenomena) are accessed, construed, consciously understood and expressed through language full of rich descriptions, metaphors, and interpreted by both the participant and the researcher herself (cf. Smith et al., 2009; Smith & Osborn, 2003).

This research builds upon both the preliminary study (as a way of triangulation of information about mental health and listening to students’ voices, as well as employing more complex way of gathering data), and the systematic literature review which forms the first paper. A number of ethical issues had to be considered, including researching distressing topics, and ways of providing help in case of any distress. Following the university’s ethical approval, I interviewed three university students through a self-selected, purposive sample, who had experiences of living with depression during their student years. I employed a three-interview series, adapted from Seidman (2013) focusing on: life context before living with
depression (interview one), the experiences of living with depression (interview two), and reflections on the meanings of living with depression (interview three). The participants experienced their lifeworlds of living with depression in a variety of ways, each of their accounts is full of poignant and lively metaphors, and these are discussed in Paper 2.

One of the study’s strengths is adapting a rigorous and systematic approach to data analysis. This was an iterative, arduous process of checking and rechecking the themes, and at each stage of the analysis; a sample was cross-checked for consistency. Discussing life stories and context of living with depression over a period of three sessions enabled to address issues of validity/trustworthiness of the participants’ stories, as a way of a member-checking. Smith (2011, p. 24) proposes a framework for appraising an IPA paper, stating it should include: a clear focus, high-quality data, and rigour in reporting (common patterns and differences, variability, each theme represented by each participant in case of small numbers of participants).

The interview process proved to be a learning journey - the participants’ words and worlds resonated with myself on many levels and I felt I have developed my skills as a practitioner, as a result. This links to my axiological stance, as I value research that makes a positive contribution, that can change practice or thinking, building a new understanding or insight, ‘new horizons’. I also value stories, language of metaphors and poetry, where ‘teller and listener enters the space of the story for the other’ (Frank, 1995, p. 18). As a researcher, I kept a research diary where I was recording (both in a written and digital form) my thoughts, considerations, and assumptions throughout the whole research journey to be able to reflect, and check my understanding and analysis of the participants’ accounts. As a practitioner TEP, this helped me to reflect on my skills, beliefs, and interactions with others.

Reflective practice forms a part of IPA process (Smith et al., 2009). Keeping a reflective diary during the whole research process, including the analysis and the write up, enabled checking my assumptions and interpretations at each stage of the analysis with diary entries, to ensure trustworthiness of interpretations. This enabled me to acknowledge that the bracketing off my own subjectivity and understanding/epoché is not fully possible, as inevitably life experiences, both professional and personal values, and beliefs impacted on the interpretation of participants’ lifeworlds. However, self-awareness of my own input in the process is an important
part of IPA; and I reflected on issues of researching distressing topics and possible power imbalances, striving to address them. The process also involved participants’ reflexivity, as after (and before) each interview, they had an opportunity to debrief about their experiences of taking part in the research. All of the participants found process of interviewing helpful. More specifically, for two of them the process of three interviews facilitated deep reflections into their own experiences, even in-between the interviews. They reported gaining a new understanding of their lifeworlds of depression, as thinking to ‘such a deep level’ helped them to make connections with their life contexts, circumstances, and perceiving living with depression as a result of a multitude of factors. Therefore it could be tentatively claimed the process opened ‘new horizons of understanding’ (cf. Gadamer, 1975; Smith et al., 2009) for the participants and the researcher (as the participants’ words resonated with me, during the interviews, analysis, and the write-up process). In addition, the readers will add their own interpretation of the paper; therefore it is vital to acknowledge this additional meaning-making, the ‘triple hermeneutics’ of this study (cf. Smith et al., 2009; van Manen, 1990).

Both Paper 1 and 2 look respectively at ways of communicating and making sense of the lived experiences of depression. Although in both papers diagnostic criteria (American Psychiatric Association, 2013) are mentioned to gain a shared understanding of the language and societal norms, there is an ongoing debate regarding social construction of depression and value-laden labelling and medicalisation of depression, serving pharmaceutical companies’ interests (cf. Horwitz & Wakefield, 2007; Moncrieff & Timimi, 2013; Timimi, 2004). For example, Timimi (2004, 2005, 2014) argues that labelling of depression in children is unhelpful and excludes contextual factors, such as sociocultural family changes, family circumstances and work patterns. Moncrieff and Timimi (2013) critique that not only defining depression is ubiquitous and that there is no clear cut as to what occurs as a normal sadness and what is regarded as a disorder, due to the lack of biological markers for depression and the fluidity of diagnosis of depression. Interestingly, studies in Paper 1 suggest heterogeneity of depression, social and cultural factors triggering of depression, for example, childhood adversities but also touch upon stigma associated with communicating depression and help-seeking. Although the participants in Paper 2 acknowledged their depression was a gradual and complex process, resulting from contextual experiences, they also recognised
that labelling of depression was helpful to all of them, as that enabled them to access help. For one participant the labelling process was seen as a relief and way of normalisation her feelings. However, all participants found the diagnosis helpful in accessing further support, making changes in their lives, increasing own self-awareness and making sense of their own experiences. Although the understanding of depression is value-laden and co-constructed, one cannot deny that people experience a real unbearable dejection that can have significant impact on their own lives and the lives of others.

Paper 3 focuses on evidence-based practice, practice based evidence and ways of dissemination, and evaluation of the research impact. I have proposed a dissemination strategy, based on my viewpoint of qualitative research, which is linked to looking at the research process as a way of dissemination, or sharing knowledge (Barnes, Clouder, Pritchard, Hughes, & Purkis, 2003). This also brings the thesis format to the foreground, as two of the papers (Paper 1 and Paper 2) are presented according to the author guidelines from my chosen journals: *Emotional and Behavioural Difficulties* (for Paper 1), and *Journal of Youth Studies* (Paper 2), therefore some of the information that might have been included in the standard thesis format may seem omitted. However, I had to make a number of decisions due to the scope of the journals and as a way of making the research accessible to a wider audience; I hope this is reflected in my thesis.

**Ontology (nature of reality), epistemology (nature of knowledge), and axiology (values associated with research and theories)**

I have adopted a critical realist stance, placed on a continuum between positivism and relativism (Maxwell, 2012). It posits the world can exist independently, ‘objectively’ of multiple realities and social constructions, but can be known in the specific contexts, and through scientific inquiry and social interpretations (Bhaskar, 2008; 2010). Therefore language plays an important role in this process; this accords well with my own linguistic experiences from my previous career as a translator/interpreter. This is also compatible with phenomenological paradigm, that adopts a scientific rigour in systematic analysis of the data, looking at the rich and detailed descriptions of the participants’ realities (an idiographic approach), mediated both through the participants’ own and the researcher’s interpretations, known as double-hermeneutics (Langridge, 2007; Smith et al., 2009; Sullivan,
Although there are debates in the phenomenology field, it is accepted that the epistemological position can be on a continuum from social constructionism to critical realism (Finlay, 2012).

References


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Paper 1

What narratives do young people use to communicate depression?
A systematic review of the literature

Word count: 7917
What narratives do young people use to communicate depression?
A systematic review of the literature

Abstract

Mental health difficulties amongst children and young people increasingly dominate the British government agenda. Despite the 2014 Special Educational Needs and Disability Code of Practice extending statutory provision up to the age of 25, the mental health needs of older young people are often overlooked in educational guidance. For many young people, the impact of depression has wide ranging social and economic implications; therefore it is important to enable early identification and intervention. Understanding self-report processes may be one way of enabling this. From this perspective, the present review aimed to investigate what narratives young people use to communicate depression. Eight studies were identified and assessed using qualitative and quantitative frameworks, and reported using PRISMA guidelines. Findings provide useful information about issues, methods and processes in communicating depression as well as perceptions about effective support. Implications for future research and practice are considered in light of these findings.

Keywords: young people; depression; communicating; narratives; systematic-review

1 This paper has been prepared in accordance with author guidelines for submission in Emotional and Behavioural Difficulties, see Appendix A1 for details.
Introduction

The role of educators in supporting the mental health of young people

Statistics have suggested that young people in the United Kingdom (UK) experience more mental health difficulties than thirty years ago (Mental Health Foundation, 2005). Office for National Statistics (ONS 2014) figures indicated that between 2009-2010 and 2012-2013, the mental health of young people aged 16-24 got noticeably worse according to responses to a seven-question survey. Positive mental health wellbeing can affect life satisfaction and impact on how young people react to and cope with life adversities (Department for Education (DfE) 2015).

Within education there is a growing body of research into how to promote mental health at school, proposing frameworks of practice and capacity building to meet both the needs of both students and staff (Hornby and Atkinson 2003; Weare 2015; Weist et al. 2006). There is also evidence of links between mental health and educational achievement and motivation (Moilanen, Shaw, and Maxwell 2010) and attendance (Attwood and Croll 2015). Recent educational advice (DfE 2015) places schools in a unique position for supporting the mental health of students.

Students with special educational needs and disabilities (SEND) may be especially vulnerable to mental health difficulties. The revised SEND Code of Practice (Department for Education (DfE) and Department of Health (DoH) 2014) extended statutory provision for young people aged 16-25 and brought into focus the need for joined up planning and commissioning to support those with mental health needs. However, while recent advice about mental health and behaviour (DfE 2015) suggests ways of promoting mental health in schools, identifying student mental health needs, referral to specialist services, sources of support and ideas for intervention, the advice is aimed at younger students in primary and secondary
schools, leaving unanswered questions about mental health support for students in further and higher education (FE and HE); and for making the transition to adulthood.

Transition to a new school, college or university often provokes anxiety and can have impact on academic achievement (Anderson et al. 2000) while during transition to undergraduate study, emotional self-control and perceived life control are predictors of personal and emotional adjustment (St Clair-Thompson et al. 2016). Adolescence and transition to adulthood represents a period of rapid changes, including re-defining identity (Klimstra 2013), making choices about romantic relationships, moving away from home, training, or starting a job. Many young people experience instability as they grapple with worries about money, unemployment and life choices, as pathways to adulthood become more complex than ever (cf. Di Blasi et al. 2016; Hurrelmann and Quenzel 2015; Mary 2014). In addition, the economic recession impacts negatively on the mental health of students as they learn how to live away from home and handle financial affairs (Macaskill 2013).

**Depression amongst young people**

Depression is one of the common mental health needs, classified as a mood disorder in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association 2013). This umbrella term covers a range of depressive disorders including: disruptive mood regulation, major depressive disorder; and persistent depressive disorder (dysthymia). It can range from mild to severe, with common features of experiencing sadness ‘or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual’s capacity to function’ (American Psychiatric Association 2013, 155). A recent UK survey of young people
aged 16-24 revealed that 26.1% young women experienced symptoms of depression/anxiety compared to 15.9% of young men, although it is recognised that figures for young men may be under-reported (ONS 2014). Worldwide, the prevalence of depression amongst university students varies between 10.3% to 44%, as investigated by Ibrahim et al. (2013) in their systematic literature review of 24 studies. Implications are significant. Depression can have serious impact on young people in all areas of life, including education; and if left untreated, in severe cases, can lead to suicide (American Psychiatric Association 2013).

Lane (1996) suggested raising awareness amongst educational professionals about student depression, while Greig (2004a, 2004b) raised the issue of medicalisation of mental health difficulties; and limited support resources being used for the purpose of diagnostic labelling. Depression in young people is under-recognised but can lead to serious impact on educational attainment, social and emotional development, school refusal and even anti-social behaviour (Birchwood 2013; Greig 2004b).

**Communicating depression**

There is a wealth of research on depression in adults, but surprisingly little on young people’s experiences of depression and so far, adult models of depression have guided help for adolescents (Shaw, Dallos, and Shoebridge 2009). Similarly, the majority of research has emerged within medical, rather than educational settings and surprisingly, given the prevalence rates, there is a gap in up-to-date research with regard to how young people communicate depression. Shaw et al. (2009) carried out interpretative phenomenological analysis (IPA) of experiences of six female adolescents, aged 14-17, who were receiving help from Child and Adolescent
Mental Health Services (CAMHS). Findings suggested the young women experienced great difficulties with being understood and communicating their distress, which impacted on help-seeking and relationships with others. This links with Rothi and Leavey's (2006) findings that perceived social support networks and communication played an important role in help-seeking.

Issakainen (2014) investigated how young people age 14 to 29 who self-identified as living with depression, negotiated the stigma associated with their experiences. The young people talked about how powerful cultural influences constructing depression as an illness or a case of ‘pulling oneself together’ impacted on their help-seeking and well-being. Kokanovic et al. (2013) critically examined the medicalisation of depression as an illness and contrasted this with experiencing ‘normal sadness’, proposing that understanding how people make sense of their experiences can inform primary care strategies for interventions.

This literature review aimed to gain insight into how young people communicate their experiences of living with depression to others; and to address the knowledge gap existing in current literature, in light of policy and legislative changes and the expanding role of education-based professionals in supporting young adults. As depression is associated with high social impact and substantial economic cost (Layard et al. 2007; London School of Economics 2006), a deeper understanding how young people talk about depression will help to inform further research in this area, contributing to the body of knowledge of post-16 mental health.

**Method**

**Data sources and search strategy**

Literature searches were carried out between September 2015 and February 2016 using the following electronic databases: Web of Science, Education Resources
Information Centre (ERIC), and Applied Social Science Index and Abstracts (ASSIA). In addition, searches of Taylor and Francis Online Journals were carried out. The search terms ‘depression’, ‘depressi*’, ‘communicat*’, ‘narrative*’, ‘talk*’, ‘young adults’, ‘young people’, as well as exclusion for ‘children’, were used.

Boolean operators such as ‘AND’, ‘OR’, and ‘NOT’ were also combined with search terms.

**Inclusion and exclusion criteria**

At the time of the literature search, 912 studies were identified as potentially relevant, although 889 were excluded after examination of titles and abstracts as not meeting the inclusion criteria. Subsequently, 23 papers were read in full and 15 were excluded, leaving eight papers to be included in the current review. The following inclusion criteria were applied: study published between 2000 and 2016 (to limit the search parameters to the most contemporary research), peer-reviewed in an academic journal, published in English, full text available, participants must include young adults (16-25 years old; or mean age within the 16-25 range), and studies investigating mainly depression narratives or language. Studies were excluded if they investigated an intervention for depression, or an aspect of depression (for example suicide), or if depression was not the main focus of the study.

**Results**

Eight studies were identified as meeting the inclusion criteria. Of these, one was mixed methods, five qualitative and two quantitative. Study characteristics can be found in Table 1. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flowchart (Moher et al. 2009) depicts process of review and numbers of studies (Figure 1).
Identification

Screening

Eligibility

Figure 1. PRISMA framework (Moher et al. 2009).
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Country</th>
<th>Sample</th>
<th>Context</th>
<th>Research design</th>
<th>Data analysis</th>
<th>Key findings</th>
<th>Quality score</th>
</tr>
</thead>
</table>
| Danielsson et al. (2011) | Sweden  | 11 male; 12 female      | Two healthcare centres Diagnosis of depression Focus: to explore impact of gender on depression narratives | Qualitative                          | Grounded theory                      | • Differences in reporting between men and women: talking about feelings and depression easier for women than for men; men tended to manage difficulties themselves  
  • Male narratives related to more aggressive emotions; female emotions more withdrawn, including sadness and anxiety  
  • Desire to talk with people other than parents about depression | 10.5/12       |
| Issakainen (2015)    | Finland | 72 female; 7 male       | Online Self-identification of depression                               | Qualitative: Online written narratives Online group discussion E-mail interview/ private messaging | Not specified - Analytical coding within one phases | • Communicating depression seen as:  
  - seeking support and burdening  
  - effective or failing, including barriers to online communication enabling the handling of distress; not communicating led to deepening distress  
  - Face-to-face preferred over online and written communication | 11/12         |
<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Sample Details</th>
<th>Data Collection</th>
<th>Methodology</th>
<th>Findings</th>
</tr>
</thead>
</table>
| Issakainen and Hänninen (2015)| Finland   | 72 female; 7 male Young people aged 14-34, mean = 19.7 | Online Self-identification of depression | As Issakainen (2015) | Not specified Narrative meaning structures of:  
  - The told  
  - The inner  
  - The lived  
  - Depression narratives situated in context of participants’ lives  
  - Adverse life situations escalated experiencing depression  
  - Narratives about causes of depression linked to not fulfilling normative expectations  
  - Participants were questioning, and in some cases, challenging these norms  
  - Depression seen by some as ‘thinking too deeply’ |
| Kokanovic et al. (2013)       | Australia | Not specified                                       | Medical Primary care Part of a larger study | Qualitative | Not specified - Data reviewed for patterns and meanings - NVivo7 used to add further categories  
  - Multifaceted explanations of causes of depression  
  - Depression conceptualised as an explanatory model, drawing from biomedical and psychological sciences  
  - Narratives linked to trauma, negative experiences in childhood, alienation, including focus on social factors  
  - Some participants acknowledged depression could be a normal response to their experiences  
  - Two styles in narratives of depression: using “I”; or more detached “it” when talking about depression |
| Kotliar (2016)                | North America | Age not specified 5 female Online blogs of depression | Online blogs of depression | Qualitative | Thematic analysis Blogs were:  
  - a way to communicate depression intimately and publicly - a coping tool  
  - a way of building a support community for others experiencing similar difficulties  
  - Participants looking for explanations of depression and seeking coherence |
<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Sample Description</th>
<th>Measures</th>
<th>Methodology</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rude, Gortner, and Pennebaker (2004)</td>
<td>USA</td>
<td>124 female undergraduate students from one university including: - 29 experiencing depression - 26 formerly experiencing depression - 67 with no history of depression</td>
<td>Scores on self-report measures</td>
<td>One-way ANOVA reported Multivariate ANOVAs t-tests reported</td>
<td>- Negative focus of language used by students with ongoing depression, predicted by BDI - No significant differences found with regard to social references between those currently experiencing depression and those with no history of depression - Significant differences found with regard to use of first person singular words for the group experiencing depression versus students with no history of experiencing depression</td>
</tr>
<tr>
<td>Whitehill, Brockman, and Moreno (2013)</td>
<td>USA</td>
<td>60 first year undergraduate with Facebook profiles, 36 female; 24 male</td>
<td>One large university</td>
<td>Mixed methods</td>
<td>Chi-square Content analysis</td>
</tr>
<tr>
<td>Wright et al. (2013)</td>
<td>USA</td>
<td>361 undergraduate students</td>
<td>Average age range 20.26 years</td>
<td>Quantitative surveys of: Interpersonal/Social Integrative Motives (Papacharissi and Rubin 2000) Perceived communication competence (Wiemann and Backlund 1980) Computer-mediated Communication Competence: CMC (Spitzberg 2006) Social Support Size/ Satisfaction (Sarason et al. 1987) Depression Scale (Radloff 1991)</td>
<td>Structural equation modelling Cronbach’s alpha (Cronbach and Meehl 1955)</td>
</tr>
</tbody>
</table>
Quality assessment

The appraisal of the selected papers was a multi-step process (see Appendices B1-B5), based on Gough's (2007) weight of evidence framework. Points were awarded for methodological quality, appropriateness and the focus of study. Quality of qualitative and quantitative studies was evaluated based on Bond et al (2013). More specifically, quality of qualitative studies was appraised according to 12 criteria for investigative qualitative evaluation framework, based on Henwood and Pidgeon (1992), Spencer et al. (2003) and Woods et al. (2011). For quantitative studies, 15 criteria were used, based on framework for quantitative investigation research (based on Choi 1998; Cohen, Manion, and Morrison 2011; Geneady et al. 2007; Wallace and Wray 2011). The mixed methods study was appraised using both the qualitative and quantitative frameworks (see Appendices B1-B2) and a median was calculated to arrive at a quality score, which was similar to both qualitative and quantitative framework appraisals (= 0.8), therefore only one score is reported in Table 1.

The second stage involved appraisal of methodological appropriateness. Points were awarded for including primary data of young people’s experiences of depression, clearly defined participant sample and clear protocols for participant involvement. Next, criteria for relevance to review question were applied: including young people in the study, narrative accounts of depression and gathering unsolicited, genuine accounts. The coding of each paper was cross-checked and discussed with the research supervisor to ensure validity of the scoring. The overall weight of evidence ratings are summarised in Table 2. As the number of the studies meeting the inclusion criteria was low, the present review includes all of the studies, of which two obtained high quality, four medium and two low quality ratings.
Table 2. Overall weight of evidence ratings

<table>
<thead>
<tr>
<th>Study</th>
<th>Methodological quality</th>
<th>Methodological appropriateness</th>
<th>Focus of study</th>
<th>Overall weight of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Danielsson et al. (2011)</td>
<td>High</td>
<td>Low</td>
<td>High</td>
<td>Medium</td>
</tr>
<tr>
<td>Issakainen (2015)</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Issakainen and Hänninen (2015)</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Kokanovic et al. (2013)</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Kotliar (2016)</td>
<td>Medium</td>
<td>Low</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>Whitehill, Brockman, and Moreno (2013)</td>
<td>High</td>
<td>Medium</td>
<td>Low</td>
<td>Medium</td>
</tr>
<tr>
<td>Wright et al. (2013)</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
</tbody>
</table>

**Overview of studies included**

The identified studies were carried out in Europe (n=3), in North America (n=4 of which three were in the United States of America) and in Australia (n=1).

**Sample**

Sample sizes varied from not specified to 361. Participants’ ages ranged from 14 to 34, with many in the 17-24 range. Two studies, which did not specify age, (Kotliar 2016; Kokanovic et al. 2013), referred to retrospective accounts of communicating depression when participants were younger and were consequently included in the present review. In three of the studies, participants were undergraduate students (Rude, Gortner, and Pennebaker 2004; Whitehill, Brockman, and Moreno 2013; Wright et al. 2013), whereas in two studies they were patients receiving care from a health centre (Danielsson et al. 2011; Kokanovic et al. 2013). In two of the included studies, participants self-selected/identified themselves as experiencing depression (Issakainen and Hänninen 2015; Issakainen 2015) and in one study public profiles of female bloggers were studied (Kotliar 2016). Unfortunately students in FE and 16-19
education were not represented in the studies located, representing a current gap in knowledge for educators and professionals working with these groups of students.

**Data collection and measures**

A few studies reported use of social media networking sites, such as Facebook and blogs as a way of gathering data (Issakainen 2015; Issakainen and Hänninen 2015; Kotliar 2016; Whitehill, Brockman, and Moreno 2013) whereas for others, a survey (Wright et al. 2013) and face-to-face interviews were carried out (Danielsson et al. 2011; Kokanovic et al. 2013; Rude, Gortner, and Pennebaker 2004). Some studies also used depression outcome measures (Kokanovic et al. 2013; Rude, Gortner, and Pennebaker 2004; Wright et al. 2013) (see Table 1).

**Findings**

Due to the variability of the literature found, it was very difficult to directly compare or aggregate the findings. For this reason, the study outcomes will be considered in turn.

*Danielsson et al. (2011)*

The authors investigated narratives of young Swedish people, living with depression using semi-structured interviews. All 23 participants were receiving treatment (either therapy, psychosocial intervention or/and medication) from two local health centres. A grounded theory approach explored the role of dialogues in identity formation during transition into adulthood.

Findings revealed participants wanted to be ‘normal’ - seen as being accepted, communicating with others, fitting in, and having a future ‘ordinary’ family. The need to belong, insecurities regarding body image, identity and ways of
living with depression were key issues discussed. Young men in the study regarded communicating depression and difficult feelings as a weakness and found it harder than the young women participants. Talking to people other than parents was regarded as desirable, while some young people emphasised the role of social media/the Internet as a way of disclosing feelings. Taking part in the interviews enabled some young men to open up and was valued.

Danielsson et al. (2011) found participants were influenced by societal normative pressures and emphasised the need for supportive professionals to be aware of gender norm-construction and how this may influence help-seeking and help-receiving.

Issakainen (2015)

In this Finnish study, self-selected participants, identifying themselves as living with depression were recruited. Eighty-two people (91.5% female), aged 14-34 participated in an online study, which collected written narratives from online group discussions. Four young people additionally took part in online interviews.

Findings suggested young people communicated depression within three frames: support, connection, and handling. In terms of support, communicating was seen as a means of accessing help; but also as burdening, with some participants preferring to distance themselves, believing they were not worthy of support. Some preferred talking to a professional to avoid the impact of emotionally charged communications on friends or family. ‘Connection’ referred to communicating depression to people, including peers and professionals, or failing to make connections. Face-to-face conversations were sometimes perceived as difficult, highlighting the usefulness of online conversations to enable young people to
articulate experiences. Finally ‘handling’ related to managing emotions and acknowledged that ‘bottling up’ might result in further distress. Participants felt that communicating depression to peers experiencing similar difficulties might result in unhelpful or harmful coping responses, which raises possible implications for self-directed support groups.

Limitations included the small number of male participants, and the fact that online data gathering may have given an incomplete picture of participants’ views. Specifically, non-verbal communication and some of the meaning of participants’ views might have been lost, as there was no opportunity to clarify this information in real time.

*Issakainen and Hänninen (2015)*

This study re-examined data from Issakainen (2015). The authors applied a framework of narrative circulation to explore how young people made sense of their narratives of depression, identifying four main themes.

The first, ‘growing up on a sidetrack’ reported participants’ childhood experiences, such as being bullied, loneliness or complex family circumstances that impacted on their resilience and ability to cope with life adversities. Participants felt left out, hopeless and unsupported. ‘Falling off the track’ referred to life adversities or single events, including external and internal causes of depression. ‘Missing the track’ was linked to not meeting societal, normative expectations, for example forming a stable relationship, or moving out of their parents’ home. Finally, ‘questioning the track’ focused on ‘deep thinking’, making alternative choices, and the tensions and challenges of not ‘complying’ with normative expectations.
These narratives suggested strategies for helping young people living with depression. These included bullying prevention and awareness; listening to the young person; and improving socio-economic status and choice options through creating job opportunities and career guidance.

Kokanovic et al. (2013)

This Australian study involved open-ended telephone interviews with participants from a larger study, recruited from 30 general primary care centres and assessed as having probable symptoms of depression. It aimed to explore ways people talk about living with depression, focusing on three extant conceptual models: ‘explanatory models’, ‘exploratory maps’, and ‘illness narratives’.

Participants utilised multi-explanatory models of their depressive symptoms, such as physiological, psychological, and social causes. Social factors included isolation, family difficulties, and inability to talk openly with friends and family. ‘Exploratory maps’ facilitated discussing their understanding of depression diagnosis. Participants grappled with therapeutic definitions of treatments for depression, chemical imbalances, environmental pressures and moral dilemmas, often moving from one conceptualisation to another. Participants’ ‘illness narratives’ were multi-faceted, embodied within time and interrelated to life context and social interactions. Narratives included childhood loss, stress and post-traumatic stress disorder, anxiety, and major life changes, and circumstances.

Kokanovic et al. (2013) noticed participants tended to use different ways of talking about depression but assign heterogeneous causes. Participants’ dominant use of language included forms of ‘I’ or ‘it’, pointing to either distancing from, or
association with depression. Using conceptual models of maps, models and narratives was reportedly useful in assimilating previous research.

**Kotliar (2016)**

Kotliar (2016) thematically analysed five unsolicited, publicly available online blogs, written by women identifying themselves as living with depression. He categorised findings into four main themes: ‘experiencing depression’, ‘blogging about depression’, ‘communicating depression’, and ‘explaining depression’. Themes were subsequently interpreted, focusing on discourse and cultural processes influencing construction and communication of depression.

Findings suggested that although the bloggers publicly and openly narrated their experiences of living with depression, they also perceived themselves as doing so incognito, hiding behind pseudonyms and differentiating between ‘real’ and online friendships. The bloggers shared intimate emotional states online, whilst at the same time being isolated and in some cases, staying in bed. Blogging about their experiences was a way of communicating depression, normalising it and building an online mental health community. One of the features of the blogs was that readers could post comments, and these comments seemed to be a source of emotional support and bonding with their online community. Kotliar (2016) coined the term ‘narrative sandboxes’ to capture the relative safety of online space for bloggers to write, remove, and re-write various sections of the blog in an attempt to make sense of causes of their depression.

Although only five female blogs were analysed, the findings pointed to some implications for practice. Specifically, blogs could be utilised as way of communicating depression and breaking social isolation, as a therapeutic approach as
well as raising awareness of public mental health. However, the adverse impact of blogging should also be considered, including emotional exposure to negative comments that could result in further social exclusion.

**Rude, Gortner, and Pennebaker (2004)**

The authors examined language use and emotional tone of university students. Drawing on a vast body of literature, they hypothesised that depression-prone students would have increased use of first person narratives and negative emotional words when writing a 20-minute essay on feelings about coming to college. The 124 participants (average age = 18.34 years) were recruited from one American university, and assigned to one of three groups, based on self-report measures: formerly-depressed, never-depressed, and currently-depressed students.

Quantitative findings revealed statistical differences between first person use (‘I’, ‘me’, etc.) between formerly-depressed and never-depressed students. The differences were only statistically significant for currently-depressed versus never-depressed students’ use of ‘I’ (first person singular) words. The authors did not report comparisons between formerly- and currently-depressed students. While limitations included that the essay topic did not promote reflections on community and group experiences, the authors speculated that the use of ‘I’ words could refer to seeing the self as a solitary being; and that greater use of ‘I’ amongst formerly-depressed students was indicative of increased self-preoccupation and self-awareness. The authors concluded that language played an important role in investigating psychological processes.
Whitehill, Brockman, and Moreno (2013)

This mixed-methods study aimed to identify the preferences of first year students at one American university for receiving help, with regard to references of depression displayed on Facebook. Eighty-four publicly available student Facebook profiles were identified as eligible, as the students provided contact information on the profiles (with publicly available content) or were linked to their university directory, and had been active on Facebook within the past month. Although all participants were invited to individual interviews, only 60 participated. Content analysis of the profiles was carried out to determine references to depression symptoms and subsequently, these were categorised into ‘depression displayers’ (n = 20) and ‘non-displayers’ (n = 40). During the interviews, participants were asked to say how they would like their friend to respond to a post they found concerning, then asked about a preference for a response from a tutor or resident advisor (RA). The final question asked about a response from an individual they had never met, ‘a stranger’, concerned about the content of the post.

Findings revealed that the students favoured talking to a friend, in a straightforward, curious, and supportive manner over contact via Facebook. Next, participants preferred a professor or RA expressed their concerns by talking to them in person, and with email preferable to phone contact. Perhaps unsurprisingly, the majority of participants did not want to be approached by a supportive stranger about depression references on Facebook; although some felt that this might be appropriate via a friend. Rates of acceptability for communicating with a stranger were higher amongst ‘non-displayers’.
Wright et al. (2013)

This quantitative research aimed to investigate how university students’ communication competence (both face-to-face and computer-mediated) linked with support networking and depression. The authors hypothesised that higher communication competence would enhance the level of social support, but also speculated that lower communication competence could be linked to higher stress levels, less social support and subsequent depression.

The authors invited 361 undergraduate university students to participate in a survey, consisting of a number of measures to investigate social/interpersonal motives for using Facebook, perceived communication competence (both face-to-face and computer mediated), size of social support networks and satisfaction. The final self-reporting measure assessed indicators of depression. Findings emerging from structural equation modelling analysis, revealed that ‘interpersonal communication motives to initiate or maintain relationships were positively related to communication competence’ (2013, 51) and that social support satisfaction was negatively correlated with depression. Social support satisfaction (but not social motives) was also positively correlated with communication competence. Time spent on Facebook was positively correlated with depression, although motives for spending time online were unclear.

The authors, highlighting single-site limitations, suggested the biggest factor in minimising depression symptoms was associated with satisfaction from face-to-face, rather than online support.

Because of variation between the studies makes it difficult to provide a direct comparison for the reader, Table 3 summarises issues found in the current review.
Table 3. Issues found in the current literature review.

<table>
<thead>
<tr>
<th>Issues</th>
<th>Details of issues (present in papers)</th>
</tr>
</thead>
</table>
| **Causes of depression**        | - Childhood experiences influential (Issakainen and Hänninen 2015)  
                                | - Life adversities triggered depression (Issakainen and Hänninen 2015)  
                                | - Heterogeneous (Kokanovic et al. 2013)  
                                | - Childhood adversity (Kokanovic et al. 2013)  
                                | - Triggers of depression: social context/ life event (Kokanovic et al. 2013) |
| **Understanding depression**    | - Managing emotions, bottling up (Issakainen 2015)  
                                | - Understanding diagnosis (Kokanovic et al. 2013) |
| **Normative experiences**       | - Normative expectations (Danielsson et al. 2011)  
                                | - Social normative pressures (Danielsson et al. 2011)  
                                | - Supportive professional aware of gender construction (Danielsson et al. 2011)  
                                | - Not meeting social/normative expectations (Issakainen and Hänninen 2015)  
                                | - Not complying with normative expectations (Issakainen and Hänninen 2015) |
| **Issues in communicating**     | - Men communicating depression find it difficult (Danielsson et al. 2011)  
                                | - Burdening, distancing, perceiving not worthy (Issakainen 2015)  
                                | - Unsupported (Issakainen and Hänninen 2015)  
                                | - Isolation, inability to talk (Kokanovic et al. 2013) |
| **Method**                      | - Role of social media (Danielsson et al. 2011)  
                                | - Usefulness of online conversations (Issakainen 2015)  
                                | - Face-to-face sometimes difficult (Issakainen 2015)  
                                | - Blogging as communicating (Kotliar 2016)  
                                | - Breaking social isolation (Kotliar 2016)  
                                | - Risks of blogging (Kotliar 2016)  
                                | - Being incognito (Kotliar 2016)  
                                | - Raising awareness (Kotliar 2016)  
                                | - Preferred method of support (Whitehill, Brockman, and Moreno 2013)  
                                | - Social media and communication (Wright et al. 2013) |
| **Process**                     | - Taking part in interviews valued by men (Danielsson et al. 2011)  
                                | - Communicating as connecting (Issakainen 2015)  
                                | - Communicating seen as support (Issakainen 2015)  
                                | - Language of communication /first person (Kokanovic et al. 2013)  
| **Support / What’s supportive?**| - Talking to people other than parents (Danielsson et al. 2011)  
                                | - Preferred talking to professional (Issakainen 2015)  
                                | - Communicating with peers potentially unhelpful (Issakainen 2015)  
                                | - Online support network (Kotliar 2016)  
                                | - Preferred person of support (Whitehill, Brockman, and Moreno 2013) |

**Discussion**

From the literature search, only eight studies, exploring young people’s narratives to communicate depression were located. Given the wealth of research on depression
and its prevalence amongst young people, this was an unexpectedly small sample and suggests a gap in the literature.

Included studies draw attention to a number of issues (see Table 3), including social construction of depression situated in culture and time (cf. Horwitz 2011). Participants grappled with understanding the causes of depression, and their own experiences. It was clear from the studies that life (including childhood) experiences and adversities were triggers of depression for some of the participants, and that the causes were seen as heterogeneous. When trying to make sense of own experiences of depression, some participants bottled up their feelings and had difficulties with managing emotions constructively. Moreover, understanding depression was inextricably linked with participants’ narratives of their life stories (e.g. Kokanovic et al. 2013).

Social normative pressures and expectations (or a lack of desire to comply with these norms) were a source of difficulties for participants, who made comparisons with their peers and struggled to communicate with others. This was particularly true for male participants. These findings suggest practitioners working with young people should be aware of gender constructions, and of normative pressures existing in Western societies (e.g. Danielsson et al. 2011), including construction of knowledge and portrayal of depression in the mass media, as this may impact on help-seeking and help-receiving (cf. Curtis 2010; Gulliver, Griffiths, and Christensen 2010). Another theme present in the current review was directly linked to issues of communicating, with participants finding it challenging to talk about their difficulties, some perceiving themselves not worthy of help or attention. Furthermore, others thought it would be burdening to others or that they might be isolated and unable to talk (e.g. Issakainen 2015; Kokanovic et al. 2013).
In terms of the method and process of communication, participants communicated depression via Facebook, blogs or social media. For some participants social media was a source of support although face-to-face communication, while sometimes difficult, was perceived as preferable. However, use of social media can be problematic, as young people may be misunderstood or criticised following a Facebook disclosure (Al-Saggaf and Nielsen 2014; Smith, Morgan, and Monks 2017). Kotliar (2016) considered risks associated with blogging, such as the blogger’s vulnerability when reading negative comments posted by a stranger on their own blog site. Self-disclosures on the internet can also leave people vulnerable to cyber-attacks, stalking and stealing personal data, as research suggests socially isolated people tend to post more personal details on their Facebook accounts (cf. Al-Saggaf and Nielsen 2014; Daine et al. 2013; Xie and Kang 2015). This may link to Whitehill et al. (2013) noting students’ wariness about wanting to be approached by a stranger via social media, even if their intentions were supportive. On the positive side, literature suggests social media can have beneficial effects in terms of connecting and community building (cf. Oh, Ozkaya, and LaRose 2014; Siriaraya et al. 2011).

The process of communicating depression was valued, perhaps most significantly by men who found it difficult to talk about their experiences of depression (e.g. Danielsson et al. 2011). Research suggests men’s experiences are underreported but that communicating their experiences may lead to positive outcomes, such as accessing support, feeling understood, or aiding recovery (cf. Danielsson et al. 2011; Issakainen 2014; Scholz, Crabb, and Wittert 2014; Valkonen and Hänninen 2012). First person narratives were mostly used by participants who experienced depression and this is also reflected in the wider literature on depression,
for example Molendijk et al. (2010) and Hoffmann et al. (2016). Communication was seen as both a process of connecting, and accessing support. Participants preferred talking to a professional, or people other than parents, and while some preferred support from friends, for others there were some potentially unhelpful consequences of communicating with peers (Issakainen 2015).

The studies employed various methodologies and involved a range of international participant samples. It is debatable whether some methods used to investigate the narratives of depression, such as writing an essay (Rude, Gortner, and Pennebaker 2004), were conducive to investigating language use when living with depression. Debatably, some data gathering methods, for example surveys and online interviews, were too reductionist or remote, especially given that some participants expressed that a face-to-face was preferable (Issakainen 2015). Additionally such methods may not enable rich descriptions of narratives used to communicate living with depression to others or led to misinterpretation of data (cf. Kotliar 2016). Moreover, gender bias within the samples was evident, with relatively few male representatives (e.g. Danielsson et al. 2011; Issakainen 2015; Kotliar 2016). This suggests the views of male participants are underrepresented in the literature, not necessarily due to the epidemiology of depression.

**Limitations of the review**

The main strength of the present review was the use of systematic quality criteria to appraise the studies. However, there are also a number of limitations. The literature search was limited to articles published in English, in peer-review academic journals, with full-text available via the university library. This strategy used might have failed to locate other relevant articles or doctoral theses. The database choice for the search
could have been widened to include, for example, Medline or Cinahl. The review investigated communicating depression in a specific age range (16-25), which might have excluded the narratives of younger people and adolescents.

The studies reviewed presented a range of methodological issues, linked to use of different meanings of narratives and communicating depression in different countries, suggesting complexity in cultural constructions of ‘communicating depression’. Finally, the low quality studies were not removed from the sample due to the overall low sample size.

**Conclusion and implications for future research**

The literature review highlights the existing research gap in this area. Given the social, mental health, and economic implications of living with depression (Layard et al. 2007; London School of Economics 2006) it is surprising that this topic has not been more widely researched.

Despite the heterogeneity of the reviewed studies, they all suggest that communicating depression is a complex, sensitive topic which requires a great deal of trust: specifically, trust in the recipient of the disclosed information (*cf.* Whitehill, Brockman, and Moreno 2013), and trust that this information will be acted upon. Additionally, trust that the communication will not be burdening to the recipient, and that the person can handle the disclosure sensitively (*cf.* Issakainen 2015).

Findings highlight the advantages and disadvantages of social media use in the communication process. Future studies could evaluate social media use in therapeutic interventions, and in developing social and problem-solving skills for young people experiencing depression.
In light of the study findings, a framework for practice is proposed and shown in Figure 2. This tentative framework was derived from looking at issues found in the current review (Table 3). For example, the ‘Assess’ stage of the framework considers participants’ experiences of causes of depression and normative pressures they found difficult to deal with. These suggest that assessing triggers of depression at individual as well as at organisational levels may be helpful to enable further provision (the ‘Enable’ stage of the framework) of support. For example, if the educational context is tolerant and supporting different paths young people may take rather than following societal norms, carries out an audit of mechanisms of communicating depression within an organisation, this may enable further actions in form of providing education on managing emotions.

Figure 2. Proposed framework for practice, considering actions to be taken at individual and organisational level.
Finally, the ‘Support’ stage of the framework looks at practice of supporting young people, linking the findings of what participants found supportive (for example, considering preferred person of support, such as talking to a professional or a friend) with suggestions how this could be applied at individual and organisational level.

To summarise, this framework presents some tentative recommendations for practitioners working with young people who become isolated, withdrawn socially, or present with externalising behaviour. These include: sensitivity to disclosures of depression by young people, understanding gender construction and how this impacts communication, and ways of disclosing and communicating depression. These issues can be addressed both at individual level and at universal or organisational level, looking at procedures and policies that can assess, enable support, and support young people, their peers, and professionals working with them. This is particularly important, given the raising prevalence of mental health issues amongst young people and budget cuts in the UK National Health Service, which put increasing responsibility upon education practitioners working with young people.

Disclosure statement

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Paper 2

‘It all fell down to chance’ – lived experiences of depression during schooling

Word count: 7892
‘It all fell down to chance’ – lived experiences of depression during schooling

Abstract

Depression is experienced by children and young people worldwide and can have serious long-term impacts, including high risk of suicide. To-date there are few in-depth qualitative studies investigating young people’s experiences of living with depression. Moreover, the studies carried out are from a medical perspective, with little information about how depression affects young people’s education. The current study investigated university students’ lived experiences of depression during their school years. Three students, aged 19-21 participated in three sequential individual interviews, each with a different focus: before living with depression; the experience of living with depression; and reflections of the meaning of living with depression. Data were transcribed verbatim and analysed using Interpretative Phenomenological Analysis (IPA), identifying master themes. This paper reports on findings from two themes: ‘the weariness of the world was upon me’, and ‘it all fell down to chance’ which discuss students’ experiences of living with depression; and facilitators and barriers to accessing help. Limitations of the study are considered and possible implications for practice outlined.

Keywords: young people; depression; phenomenology; lived experiences; schooling

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2 This paper has been prepared in accordance with author guidelines for submission in Journal of Youth Studies, see Appendix A2 for details.
Introduction

Depression

Depression is one of the major mental health difficulties, experienced by children and young people globally (Kirmayer, Gomez-Carrillo, and Veissière 2017; Suhrcke, Puillas, and Selai 2008). Ibrahim et al. (2013) estimated the prevalence of depression amongst university students worldwide, with numbers ranging from 10.3% to 44%. Moreover, in the United Kingdom (UK), these numbers for young people (within the age range 16-24) experiencing depression or anxiety vary from 26.1% for young women to 15.9% for young men, although male depression may be under-reported (Office for National Statistics (ONS) 2014).

Depression is conceptualised as a mental disorder in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders: DSM-V (American Psychiatric Association 2013). However, the features of depression are often similar to those experiencing sadness (Horwitz 2011). For young people these may range from: feeling irritable, persistent sadness, hopelessness, tiredness, low self-esteem, fatigue, failure of rejection, sleep disturbance, anger and risk-taking activities (e.g. drug and substance misuse), wanting to withdraw from social life, sensitivity to criticism, lack of interest in previously enjoyed activities, and psychosomatic symptoms (American Psychiatric Association 2013). This list is not exhaustive, as depression is also associated with a higher risk of suicide (Hawton et al. 2013) and impacts all areas of life, including educational and social outcomes (Greig 2004).
Mental health in schools and help-seeking

Schools play a crucial role in supporting the mental health of their students (Department for Education (DfE) 2015; Thorley 2016). However, embedding mental health support at a school level is a complex issue and often young people do not report their difficulties due to the perceived stigma associated with mental health difficulties (Curtis 2010; Issakainen 2014). Rothi and Leavey (2006) explored the mental health help-seeking behaviour of young people in the UK. Their review revealed that often young people’s needs only become recognised when their mental health difficulties are serious, missing the opportunity for earlier interventions. Moreover, Gulliver, Griffiths, and Christensen (2010) found that significant barriers to help-seeking for students were: people’s attitudes towards mental health needs, self-stigmatising, issues of trust, and knowledge about mental health and services.

A review of young people’s narratives in communicating depression (Martin and Atkinson, in preparation) revealed a surprisingly small number of studies. Additionally, the few studies which have explored children and young people’s lived experiences of depression have done so from a medical perspective (cf. McCann, Lubman, and Clark 2012; Shaw, Dallos, and Shoebridge 2009) with no focus on schooling experiences whilst living with depression.

In-depth understanding of these issues can be facilitated by use of phenomenological approaches. Phenomenology has its origins in philosophy and the work of Husserl (1964), who proposed that in order to understand the essence of experience (‘things in their appearing’), the researcher has to stand back, ‘bracket off/suspend’ her/his assumptions, ideas and judgements about the topic of investigation (Langdridge 2007). There are many variants of phenomenology used
in psychology, with the common theme of trying to get an insight into the essence of a person’s life (or lived) world (Langdridge 2007; Smith, Flowers, and Larkin 2009). One of the phenomenological approaches is interpretative phenomenological analysis (IPA), a methodological framework. IPA draws on hermeneutical phenomenology and the work of Heidegger (1962), placing interpretation as inevitable component of our ‘being-in-the-world’ with its features: embodiment (as experienced through bodies), temporality (situated in and experienced over time), spatiality (situated in space) and intersubjectivity or inter-relatedness, as experienced through relationships and with relation to others (Langdridge 2007; Smith, Flowers, and Larkin 2009). IPA relies on language input, usually in a verbal form that requires listening to participants’ experiences, what it is like for them to experience something (phenomenology), interpretation (hermeneutics) of participants’ experiences, and then researcher interpretation (double hermeneutics) (Smith, Flowers, and Larkin 2009).

The current study aimed to explore experiences of UK university students of living with depression during their student years. The term ‘student years’ encompasses educational, schooling, and university settings. Gaining a better insight and deeper understanding of the reality faced by young people, in wider context of their lives, will help to raise awareness amongst professionals working with young people about support, management of depression and will help to inform future research in the area of post-16 educational practice.
Method

This qualitative study employed IPA (Smith, Flowers, and Larkin 2009) in order to gain insight into experiences and meaning-making of living with depression of purposive sample of young people.

Participants

Three undergraduate students from different host university courses, aged 19-21, volunteered to take part. Participants’ names and other identifiable data were anonymised in order to protect their identities, and pseudonyms (over which participants were offered a choice) are used throughout this paper. A brief overview of participant profiles can be found in Table 4 below.

Table 4. Participant information.

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Gender</th>
<th>Age when started living with depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>James Cared</td>
<td>21</td>
<td>Male</td>
<td>Experienced ‘melancholy’ in his life; living with depression started on transition to university. Managing living with depression well.</td>
</tr>
<tr>
<td>Jules</td>
<td>20</td>
<td>Male</td>
<td>Lived with depression during secondary school/sixth form but experienced living with major depression on transition to university. Had to take a year out of university to ‘get better’. Managing living with depression well.</td>
</tr>
<tr>
<td>Lucy</td>
<td>19</td>
<td>Female</td>
<td>At primary school but no support given. Second bout of depression during secondary school, when 16/17, support offered. Not currently living with depression.</td>
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</tbody>
</table>

Ethical considerations and inclusion criteria

Following ethical approval (Appendix C1), posters with an invitation to participate (Appendix C2) were displayed across university. Prospective participants could
enquire about the study via email. The researcher contacted interested parties to arrange a telephone conversation to provide more detailed information and check eligibility criteria, which were: age range 18-25; current students with experience of living with depression and were managing it well; no history of suicide attempts; no current involvement from outside agencies. Subsequently, the first three participants (out of 14 who replied to the poster) who met the eligibility criteria were invited to take part in the interviews and sent information about the study. Participants were reassured about their right to withdraw at any time during data gathering, up to transcription and the anonymisation process. Consent was recurrently checked during each individual interview and the distress protocol revisited. All participants completed three interviews. Full details can be found in Appendices C1-C9.

**Data gathering and analysis**

Three semi-structured, open-ended interviews took place with each participant, according to the three-interview series from Seidman (2013). Each interview had a different focus: the first was on a life story before depression, the second on details of experience of living with depression, and the third on reflection of the meaning of living with depression. An interview guide was developed with prompt questions (see Appendix C9).

This format of interviews was compatible with a phenomenological approach and allowed participants time to talk about and reflect upon their experiences in a safe environment, without feeling judged. This also allowed for building rapport with the researcher before discussing sensitive topics of living with depression. Each participant was individually interviewed three times, over a
period of one month on average, with interview duration from 47 minutes to 92 minutes (mean = 70 minutes). Interviews took part in a designated private and quiet university space, with pre-established access to support if needed.

The interviews were digitally recorded and transcribed verbatim. The analysis followed the IPA framework from Smith, Flowers, and Larkin (2009), where completion of analysis of one interview enabled progress to transcription and analysis of a subsequent interview. For more details, see Figure 3 and Appendix D for examples of the process.

Figure 3. Stages of IPA analysis. Adapted from Smith, Flowers, and Larkin (2009).
Findings

Four recurrent themes were identified (see Figure 4 and Appendix D6). Detailed analysis of all four themes is beyond the scope of this paper. For this reason, this paper will focus on the two themes most relevant to linking the lived experiences of depression with perceived barriers and facilitators to accessing help whilst living with depression: “The weariness of the world was upon me” and “It all fell down to chance”. The remaining two themes: “Whoa, I can’t believe what I’ve been through and how that’s changed me as a person”; “I was in an atmosphere where I was not quite fitting in”, focused on self-identity and school context before living with depression, respectively. The author has established the precedent for being selective about reporting themes from wider IPA literature (Smith, Flowers, and Larkin 2009). In the following extracts, underlining is used to indicate participants’ emphases. Subthemes are highlighted through the use of italics (please refer to Figure 4).

“The weariness of the world was upon me”

This theme is about lived experiences of depression. Although triggers of depression were heterogeneous for participants, all felt disengagement from the world, and experienced a gradual process of ‘getting depressed’, like ‘a great steam engine, running out of steam and grinding to a halt’. James Cared reflected how this had started in boarding school, where he had been constantly comparing himself to others and eventually ‘came to a halt’ during his first year at university. Even then, it took him a while to notice and realise what he was experiencing. He describes this process vividly:

I think a lot of people think it is like an immense just being sad, you know, being a bit blue. It’s not that at all it’s like I think you could describe it like imagine a great steam engine just running out of steam
and just coming to a halt and just rusting. That’s what it’s like. It’s not even like sad it’s kind of just finding yourself grinding to a halt and just not being able to stop it and just inevitably just, you know, kind of entropy. And everything goes to just chaos and, you know, that's kind of what it is.

It seems that James Cared sees himself as someone outmoded, not keeping up with others, someone who feels inadequate and ill-equipped to cope with everyday life. This is supported by powerful metaphors of ‘entropy’ and ‘chaos’. Descriptions of the ‘great steam engine’ are reminiscent of the past era - one can almost sense his longing for the old self, but it seems that his world disintegrated, became disorganised, and is no longer predictable as a result of living with depression.

By contrast, for both Lucy and Jules this process of gradual isolation and disengagement followed earlier traumatic experiences. Lucy experienced two bouts of living with depression at primary and secondary school. Her first time living with depression was: ‘hell on Earth, it was really awful… you’re just in a completely different world, in a completely different mindset, you just cannot enjoy your life at all’. Her embodied experiences are conveyed through rich descriptions of living with depression as feeling: ‘trapped in your own body and you can’t get out, you can’t live your life… you’re just so trapped in yourself… and in your own thoughts’. She felt ‘trapped by fear’ and reflected this period in a subdued, emotionless tone:

I got such in a bad way that I was not, I could not be thrilled, I could not understand why people are happy, why they could love in this life, or not, be miserable, I was not, not in a good way… I mean when you’re depressed you’re not, you’re not there, you’re not living your life, just existing, you’re just existing till the next day, even then, I was… just really wanted to go to sleep…
It all fell down to chance. I was in an atmosphere where I was not quite fitting in. Whoa, I can’t believe what I’ve been through and how that’s changed me as a person.

The weariness of the world was upon me. That’s who I am…

Going to redefine myself. Family matters. I don’t need to think like this anymore... but it all takes time.

I was in an atmosphere where....I was not quite fitting in. It all took time.

I wish I had…

I developed some (!) problems. Serious or trivial? And to deal with that, I...

A great steam engine running out of steam and grinding to a halt.

Bullied? Unbelievable!

Trying to fit in. School vs what you need in university. Things were expected of you.

Not that many friends.

Wellbeing treatment. Nobody noticed?

I knew I needed help. I wish I had…

No one here was helping me out?

Figure 4. Findings: master themes (big circles) with subthemes.
Whereas Jules kept on piling on and on more work:

it was starting to get difficult…because I’d…I’d carried on piling on more things and obviously sixth form’s a lot more work than it was previously and so I was… the low points were getting lower and the sort of… the length of them was increasing… and there were a few times where it came close to just being a full breakdown and not being able to carry on with work just because like having to take, take some time off because of a… but yeah, it became very difficult around that time…

Eventually he experienced an unstoppable force that spiralled things out of control, resulting in a ‘nervous breakdown’ (his words) when he started university.

Although Lucy, Jules, and James Cared describe their existential struggles in philosophical language, for James Cared this takes a whole new dimension. He almost carries on an internal/external dialogue, discussing some deeply philosophical issues:

Existentialists like Nietzsche and Kierkegaard they had, you know, me going through all this and thinking about all of this, like, actually the conclusions that I’ve come to are, are the same as those people came to because what - the issues that they face is the exact same as me and it’s like this feeling of shame and guilt and it’s not just about stuff you’ve done it’s like, it’s a kind of a world weariness, you know, the weariness of the world. It’s like the whole world is kind of somehow like rotten at the core.

For James Cared, difficult feelings are multi-faceted: he not only experiences shame and guilt himself, but also feels ashamed for the ‘rotten’ state of the world he lives in, and he does not wish to contribute to its degeneration. Overpowering feelings of shame and guilt are also present in the narratives of Lucy and Jules. For Lucy, this almost takes a physical form of pain, ‘hurting inside’, powerlessness, and not being able to express how she felt. One can almost feel that pain when she says:
I wanted to cry all the time but it wouldn’t come out, you know? I don’t know if you’ve ever felt this level of despair, where you… so… scared… that you just want to cry and scream and it doesn’t come out and it’s so much worse, ‘cos like when you’re crying, you sort of get it out of you but when you’re holding in it’s just… just deeply, deeply depressing, everything was just… everything was just really terrible to me.

The participants felt lonely, for Jules it was:

Lonely but lonely with other people around me, so it was lonely in that I wasn’t really sharing anything about my experiences with everyone … anyone, even though I was seeing people, like around all of the time during school.

Whereas for Lucy the loneliness whilst living with depression had also another dimension - she did not feel she could be left on her own, as being alone was a terrifying experience:

I felt very lonely a lot, and then I felt better, and if anybody left me on my own I’d just get really terrified, just really scared of something, it was sort of like living in a constant, constant dread… of nothing…

None of the participants knew what was happening to them at first, and whether what they were experiencing was ‘serious or trivial’. They even did not believe themselves when they started noticing something was not ‘quite right’, as Jules exemplifies:

I really needed someone to tell me how bad it was because in my head I was minimising it quite a lot and thinking… ‘well, this isn’t as bad as it could be…’ and… not really… not really admitting to myself that things actually were getting really bad

This also might have seemed trivial to others, or perhaps other people did not recognise the issues of living with sadness:
At that point no-one mentioned sort of depression or like anxiety as this might be something that you have. The people around me were just… ‘oh, you’ve been a bit quiet today or… I’ve not seen you in a while…’ it wasn’t… there was no real labelling of what was happening and definitely with my parents as well… they… more commented on this side of things, that I wasn’t really doing very much (Jules)

Jules felt he could not talk to anyone at school or at home about his feelings, because there were more important issues to be addressed and perhaps his difficulties were not worth mentioning. James Cared wondered if he was ‘lazy’ at first, then he started feeling ‘groggy’ and lacked motivation, and these feelings urged him to go to see a doctor. Following the medical consultation, he was advised it was carbon monoxide poisoning, so he went and bought a carbon monoxide detector. This, however, did not help with alleviating his ‘trivial symptoms’. Because he felt other people would not believe how he felt, he started writing a journal: ‘so I started keeping this book so that… I’d write in it when I was down and then… when I was feeling better again, erm, you know, and I needed to go and talk to someone, I can show them that.’

To deal with difficult feelings of hopelessness, disengagement from life, powerlessness, physical and psychological pain, participants made use of helpful and less helpful coping strategies. Lucy, for example, found that going to school provided a distraction:

When I went to school I was quite distracted, but actually, I didn’t feel as much effect, I felt a bit more normal… ‘cos I needed to get on with my work and erm, but if I was left on my own I would just feel terrible.

Later on, she adds that ‘it was constant distraction that helped me a bit’.

Similarly, Jules created increasingly more and more distractions when he was in high school and sixth form: ‘piling on work’, getting into a school orchestra and various after-school clubs. He also kept adding more subjects and set high
expectations of himself to do great homework, even if this meant he was sitting
until late night. But in the end, these distractions did not help:

I think if it hadn’t been them…for them, it would have been a very
monotonous…and…even more so lonely experience…which was part of
the reason why I kept adding more things later thinking…more things
will make things less monotonous, but it just made things more stressful

At school, when things were becoming increasingly difficult for him, he would:

…just sit somewhere alone… and… somewhere quiet and not… not
really do anything, I didn’t have a phone that I carried round with me
everywhere at this point and I didn’t… I didn’t really listen to music that
much… and… it had rarely been a situation where I’d have something to
read… I’d just find a quiet space and just sit there for a while.

This evocative account suggests how important it was to have a quiet, safe space
where he could ‘just be’ on his own. Jules also worked with a therapist in sixth
form, so he ‘got a little bit better with managing stress’. ‘Coping’ mechanisms
for Jules included ignoring things or ‘pushing things aside’, and finding some
‘quiet moments’. All the participants found routine was vital in managing their
experiences of living with depression. For Lucy, it ‘highlighted the importance
of being productive and being an active person.’ She now tries to maintain an
active lifestyle to ’stay sane’. Jules has lost a lot of weight as a result of not
eating enough and now exercises to get back to healthy weight:

I started doing some exercise because… like… I’d spent several months
not eating and when I was just eating toast so I’d gone down from…
from about ten stone to just under eight stone. So I was pretty skinny at
this point and so I was eating quite a lot and trying to exercise to get back
to a healthy… just be a healthy weight and a healthy person.

For all participants, meeting with friends or having a ‘strong’ group of friends is
a way of building resilience, James Cared noting: ‘I’d like to have a stronger
group of friends at uni and I’m jealous of people that do… I’d like to be a bit more varied and have a few different things that I do and that’. James Cared elaborates on this even more, talking about importance of work and having something to be proud of, including a small steps approach (‘it’s not just a grand scheme like it’s not the big things it’s the little things that get you and you have to start there’):

I find sometimes going to the gym helps because you come back and you do you just feel proud because the first few times it actually aches quite a lot but after a bit like, you know, you come back and you’re like I’ve done good and that’s a nice feeling to feel proud of yourself because that’s the opposite of feeling shame about yourself I think.

The participants report developing physical and psychological issues during the experiences of living with depression. Jules was having difficulties ‘with the heart strain and the fainting stuff’, blackouts where his ‘vision would just go’, and stopped looking after himself during his first year of university:

I stopped looking after myself, I stopped… stopped showering, stopped eating… there was a period of about six days at one point where I just never left my room for food or water. I’d got… like a two litre bottle of water… just that I’d had lying around and that was all I drank and I didn’t eat anything for those, for those six days.

Eventually, this had impact on his memory and ability to function:

I used to just eat lots and lots of toast and nothing else because I… I couldn’t motivate myself to make proper food… and it was a time when my memory had just failed and I put on this toast and then left and not come back for it

Jules describes his struggles in a simple, yet very evocative way, illustrating this with making, or rather failing to make, some food. His memory ‘failed’, he could not look after himself, became incapacitated and powerless when experiencing severe
symptoms of depression. His body went into shutdown mode and following a nervous breakdown, he had to take a year out of university. Both Jules and James Cared felt the academic impact of living with depression. While James Cared did not take a year out, he experienced similar struggles:

I got to the point where…writing it [exam] where I was… I think I had like a little breakdown or something because just the stress and the anxiety and all these things, you know, feeling like… just like… I was just terrified of cocking it up I guess and in the end… at that point, you know, I was like… I really have an issue here, like this is… you know, it’s stopping me from functioning as a person anymore, so I, I… at that point I called the counselling service

It was difficult for James Cared to leave his room for weeks at times, and even when he managed to his lectures he felt inadequate and as if he did not belong.

In describing his feelings about trying to catch up with the curriculum having missed lectures, he recalls:

It’s like trying to join the motorway without actually being at the right speed or understanding how to drive a car. Do you know what I mean? It’s literally like you’re there behind the wheel and you're like what, how did this happen? I can probably handle like driving up and down my street at about five miles an hour but Jesus, you know?

James Cared has been recently diagnosed with Attention Deficit Disorder (ADD) and dyslexia. This contributed to his difficulties with managing coursework on time and attending lectures. Forgetting lectures made him feel ‘shameful’ and consequently led to missing more lectures and work submission deadlines. Lucy did not feel any academic impact of living with depression whilst at primary school and enjoyed going to school and ‘loved learning’ which provided a welcome distraction for her. Nevertheless, she developed severe anxiety and phobias, in addition to self-esteem issues and losing confidence. During secondary school, Lucy was not living with
depression; but experienced anxiety that continuously impacted on her social and emotional life. She had her second bout of depression when she was 17, prior to her A-level exams:

I was extremely anxious, even, prior, - my exams as well, erm, just before the start of the summer, prior to my Chemistry A-level exam, I had a panic attack the night before and I was up all night, I didn’t sleep, went and done it.

However, due to her personal beliefs and values she did not ask for help or mitigating circumstances. When asked what impact it had, she says:

I’ve done all the work, it wasn’t like I hadn’t revised, I was at the end of my tether, it was my last exam… I think I was just too far gone with… studying and I had panicked because of that. Obviously, I was just too, too worked up, it was too late, that’s all it was. I went down, I felt really ill, I felt horrible, I went down and done it, and it was fine, ‘cos I still knew my stuff, I haven’t forgotten it overnight, so it was all OK in that respect.

Lucy later adds that she got an A in her exams.

“It all fell down to chance”

It seemed at first nobody noticed what the participants were going through. When Jules moved to another school, he made new friends. He recalls that much later that people started asking ‘are you OK? Is there something wrong?’ Specially, one friend recommended that Jules should seek help. The teachers in the new school only found out Jules needed some help when he had to ask permission to leave school earlier, in order to go to some therapy sessions at a local hospital. Once he was at university, living in the halls, he poignantly recalls:
I didn’t really know the people in my flat well enough… so when I was in my room for a week and never came out… they never really noticed that I wasn’t there… and… on the actual night I was leaving… I sat down and told someone in the flat what had happened and… she said the weirdest thing which was… ‘you know, I had a feeling a few months ago that something was wrong because there was some toast in the toaster that had just been left and no-one came and collected it.’ So even… even then people had noticed something was wrong, they didn’t feel like they knew me well enough to… ask what was wrong until I said to them.

Both Jules and James Cared had similar experiences of staying in the room and nobody noticing. James Cared mentions: ‘you could sit in a room for three weeks at a time and people probably wouldn’t notice you know? That’s the thing. And I think I spent a lot of first year doing that and nobody noticed- [sighs]’. These are moving reminders that both participants experienced, at least initially, social isolation and lack of interest from other people, almost as if they were invisible to others. Or perhaps other people did not know how to approach them, what to say? These musings are also reflected in what James Cared says about some of students, who made an attempt to invite him on a trip: ‘they didn’t have any obligation at all… other than just being good people’.

Both James Cared and Jules grappled with their identities: *they knew they needed help* but did not know how to ‘do it’. They seemed to face their own inhibitions, lacked knowledge of mental health and language of emotions, or even energy when trying to describe what they were going through. For Jules, it ‘was frustrating’ and ‘just… got more frustrating… frustrating that I couldn’t tell anyone and frustrating that I couldn’t even really understand… myself.’ He blames himself for not accessing help: ‘the support was there and I knew the support was there but I didn’t feel able to use the support because I was too ill or not too ill but… I didn’t feel able to do it because of the illness’. He later adds
that ‘it was more… more me not accessing it and… a problem with me as an individual than… anything bigger’. He ‘wasn’t in the know’ regarding help options, ‘treatments’, medication and that left him feeling powerless, frustrated and sad.

James Cared experienced similar issues: ‘it’s hard to like… express what it’s like when you’re not… there’. He felt that others would not believe him, as he was an outgoing person. His constructions of masculinity withheld him from asking for help: ‘I knew I needed help I just didn’t know how to do it and I found straight up admitting my issue shameful so I couldn’t do that’.

It’s quite hard to like… I guess part of it, you know, being a bloke and that, like you’re meant to be like, you have this thing about being strong, you know, you’ve got to be successful and all that kind of thing and like, you know, you don’t need help, you don’t ask for directions.

All participants felt let down, to some extent, by the systems they were in. When Lucy was a child, it seemed that nobody at school noticed what she was going through. At home, her mum did not empathise with her, thinking that she was playing up or being stubborn about not eating her meals. Eventually Lucy’s dad noticed his daughter’s difficulties but no actions were taken to help her in terms of seeking professional help. It seems that Lucy feels a deep resentment, being terribly let down by her parent and teachers, following a disclosure of abuse by another child that triggered her living with depression. She emotively recounts:

First experience of depression, erm, there was no help from school whatsoever even though they were aware what had happened. Nobody talked to me, nobody said anything, nothing was done, I wasn’t changed class, wasn’t offered any counselling, any support whatsoever.
Her feelings are complex: sorrow mixed with resentment and regret that ‘nothing was done’. Conversely, when she was in secondary school, she ‘was offered all the counselling’ but she feels that was too little, too late.

Both Jules and James Cared feel that at university, there were let down by the pastoral support system in the halls: ‘there wasn’t really any’ and that ‘there were no checks and balances in place’. For both of them, accessing help was really difficult:

The University provides a lot of support but you have to go out of your way to find it. I didn’t realise the counselling service was there until, you know, and like the first time I went and it was like it took me ages to find and I arrived late and I was just stressed out and the whole thing was stress so I just didn't go back and then I ended up going back because I needed it and actually it was just very hard to kind of access it at first and it’s like,… we provide this support for students but actually it’s not, it’s not about necessarily the support it’s about the accessibility and it was just like really hard to like it was so much effort to kind of admit to yourself that you have a problem and you have to go out of your way to find people who will help you (James Cared)

When Jules finally was able to access the university support, it was too late for him and he had, as he describes, a ‘nervous breakdown’. When he was in secondary school, he was friendly with some teachers which seemed to help a bit, although he does not recall any support. He later found out that another student had dropped out of school due to living with depression: ‘it is… difficult knowing it could have… could have very easily turned out… very differently and… I didn’t massively have control of which way it turned out, it just fell down to chance… which is scary to think about’. This poignant expression of ‘falling down to chance’ highlights his powerlessness, lack of control and structure of support for Jules, especially when it emerges that in the same school, there was a teacher who was a trained counsellor. At sixth form, Jules’s main source of support was through empathic friends. For
James Cared, who got a summer job during after his first year at university: ‘it was the regimentation of, of having a 9-5pm job, compared to like at uni… that was, that was important’. He reflects how ‘community and routine’ are most important to him, as before he started university, he had some ‘strong support networks’.

When Lucy reflects back on her secondary school years, she recalls that some teachers were ‘very supportive’ and ‘very sympathetic’, especially her Head of Year. This refers both to Lucy being offered counselling, and her difficult home circumstances. Although she was offered some mitigating circumstances for her A-level exams and university exams, she did not take up on this offer. Jules, however, was offered only help at his secondary schools ‘during exam time’, in form of additional time but no other considerations. He and his friends were bullied at secondary school, but the school failed to address this: only a ‘safe space’ was informally offered and some teachers tried to make his life a bit ‘easier’.

All of the participants experienced a kind of, as Jules expresses: ‘wellbeing treatment’. For Lucy, this involved counselling but this was not helpful for her:

If that worked for another people, I think that’s great, but it really did not work for me. Like some women [laughs] were just getting so desperate and one of them was like: ‘oh well, you know, if you cannot do anything else, just say a prayer to God ’ [laughs], and I’m just saying: ‘well, thanks for all of the suggestions, but you know, it’s not very practical right now [laughs] at the moment.

When she was 17, she had her second bout of depression and her dad ‘made her go’ to the doctors. As a result, she received help from a psychiatrist from children’s mental health services. Lucy describes the professionals as ‘gentle’, ‘kind’, and ‘caring’. Although she did not get antidepressants, it was ‘the fact that they understood me and… they understood what I was going through helped
me’. She adds: ‘it was nice that I had someone who recognised what my illness, - and actually made me feel much better about it, made me feel like I was a normal person for it’. The expression of ‘normal person’ Lucy uses is a powerful reminder of stigma, existing in society and community where Lucy lived, and also her deep beliefs about what constitutes ‘illness’. She deeply regrets this help was not available to her when she was a child, going through her first experiences of living with depression.

Jules experienced cognitive behavioural therapy (CBT), mindfulness, medication, and counselling. He evokes this as ‘I thought it would be mostly receiving treatment and just fixing the depression and the anxiety but it was… much more of a well-rounded improving wellbeing treatment and I think it was a much more positive thing’. And ‘this was needed in getting better’. He returned to university after taking a year out and he is managing well. The participants express the longing for better support, or in case of Lucy, any support when living with depression. This longing is almost tangible, one can sense the psychological pain and distress they had been through whilst living with depression.

Discussion

The aim of the study was to gain insight into young people’s experiences of living with depression, and facilitators and barriers to accessing help. The data gathering process and analysis resulted in rich and vivid descriptions of participants’ lived worlds, or lifeworlds. The reported themes are intertwined and present the essence of living with depression; although uniquely different for each participant, however, there are common patterns in their experiences. These were unravelling through time
and space, from primary schooling up to student years; difficult events and complex circumstances; psychological trauma, abuse (for two participants); and suffering and pain, experienced in relation to their bodies and to other people. The participants used lively and powerful metaphors to express their painful, lonesome experiences and existential struggles, for example: ‘trapped by fear’, ‘what does it take to be alive?’, ‘steam train engine grinding to a halt’, ‘hurt inside’ or feeling lonely ‘with people around me’.

All participants discussed their experiences of accessing help. Some of the barriers to seeking help included seeing this as a sign of weakness (James Cared, Jules), a weakness that would jeopardise their construction of masculinity and what is the normative pressure ‘being a bloke… you don’t ask for help’. Some barriers included issues of stigma, associated with acknowledging difficulties (Lucy, James Cared) or not having anyone trusted to talk to, as others’ experiences and needs seemed more important. Although all students experienced this, it seemed that for Jules and Lucy this was particularly disempowering, as they felt insignificant in the context of both school, and family circumstances. It seems that they were in survival mode, struggling to understand the world around them and their own selves. This impacted on their further experiences, spiralling out of control, of an unstoppable force that ‘gained a six, seven years’ momentum’, or in case of one participant, ‘chaos and entropy’. However, this also relates to lack of awareness of mental health needs, as at the time neither of the participants knew what was happening to them. These findings link with what other young people experienced in terms of beliefs and lack of understanding about what is ‘normal’ (Danielsson et al. 2011; Issakainen 2014; Issakainen 2015).
Two of the participants were misdiagnosed (‘stress’ and ‘carbon monoxide poisoning’) and as a result, received advice that although was not harmful (‘I am better at managing stress’, ‘I guess I’m safe from carbon monoxide poisoning’) did not help to understand their experiences or alleviate symptoms. Similar experiences of misdiagnosing or underdiagnosing depression in young people are echoed in wider literature (Farmer 2002; Ibrahim et al. 2013). All the participants wished they had more support when they were living with depression. These wishes related to counselling at primary school: ‘I could have really done with counselling at that age’ (Lucy); counselling in secondary school (Jules); awareness about mental health needs (all); community building (all); and sexual abuse (Lucy, Jules). Lucy suggested: ‘the school has to have more responsibility to refer the child to get psychological help’ and ‘wanted some justice done’ when she disclosed some sensitive information to her parents. James Cared wondered if there could be a system to report things informally, without reporting an issue. He reflected that could have helped him, as he had ‘no idea what to do or where to turn to.’ Jules also wished that there had been an official support system in schools, for example, a ‘permanent school nurse’, or a ‘counsellor’. All participants wanted support that was unavailable, insufficient, or hard to access when they really needed it.

The participants’ lifeworlds of transitioning to university were multifaceted as they were trying to establish and ‘reinvent’ themselves, whilst at the same time coming to terms with their past experiences. This left two students particularly vulnerable to isolation, overwhelmed by feelings, and not knowing where to turn to for support. This links with Danielsson et al.’s (2011) findings about young people bottling up their emotions and mulling over their problems. Participants in the current study found it helpful having friends they could talk to. Being listened to
without being judged was important to them, and normalising their feelings enabled them to move on, minimising their overpowering feelings of shame and guilt.

**Limitations of the study**

Admittedly, the focus of the current study was idiographic and did not seek an objective ‘truth’; therefore the results could not be generalisable to a wider population of students. The author analysed the data within her experience and meaning making of the participants’ lifeworlds, therefore it could be probable that another researcher might have provided a different narrative. Likewise, the interviews were co-constructions of the meanings and the participants might have shared a more expanded account or chosen a different focus with another researcher.

However, this research provides insight into young people’s experiences of living with depression that goes beyond the scope of quantitative studies. It is increasingly recognised that people’s experiences help to shape services, for example listening to patients’ views to inform commissioning the National Health Services in the UK (Barker 2015). It is hoped that although the findings of the current study are situated in time, culture and specific location, they will contribute to improving students’ experiences and informing practice.

**Conclusion and implications for practice**

The study aimed to explore university students’ lifeworlds and meaning-making of living with depression during their student years. The participants identified what was helpful for them, barriers to accessing help as well as what they would have liked to happen when they were living with depression. The study, despite its limitations, has a number of theoretical implications for parents, young people, and professionals working with them. These include the importance in raising awareness about depression; reducing stigma around mental health needs and mental health help
seeking; and being aware of vulnerability to depression factors, such as transitions, bullying and abuse and complex environmental circumstances. There are also some implications regarding university student services and transition to student life, including not only providing support for students but also ensuring this is easy to access.

Idiographic in nature, the study valued individual and unique experiences of students, by exploring patterns of divergence and convergence between different narrative accounts. The lifeworlds of living with depression were complex and multifaceted; however, one of the pertinent messages was that of being listened to was valued. Hobbs, Todd, and Taylor (2000) discussed how the importance of professionals listening to young people cannot be underestimated. It is through the process of listening, that new meanings emerge that could make a positive change in people’s lives.

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Paper 3

The dissemination of evidence to professional practice

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Introduction

This paper provides an overview of the dissemination of evidence to professional practice, relevant to educational psychology. It will briefly look at evidence-based practice, practice-based research, and ways of disseminating research, before examining how the author plans to disseminate her research in the area of mental health at participant, local, and universal level. The author will also outline the research impact and implications for professional educational psychology practice with relevance to her findings.

Section A: Overview of evidence-based practice (EBP) and practice-based research

EBP has its roots in medicine and health-related professions, such as physiotherapy and occupational therapy (Kratochwill, 2007). Within psychology, American Psychological Association (APA) appointed, in 2005, a Presidential Task Force to develop guidelines and define effective EBP. According to the APA (2006), ‘evidence-based practice in psychology (EBPP) is the integration of best available research with clinical expertise in the context of patient characteristics, culture, and preferences’ (p. 273).

A commonly accepted hierarchy of evidence see Figure 5 (APA, 2006; Raines, 2008) identified systematic reviews, meta-analyses and randomised-controlled trials (RCTs) as the ‘gold standard’ of EBP. This same hierarchy considers qualitative research to be a ‘weaker’ form of evidence (cf. Robson, 2011).

![Figure 5. Traditional hierarchy of research design, adapted from APA (2006) and Raines (2008).](image-url)
The role of the educational psychologist (EP) in the United Kingdom (UK) as an applied psychologist is complex and varied (Kelly & Woolfson, 2008). The Health and Care Profession Council (HCPC), a professional body regulating practitioner psychologists, sets requirements for adherence to codes of conduct and professional practice, which include a set of professional standards to reflect use of EBP (HCPC, 2012). These indicate that psychologists should draw upon scientific evidence in their professional practice. Lane and Corrie (2006) propose that the modern scientist-practitioner acts within the following framework:

- the ability to think effectively;
- the ability to produce a formulation or a story, based on gathered information, that is grounded in psychological knowledge;
- the ability to act effectively, including creative and inventive solutions to produce intervention plans;
- the ability to critique own work, including evaluation and reflections upon own actions and “the use of scientific inquiry to guide and evaluate own work” (p. 3).

There are, however, some issues associated with EBP in educational psychology. As the research, and knowledge produced as a result of it, is a product situated in time and culture and not completely value-free (cf. Hollway, 2012; Kennedy & Monsen, 2016). For example, Burden (2015) critiqued the use of RCTs in educational settings, such as schools, as having a limited value in terms of their quality of evidence; giving an example of one RCT study used in one local authority (LA), using information and communication technology (ICT) to improve literacy (cf. Brooks, Miles, Torgenson, & Torgenson, 2006). Burden (2015) questioned whether results could be generalisable to other LAs, given the specific localisation of the study (with a specific population and socio-economic background), lack of important demographic data and various design flaws. This raises speculation over whether the ‘gold standard’ of RCTs is perhaps overemphasised or even ethical in school settings - a question shared by others in the educational psychology profession (Burden, 2015; Dunsmuir, Brown, Iyadurai, & Monsen, 2009; Fox, 2011).

Moreover, there are proposed frameworks for practice for EPs (Kelly, 2008, 2012) and British Psychological Society (BPS, 2002) codes of practice and
guidelines that require collaboration with service users to enable their involvement in the process of planning, assessing, implementing, and reviewing interventions. These draw on practitioner judgement, specific contextual issues, and individual preferences and/or viewpoints of service users; and this is where the concept of EBP is sometimes difficult to implement, as interventions have to be tailored to individual case(s) (Fox, 2003; Kennedy & Monsen, 2016; Spencer, Detrich, & Slocum, 2012). EPs working with complex, real life cases may feel tension to reconcile EBP with idiographic findings (Miller & Frederickson, 2006). Spencer et al. (2012) proposed that in addition to considering methodological quality ‘best available evidence’ should not only address issues related to the specific context of the school, classroom or student, but also look at desired outcomes and stakeholders’ values. Spencer et al. (2012) acknowledged this approach may be inherently flawed, as the term ‘best available evidence’ suggests indirectly relevant evidence that may not be a perfect match to the particular outcomes or context, and that stakeholders’ engagement in implementing ‘best evidence’ interventions is often crucial to success of these interventions. They argue that relying otherwise on best evidence of RCTs may miss other valid forms of evidence, and that replication and implementation of these RCT interventions may lack internal validity, for example in the case of Content Literacy Continuum programme (Corrin et al., 2012).

To understand how and why certain behaviours and issues occur, or gain an insight into service users’ perceptions about certain interventions and programmes, qualitative approaches to research provide ways of answering these questions (cf. Smith, Flowers, & Larkin, 2009; Willig, 2013). It is increasingly recognised (including amongst medicine and allied health professions) that understanding service users’ experiences is important in improving access to health or customer care. Some examples of this approach to research include: investigating social determinants of health in rural areas (Harvey, 2010), patients’ experiences of psychosis (Pyle & Morrison, 2014), or the use of qualitative research in re-designing and commissioning the UK National Health Service (NHS) (Barker, 2015). It is proposed that small-scale research may help to develop theory that could be further investigated via single-case study designs, to inform further research and practice (Aveline & Shapiro, 1995). In terms of its application in education, qualitative research provides more in-depth information about
pedagogical practices, for example using methods encouraging reflective practice and understanding, such as hermeneutic (interpretative) phenomenology (Friesen, Henriksson, & Saevi, 2012; van Manen, 1990).

The above also links with the notion of practice-based evidence, which is regarded to be complementary to both EBP and the scientist-practitioner model (Barkham, Hardy, & Mellor-Clark, 2010). Practice-based evidence is defined as ‘integrating both individual clinical expertise and service-level parameters with the best available evidence drawn from rigorous research activity carried out in routine clinical settings’ (Barkham & Margison, 2007, p. 446). It could be argued that with the recent UK legislation and subsequent government advice to include the voice of children, young people and their parent/carers (Department for Education (DfE) & Department of Health (DoH), 2014), practice-based evidence could play an important role in bridging the research-to-knowledge gap (cf. Barkham, Stiles, Lambert, & Mellor-Clark, 2010). Moreover, views about the usefulness of practice-based evidence are also endorsed by the APA (2006) which suggested that context and practitioner expertise (clinical practice) should be also taken into account.

Studies of effectiveness, or practice-based studies not only have relevance to daily practice but also employ a wide range of methodologies to explore an issue or evaluate an intervention, whilst not placing limitations on gathered data (Barkham, Stiles, et al., 2010). Additionally, qualitative feasibility studies can inform further RCT research (O’Cathain et al., 2015).

However, this also calls for caution as rigour and relevance are important factors in conducting research, whether using EBP or practice-based evidence (Barkham & Mellor-Clark, 2000). This is where the proposed scientist-practitioner model, advocating the ability to critically analyse data, assess evidence and make formulations, comes to the fore for EPs, as not all studies published in peer-review journals pay sufficient attention to validity, and no study is free of bias or political/cultural influences (Fox, 2011; Kennedy & Monsen, 2016). Woods, Bond, Humphrey, Symes, and Green (2011) point out that EBP ‘provides a starting point, rather than a final word, for effective and safe practice’ (p.53).

Section B: The effective dissemination of research: outcomes and impact

It is commonly accepted that dissemination is seen as vital part of the research process (Economic and Social Research Council (ESRC), n.d.; Grimshaw,
Eccles, Lavis, Hill, & Squires, 2012; Lakey, Rodgers, & Scoble, 2014). However, the topic is highly debatable in terms of what the most effective ways of dissemination are and what the meaning of what dissemination is (Pardoe, 2014). A variety of terms have been constructed, for example ‘knowledge transfer’, ‘knowledge exchange’, ‘research dissemination’ or ‘communication’ as ways of capturing the meaning (cf. Pardoe, 2014; Wilson, Petticrew, Calnan, & Nazareth, 2010). For Wilson et al. (2010), dissemination is:

a planned process that involves consideration of target audiences and target setting in which research findings are to be received and, where appropriate, communicating and interacting with wider policy and health service audiences in ways that facilitate research uptake in decision-making processes and practice (p.2).

Typically, one of the methods of dissemination is publishing in a peer-review journal. This enables reaching a wide-range of audiences (at national and international level). However, many qualitative studies are underreported - an online survey of 1032 participants (of whom 859 were researchers) revealing that ‘68.1% of the researchers, who carried out at least one qualitative study, had not published in a peer-review journal’ (Toews et al., 2016, p.5). The authors suggest a number of implications: firstly, the unreported study may raise some ethical issues in terms of professional accountability to participants, who invested their time and often emotional resources into the process (p.3). Next, that there may be issues of professional accountability to the funding body and profession, as they argue that not disseminating findings could be a waste of public resources (in case of funded studies). Thirdly, a lack of visibility in search engines may lead to bias in systematic literature reviews; and subsequently an overestimation of the number (and effect) of quantitative studies may lead to making decisions based on incorrect assumptions, or choosing inappropriate interventions (p. 3). Toews et al. (2016) found that editors (16% of the participant sample) of peer-reviewed journals often did not understand qualitative research assumptions and rejected the paper for these reasons, that journal aims did not lend themselves to publishing qualitative research, or that the studies were lacking quality. Although Toews et al. (2016) provide an interesting discussion, considering bias in the dissemination of
qualitative findings, they do not include advice about how to bridge that dissemination gap.

Barnes, Clouder, Pritchard, Hughes and Purkis (2003) propose a deconstructive model of dissemination, looking at how language and meanings of dissemination are embedded in culture and knowledge, and acknowledge that dissemination is influenced by social, ethical and political issues (p.148). They recognise that knowledge is not value-free and that processes involved in the research actually form a part of dissemination. They propose a series of steps that are part of dissemination itself, such as:

- the literature review and research design (forming a key aspect of the research, with choice of topic studied, evaluation of literature, search strategy, design and ways of involving participants);
- interviewing participants (and joint production of meanings and interpretations of investigated issues during interviews);
- the analytic framework (influencing ways of interpretation of findings);
- presenting findings (to various audiences, for different purposes including changing practice or enhancing understanding of issues, with the proviso that this is only limited view of the world);
- publishing in a journal article (choice of journals, their aim, audience, and ways of presenting manuscript for publishing purposes).

What follows, dissemination, is seen as an ongoing and multi-faceted process rather than a linear one (Barnes et al., 2003). This framework will be discussed in more detail in later sections of this paper, with relation to the current research.

Harmsworth and Turpin (2000) proposed that we can think of dissemination in terms of: awareness (awareness of activities, project, and outcomes), understanding (of specific audiences, and their understanding of the project), and action (change of practice as a result of the project and its outcomes and materials). Keen and Todres (2007) concluded from their systematic literature review that dissemination of qualitative studies went beyond simple ‘messages’: it included theatre/ethnodrama/dance productions, film, DVD, poetry, writing and storytelling, multi-media presentations, workshops and brochures. Infographics\textsuperscript{3} could

\textsuperscript{3} ‘An infographic is a visual display of information, presented in a way that communicates a compelling story about data’ (Chandler et al., 2015, p.6). Infographics could be static, animated, audio, video or interactive multi-modal ways of research dissemination (Chandler et al., 2015).
be another way of disseminating findings, although used to present quantitative data, these can also be used to synthesise qualitative data (Chandler, Anstey, & Ross, 2015). These suggestions exemplify the role of research in awareness raising, creating understanding of issues researched; and in engaging audiences to interact with the outcome (for example, performance); which is congruent with the assertions of Harmsworth and Turpin (2000, p.2), who also suggest the following points to consider when planning dissemination:

1. What is dissemination?
2. What do we want to disseminate?
3. Who are our stakeholders and what are we offering them?
4. When do we disseminate?
5. How do we prepare our strategy?
6. How do we turn our strategy into an action plan?
7. How do we cost our dissemination activities?
8. How do we know we have been successful?

Harmsworth and Turpin (2000) also give some ideas of ways of dissemination, including: careful consideration of target audience, use of mailing lists, newsletters, briefings, reports, presence and presentations at conferences, and use of media. Given the complex nature of work of EPs, this multiple method dissemination seems to fit well with a range of professional activities (Fallon, Woods, & Rooney, 2010; Farrell et al., 2006; Woods, Stothard, Lydon, & Reason, 2013). There are numerous opportunities within BPS, NAPEP (National Association of Principal Educational Psychologists) and AEP (Association of Educational Psychologists, the leading EP trade union) for EPs to be actively involved in dissemination, by utilising existing resources such as professional journals, events (such as conferences and training/workshops, for example on issues of mental health in schools), or routinely during day-to-day work, for example during consultations (Kelly, 2012a).

So far, this section explored frameworks and ways of disseminating research. An important component of applied research process is outcome evaluation to establish efficacy of interventions and treatments, and their applicability to bridge the research-to-practice gap, for example within school mental health area (Raines, 2008). Case tracking (collecting information about outcomes to combine them in a database) (Leach & Lutz, 2010) is one of the
methods, with benchmarking being another well-known method of evaluation, focusing on ‘quality improvement by examining the processes of more successful interventions that are superior in outcomes and efficiency’ (Lueger & Barkham, 2010, p. 121). Although benchmarking was originally developed by Camp (1989) for the manufacturing industry sector (Xerox), it quickly became an effective tool/process to monitor good practices (p.122). Camp (1989) differentiated between four types of benchmarking:

- internal (within a unit of service delivery, for example identification of most effective therapist, or comparing outcomes of a clinic), where sharing of information to the public is limited;
- competitive (comparison of units/individuals outside the system but in the same industry, for example between different educational psychology professional doctorate courses), where sensitivity to comparison has to be considered;
- functional (non-competitive, between different industries that share some similar roles, for example between practitioner psychologists);
- generic process (between specific processes in different domains, for example person-centred approaches, or business processes) to establish effectiveness of a process or a component part of the process.

This final benchmarking process seems to be challenging to carry out, as only a limited number of studies of processes with positive outcomes have been identified, for example: therapeutic alliance and remaining in therapy (Lueger & Barkham, 2010) or auditing recruitment and selection processes (Ifill & Moreland, 1999).

Section C: The implications of the current research

This section will overview the implications of the current research, presented in Paper 1 (T1) and Paper 2 (T2) as part of this thesis. The research focused on exploring young people’s experiences of depression: firstly, looking at a systematic literature review (SLR) of young people’s narratives used to communicate depression (T1), then investigating empirically young people’s experiences of living with depression during their student years (T2). The findings suggest a number of implications which will be looked at from a stakeholder point of view (cf. Harmsworth & Turpin, 2000) at the research site level, organisational level, and the professional level.
Implications and impact at the research site level

These will be discussed with reference to T2, the empirical study carried out to explore students’ lived experiences of depression. Three students (this term will be used interchangeably with ‘participants’) took part in the research, each was interviewed individually three times over a period of approximately one month. The findings were analysed within a framework of interpretative phenomenological analysis (IPA) (Smith et al., 2009) and a number of themes emerged from the analysis. The students experienced an overall lack of support from school staff during their school years when living with depression. Two of the students reported their struggles when living with depression and being at university. They felt isolated, unable to talk to others about their experiences, and unable to study. One of the students had to take a study break to ‘get better’. Discussing difficult and traumatic experiences that preceded or occurred whilst living with depression could be distressing, however, the participants in the current study reported they felt listened to, without being judged. The three-series interview format (Seidman, 2013) enabled the students to establish rapport with the researcher during the first interview, which focused on the experiences and context before living with depression, prior to exploring living with depression during the second interview. The third and final interview focused on reflections on the meaning of living with depression in the participant’s life, and also served a purpose of a closure or ending to the participation in the research. Immediate feedback was sought from the participants after (and during) each of the interviews; this allowed for adjusting pace of the interviews and asking questions. For example, one participant found it difficult to talk about family life experiences and the researcher noticed and acknowledged that difficulty. This ensured the participant had the option to discuss or not discuss this, sharing only aspects of his story he felt comfortable with. As a result, he was able to further disclose some painful memories and that did not distress him. Similar experiences were reported by all students, who found participation in the interviews a positive experience, which facilitated their understanding and making sense of living with depression as a whole picture rather than separate events. Or, as reported by one student, rather than a counselling session he had previously attended at the host university students’ services, which was not linked in any way to the current study or the researcher.
Participants were consulted about data anonymisation, choice of pseudonyms, seeing transcripts and further contact with regard to follow up (publication of the findings). All of the students expressed that they would like to see a published paper and will be contacted in due time. Interestingly, findings from the T1 paper also show, to some extent, support for an important implication of one of the T2 findings - that experiences of being listened to were valued (cf. Danielsson, Bengs, Samuelsson, & Johansson, 2011; Issakainen, 2015). Moreover, students identified a number of strategies and ideas for improving their schooling experiences; these will be discussed in later sections of this paper. Inadvertently, the researcher herself was affected (both professionally and personally) in the process of carrying out the current research, deepening her understanding of mental health issues, her appreciation of complexity of human nature; and developing her own interpersonal and reflective skills. This process occurred over a period of more than two years and although not anticipated, it was a deeply constructive and desirable outcome of the co-production of the research, opening up ‘new horizons of understanding’ (cf. Gadamer, 1975; Smith et al., 2009; van Manen, 1990) for both the participants and the researcher. Interestingly, the impact of research on the researcher has been also considered in a wider literature, for example Etherington (2004) and Todres (2007).

Implications at the organisational level

Feedback from the current research (T2) will be provided to the students, and the host university schools via letters and a summary of the findings, together with possible implications. More specifically, the information will include participants’ ideas how to improve student services, first year experiences, including community and capacity building, and transition to university life. Given an interest from students to participate in the study during the participant recruitment process, it is perhaps indicative of a need for raising awareness and understanding of mental health (including living with depression) amongst students and university staff.

The findings from the T1 systematic literature review will also be incorporated within that feedback, as it will be important for student services (including counselling service and residential halls) to be aware of ways of facilitating communicating depression and how to plan, assess and implement the
recommendations within their practice. It is acknowledged that both T1 and T2 had limitations, and that the findings from T2 are not necessarily generalisable to a wider student population, as they focused on particular, idiographic experiences of a small participant sample. However, this could point to wider organisational implications and issues which further research could explore in more detail. Additionally, the researcher hopes that suggestions from these findings will have implications at EPS level (see section below).

Implications at the professional level

Fallon et al. (2010) discuss the role of EPs as scientist-practitioners, involved in the dissemination and production of psychological knowledge through training and research, consultation, assessment, and intervention (p.14). To the best of the present author’s knowledge, the current research into communicating depression and exploring lived experiences of depression (T1 and T2) proposes a unique contribution to the EP profession, adding to a relatively new area of practice for EPs - post-16 mental health.

The findings of T1 may be of interest to EPs and other professionals, working with young people in various roles, as the paper not only explores issues of communicating depression, but also proposes a framework for practice with regard to steps taken: to assess, enable and support young people (at individual and universal levels), thus fulfilling the role of bridging knowledge-to-practice gap (see Section A of the current paper). This is likely to be of interest to both national and international audiences, as the SLR reviewed international studies and highlighted an existing research gap in the area of communicating depression, especially as the SLR did not locate any eligible UK research. It is worth noting that depression can have serious impact on all areas of life, including education, and that early intervention and identification is crucial (cf. Layard, Clark, Knapp, & Mayraz, 2007), given the rising numbers of young people reporting poor mental health (Office for National Statistics (ONS), 2005, 2014, 2015).

The findings from both T1 and T2, suggest that listening to students’ voices is a valuable and empowering activity. Hobbs, Todd, and Taylor (2000) provided an interesting discussion about the role of the EP in terms of consultative approaches and gaining the views of children and young people. They asserted that co-production of what is important to the child/young person, and exploration of
the contextual factors should help to create a positive change whilst at the same
time addressing the power imbalances between practitioner EP and the child:

The process of psychological assessment should not only provide the
educational psychologist with a fuller understanding of the child’s
educational world (and other worlds), it should also provide the child
with a greater understanding of their own situation and what actions
may be open to them to undertake positive change (p.113).

The above addresses implications at the consultation level for T1 and T2,
advocating listening and considering different viewpoints, which is a core activity
for the EP. Furthermore, the findings from T1 and T2 could inform the
development of mental health training awareness for schools and education
professionals, discussing the factors that can affect mental health and ways of
identifying and supporting young people. Thus they have implications at another
core EP activity - training. It should be noted, however, that the potential training
package would incorporate evidence beyond the scope of T1 and T2 papers, as the
current research is limited and could not be generalisable. In terms of implications
for assessment and intervention, both T1 and T2 provide useful information about
understanding issues related to living with, and communicating depression.
Arguably, although understanding is not sufficient enough in itself to provide an
intervention, it can enrich delivering resilience and community building activities
and appropriate interventions whether these are delivered at individual, group, or
organisational levels. Admittedly, the findings from T2 are idiographic and not
generalisable to a wider population; however, participants made clear suggestions
as to how student services can be improved both at school and university, including
practitioners’ accountability for their actions; and these suggestions have also been
found in a wider literature of EBP and practice based evidence (cf. Gulliver,
Griffiths, & Christensen, 2010; Weare, 2015; Weist, Lindsey, Moore, & Slade,
2006). There are also implications for the profession in terms of identifying
research gaps and a need for further evidence with regard to exploring post-16 area
of mental health and depression, with the latter also advocated by other EPs (Greig,
2004a, 2004b; Lane, 1996).
Section D: Promoting and evaluating the dissemination and impact of the current research

A proposed strategy for disseminating and evaluating the impact of the current research findings can be found in Figure 6 below. This considers suggestions from Barnes et al. (2003), and Harmsworth and Turpin (2000).

Participant level (including research site)

As advocated by Barnes et al. (2003), reflexive methodologies acknowledge the role of the researcher and participants in the co-production of knowledge. This includes the reflexivity of the participants, as they kept reflecting on their life experiences and the interviews, even after they had ended. All participants felt positive about taking part in the research, as the interview process facilitated for them a deep introspection and linking their experiences in a new way. The conversations between the participants and the researcher may have contributed to sharing (dissemination) of some issues, or ideas that may have previously been indistinct, or not easily communicated to others (cf. Barnes et al., 2003). This is further supported by their quotes: ‘it was helpful to think about experiences as a whole’ (Jules), ‘hearing own thoughts helped to rationalise certain things’ (James Cared), and:

You don’t tend to think so retrospectively and to such a deep level and talk about it so much. When you do it’s a little bit like whoa I can’t believe what I’ve just- … what I have been through and how that’s probably actually changed me a lot as a person. (Lucy)

The participants’ experiences of taking part in the research have also links with the wider literature, for example Crocker, Boylan, Bostock, and Locock (2016) or Faulkner (2004), who acknowledged the impact of taking part in the research on participants. There are plans to contact participants with summary of the findings, and when publishing the research in a peer-reviewed journal.

With regard to the research site, a short briefing letter will be sent to the university schools and student services of the host university with summary of the findings.
**Local level**

At local level, a summary of the findings from the pilot study was distributed to two post-16 colleges and three EPS in different LAs. The researcher also presented the pilot study findings at a local university research IPA group (Appendix E) and discussed her T2 plans with fellow researchers, who were doctoral students from various disciplines (counselling, educational psychology, education, health) and qualified counsellors. It is important to acknowledge that research does not happen as a separate activity or as an end product in itself and that it is interlinked with everyday experiences, conversations, choice of methodology, analysis process and further activities, for example, publication (Barnes et al., 2003). Whilst the impact (and dissemination) of research can be understood in terms of awareness, understanding, and action (Harmsworth & Turpin, 2000), the primary goal of the current research was to raise awareness and understanding of the issues linked to mental health, and depression in particular. The researcher is actively involved in a LA-wide project of championing person-centred planning and approaches at her current EPS place of work. The aim of the project is to make a positive contribution to changing practices of working with children and young people, including consultation, assessment, and intervention and as such, it provides an opportunity to also champion the EP role in disseminating research via presentations at local teams, schools, and multi-agency meetings.

**Regional level**

At regional level, there are plans to present the findings from T1 and T2 at a regional *Preparing for Adulthood* event, where traditionally colleagues from EPSs present various topics, including thinking about transition to college/university. This event gathers a wide audience, including young people, parents/carers, educators, social services and community providers; offering the researcher an opportunity to disseminate her findings and recommendations to raise awareness. Moreover, the researcher plans to develop a training package based on the current research to further share her knowledge from the research to schools, and colleges in the region.
National/international level

At this level, there are plans to publish the current research in two international journals, identified for T1 and T2 (Appendix A): *Emotional and Behavioural Difficulties* (T1) and *Journal of Youth Studies* (T2), reaching a wide multi-disciplinary audience, including educators and practitioners working with young people. The impact of publishing of qualitative research was discussed earlier in Section B. Additionally, there are plans to prepare a third manuscript with another set of findings from T2, as due to journal requirements and richness of data, the researcher made a considered decision to include only findings from themes most relevant to living with depression (see T2). This would answer the moral and ethical accountability of the researcher to both the participants, and the funding body, that is National College of Teaching and Learning (NCTL), part of England’s DfE.

An earlier, preliminary (pilot) study was presented at a 5th Conference on Applied Qualitative Research in July 2016 (Martin, 2016, July) to a multi-disciplinary audience of qualitative researchers, counsellors, students, and academics, and was well-received (Appendix E). During the conference, the researcher had an opportunity to answer further questions about IPA methodology and regarding raising awareness about the role of educational psychology in supporting the mental health of children and young people; as well as introduce her thesis plans (T1 and T2) to the audience. The researcher has been invited to present her thesis findings at a subsequent conference and is making plans to apply to present at national Division of Educational and Child Psychology (DECP) annual conference, subject to funding availability. Additionally, to increase the presence of the research findings, the researcher considers use of social media and professional networks, for example, updating profile information on ResearchGate (an international professional networking website) and promoting research on professional fora mailing list, for example EPNET (an ‘EPs’ and educational professionals’ e-mail network) or IPA e-mail based international forum. The impact of publication and the research papers’ visibility is yet to be measured via citation and/or number of article views provided by publishers and this will unfold over a longer period of time.

The researcher is considering attending a research commissioning day in 2017/8 for the University of Manchester Trainee Educational Psychologists, to
propose further research in the post-16 mental health area, building on the findings from T1 and T2 to further contribute to the production and dissemination of knowledge to the EP profession.

Conclusions

This paper briefly overviewed EBP and practice-based evidence, looking at issues (both general and specific to educational psychology) associated with the implementation of research to professional practice. It also discussed ways of disseminating research and evaluating impact, looking at mainstream and non-traditional ways of promoting and conceptualising research. The present author proposed her strategy for sharing knowledge based on the findings from her research and ways of impacting educational strategies at local, regional, national and international levels.
National/International level

National conference presentation of pilot study findings in July 2016 (5th Applied Qualitative Research Conference) to multidisciplinary audience

Application to present at DECP conference in 2018

Dissemination via publication, two international peer-reviewed journals will be targeted (three papers planned)

Social media/network visibility via ResearchGate, EPNET

Regional level

Presentation at regional Preparing for Adulthood event(s) to professionals, parents, and carers (planned)

Developing training for education professionals on depression (dissemination of findings - planned)

Local level

Within EP Team and stakeholders within a Local Authority (LA)

Within EP Teams from two different LAs (preliminary study findings in 2015 and 2016)

Presentation to the university's IPA research group in 2016

Dissemination through engagement with LA Person-Centred Planning Champions - an LA-wide multi-agency work (including transition planning) to improve outcomes for children and young people (ongoing)

Participant level

Dissemination of findings to participants

Immediate feedback after each interview and at the end of the interview series

Taking part in research had positive impact on participants' perceptions and making sense of their own experiences of living with depression

Research site:

Communicating findings to student services and schools via brief summaries/e-newsletters

Figure 6. Proposed dissemination strategy at national, regional, local, and participant level.
References


Department for Education (DfE), & Department of Health (DoH). (2014). *Special Educational Needs and Disability Code of Practice: 0 to 25 years. Statutory guidance for organisations who work and support children and young people with special educational needs and disabilities.* Retrieved from https://www.gov.uk/government/consultations


Kelly, B. (2012b). Implementation Science for Psychology in Education. In B.


Blackwell.


Appendix A

Appendix A1: Emotional and Behavioural Difficulties author guidelines

Appendix A2: Journal of Youth Studies author guidelines
Appendix A1: Emotional and Behavioural Difficulties author guidelines

Manuscript preparation
1. General guidelines
   †Back to top.
Manuscripts are accepted in English. British English spelling and punctuation are preferred. Please use single quotation marks, except where ‘a quotation is “within” a quotation’. Long quotations of 40 words or more should be indented with quotation marks.
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When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.

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Updated September 2016
Appendix B

Appendix B1: Methodological quality (qualitative investigation research)
Appendix B2: Methodological quality (quantitative investigation research)
Appendix B3: Methodological appropriateness
Appendix B4: Focus of study – relevance to review questions
Appendix B5: Overall weight of evidence ratings
Appendix B1: Methodological quality (qualitative investigation research)
Scores: 1 indicate criterion met, 0.5 = partially met, 0 = not met.

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<th>Appropriateness of research design</th>
<th>Clear sampling rationale</th>
<th>Well executed data collection</th>
<th>Analysis close to the data</th>
<th>Emergent theory related to the problem</th>
<th>Evidence of explicit reflexivity</th>
<th>Comprehensiveness of documentation</th>
<th>Negative case analysis</th>
<th>Clarity and coherence of the reporting</th>
<th>Evidence of researcher-participant negotiation</th>
<th>Transferable conclusions</th>
<th>Evidence of attention to ethical issues</th>
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</table>

Note: Low = 0-4; Medium = 5-8; High = 9-12
Appendix B2: Methodological quality (quantitative investigation research)

Scores: 1 indicate criterion met, 0.5 = partially met, 0 = not met.

<table>
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<th>Clear research question or hypothesis</th>
<th>Appropriate process for participant/item identification</th>
<th>Appropriate data gathering method used</th>
<th>Comprehensive data gathering method</th>
<th>Reduction of bias within participant recruitment/item selection</th>
<th>Response rate/item elicitation maximised</th>
<th>Population subgroup data collected (e.g., participant gender, item context)</th>
<th>Missing data analysis</th>
<th>Time trends identified</th>
<th>Geographic considerations</th>
<th>Appropriate statistical analyses (descriptive or inferential)</th>
<th>Multi-level or inter-group analyses present</th>
<th>Clear criteria for rating of findings</th>
<th>Limitations of the research considered in relation to initial aims</th>
<th>Implications of findings linked to rationale of research question</th>
<th>Total (/15)</th>
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<td>Rude, Gortner, &amp; Pennebaker (2004)</td>
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<td>1</td>
<td>11.5/15</td>
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</table>

Note: Low = 0-5; Medium = 6-10; High = 11-15
Appendix B3: Methodological appropriateness

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<th>Study</th>
<th>Study includes primary data of young people’s experiences of depression</th>
<th>Clearly defined participant sample</th>
<th>Clear protocols of participants’ involvement</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Danielsson et al. (2011)</td>
<td>0.5</td>
<td>0.5</td>
<td>0</td>
<td>Low</td>
</tr>
<tr>
<td>Issakainen (2015)</td>
<td>1</td>
<td>1</td>
<td>0.5</td>
<td>High</td>
</tr>
<tr>
<td>Issakainen and Hänninen (2015)</td>
<td>1</td>
<td>1</td>
<td>0.5</td>
<td>High</td>
</tr>
<tr>
<td>Kokanovic et al. (2013)</td>
<td>0</td>
<td>0.5</td>
<td>0</td>
<td>Low</td>
</tr>
<tr>
<td>Kotliar (2016)</td>
<td>0</td>
<td>0.5</td>
<td>0</td>
<td>Low</td>
</tr>
<tr>
<td>Rude, Gortner, &amp; Pennebarker (2004)</td>
<td>0</td>
<td>1</td>
<td>0.5</td>
<td>Low</td>
</tr>
<tr>
<td>Whitehill et al. (2013)</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>Medium</td>
</tr>
<tr>
<td>Wright et al. (2013)</td>
<td>0</td>
<td>1</td>
<td>0.5</td>
<td>Low</td>
</tr>
</tbody>
</table>

Note: Scores 0.5 = criterion partially met. Low = 0-1; Medium = 1.5-2; High = 2.5-3
Appendix B4: Focus of study – relevance to review questions

<table>
<thead>
<tr>
<th>Study</th>
<th>Study includes young people</th>
<th>Narrative accounts of depression</th>
<th>Unsolicited, genuine accounts</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Danielsson et al. (2011)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>High</td>
</tr>
<tr>
<td>Issakainen (2015)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>High</td>
</tr>
<tr>
<td>Issakainen and Hänninen (2015)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>High</td>
</tr>
<tr>
<td>Kokanovic et al. (2013)</td>
<td>Not specified = 0</td>
<td>1</td>
<td>0</td>
<td>Low</td>
</tr>
<tr>
<td>Kotliar (2016)</td>
<td>Not specified = 0</td>
<td>1</td>
<td>1</td>
<td>Medium</td>
</tr>
<tr>
<td>Rude, Gortner, &amp; Pennebarker (2004)</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>Medium</td>
</tr>
<tr>
<td>Whitehill et al. (2013)</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>Low</td>
</tr>
<tr>
<td>Wright et al. (2013)</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>Low</td>
</tr>
</tbody>
</table>

Note: Low = 0-1; Medium = 2; High = 3
### Appendix B5: Overall weight of evidence ratings

<table>
<thead>
<tr>
<th>Study</th>
<th>Methodological quality</th>
<th>Methodological appropriateness</th>
<th>Focus of study</th>
<th>Overall weight of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Danielsson et al. (2011)</td>
<td>High</td>
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</tr>
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<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Issakainen and Hänninen (2015)</td>
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<td>High</td>
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</tr>
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<td>Low</td>
<td>Low</td>
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<td>Kotliar (2016)</td>
<td>Medium</td>
<td>Low</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>Rude, Gortner, &amp; Pennebarker (2004)</td>
<td>Medium</td>
<td>Low</td>
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<td>Medium</td>
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<tr>
<td>Wright et al. (2013)</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
</tbody>
</table>
Appendix C

Appendix C1: Ethical approval and ethics forms
Appendix C2: Invitation to participate in the study poster
Appendix C3: Request for permission to carry out research
Appendix C4: Preliminary questions to establish participants’ eligibility
Appendix C5: Participant information sheet
Appendix C6: Participant consent form
Appendix C7: Distress protocol for participant
Appendix C8: Distress protocol for the researcher
Appendix C9: Interview guide and Participant debrief sheet with sources of support
Appendix C1: Ethical approval and ethics forms

Ref: ethics/15500

Mrs Dorota Martin c/o Dr Cathy Atkinson
School of Environment, Education and Development
Ellen Wilkinson Building A6.5
5th January 2016

Dear Mrs Martin

Study title: Student Own Experiences of Depression During Their School Years

Research Ethics Committee 2

I write to thank you and Dr Atkinson for coming to meet the Committee on 23rd November 2015. I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form and supporting documentation as submitted and approved by the Committee.

This approval is effective for a period of five years. If the project continues beyond that period an application for amendment must be submitted for review. Likewise, any proposed changes to the way the research is conducted must be approved via the amendment process (see below). Failure to do so could invalidate the insurance and constitute research misconduct.

You are reminded that, in accordance with University policy, any data carrying personal identifiers must be encrypted when not held on a secure university computer or kept securely as a hard copy in a location which is accessible only to those involved with the research.

Reporting Requirements:

You are required to report to us the following:

1. Amendments
2. Breaches and adverse events
3. Notification of Progress/End of the Study

Feedback

It is our aim to provide a timely and efficient service that ensures transparent, professional and proportionate ethical review of research with consistent outcomes, which is supported by clear, accessible guidance and training for applicants and committees. In order to assist us with our aim, we would be grateful if you would give your view of the service that you have received from us by completing a feedback sheet [https://survey.manchester.ac.uk/pssweb/index.php/739925/lanq-en]

We hope the research goes well.

Yours sincerely,

Ms. Genevieve Pridham
Secretary to University Research Ethics Committee 2
From: Genevieve Pridham  
Sent: 05 January 2016 08:52  
To: Cathy Atkinson; Sarah Willis  
Cc: dpak292@gmail.com; Dorota Martin; Alison Alborz  
Subject: Ethical Approval of Project: Martin: Student’ Own Experiences of Depression During Their School Years (Ref: 15500)

Dear Dr Atkinson and Mrs Martin,

I am pleased to confirm that your email of 15/12/2015 satisfies the points raised by the Committee and that the above project has a favourable ethical opinion on the basis described in the application form and supporting documentation as submitted and approved by the Committee.

Please find attached a letter confirming that your project now has ethical approval and ensure that you read the contents as the information has been updated. There is also a link to an anonymous feedback sheet that we would be grateful if you could complete.

Good luck with your project.

Best wishes,

Genevieve

Ms. Genevieve Pridham  
Secretary to University of Manchester Ethics Committees 2 and 6 | Research Governance, Ethics and Integrity Assistant | Directorate of Research and Business Engagement Support Services | Christie Building | University of Manchester | Oxford Road | Manchester M13 9PL  
Phone: 0161-275-2674 | Website: Research Governance, Ethics and Integrity | Twitter: @RGEIUoM
Application form for ethical approval of a research project by a
University Research Ethics Committee

The University Research Ethics Committees meet on a weekly basis between September and July each year. All applications must be submitted to your School/Institute Signatory by the end of June or it will not be considered until September. Please see here for the calendar of UREC meetings. The normal expectation is that your application will be reviewed in the third week after submission by the School/Institute Signatory. Please note that the School/Institute signatory process aims to take an average of 10 working days.

Guidance on completing the form

This form should be completed by the Principal Investigator(s). For student research, the Supervisor must provide guidance to the student on the application and sign off the form.

Guidance can be found by clicking on the links provided with some sections. Additionally, guidance can be found here.

The form must be completed succinctly and in plain, jargon-free English so that committee members, who may not be familiar with your academic discipline, are able to understand it.

Applicants are asked to forward all supporting papers in one document, preferably in a PDF format. Experience indicates that it is easy for separate documents to get misplaced as they are transferred from one office to another during the review process.

Submitting the form

Your form must be submitted to the UREC via your assigned School/Institute Signatory. Please see here for a list of current Signatories:

Checklist of documentation to include

Please DO NOT include CVs

√ Participant Information Sheet

√ Consent form

√ Letters to gatekeepers (i.e. those from whom permission is required such as employer or data custodian) if applicable

☐ Questionnaire (if using)

√ Interview/focus group schedule (if using)

√ Any advertisements/flyers/posters to be used

☐ Research Protocol (if applicable)*
Insurance Questions

Please answer the following questions. If in doubt, err on the side of caution and answer yes. If you answer yes to any of the questions below then your application, Participant Information Sheet and Consent form will be forwarded to the Insurance Office by the Research Governance, Ethics and Integrity team. For additional guidance for completing the Insurance Questions, please see here.

Title of Research: Students’ own experiences of depression during their school years

Principal investigator: Dorota Martin

School/Institute: Manchester Institute of Education

** Is any part of the research, or use of the protocol, to be carried out outside the UK (including internet-based research that could include respondents from abroad)?

Yes  No

** If yes, does the research also involve medical content?

No

Does the research involve “first into man” use of a medicinal product?

No

Do the research subjects deliberately include:

- pregnant women? No
- children aged five or under? No
- adults who lack the capacity to give informed consent? No

Does the research include medical intervention involving:

- investigating a medical device? No
- contraception? No

Is the research to be carried out by other organisations where the University is required by contract to provide insurance cover for the research if it proceeds?**

No

Signed (PI): [Signature] (9563168)

Date: 15/12/2015

**If you are unclear of the responsibilities please provide any contract conditions/agreements for review.

Signed: [Signature]  Date:

Insurance Office approval (not required if all answers above are ‘No’)

** Do you also need to obtain NHS R&D approval?

☐ Yes  ☒ No

** If yes, have you already contacted your University sponsor regarding NHS R&D approval?
1. Title of the research:

Students’ own experiences of depression during their school years

2. Investigator(s) (nb. In the case of postgraduate student applications the supervisor is always the joint investigator):

<table>
<thead>
<tr>
<th>Title</th>
<th>Student</th>
<th>Supervisor/Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs</td>
<td>Martin</td>
<td>Atkinson</td>
</tr>
<tr>
<td>Dr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First name</td>
<td>Dorota</td>
<td>Cathy</td>
</tr>
<tr>
<td>Post</td>
<td>Trainee Educational Psychologist</td>
<td>Curriculum Director for Doctorate in Educational and Child Psychology Programme</td>
</tr>
<tr>
<td>Qualifications</td>
<td>BSc, MBPsS</td>
<td>BSc, PGCE, MSc, DEdPsy, CPsychol</td>
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<td>School/Unit/Institute</td>
<td>Manchester Institute of Education School of Environment, Education and Development (SEED)</td>
<td>Manchester Institute of Education School of Environment, Education and Development (SEED)</td>
</tr>
<tr>
<td>Contact Address</td>
<td>Ellen Wilkinson Building Oxford Road Manchester M13 9PL</td>
<td>Ellen Wilkinson Building Oxford Road Manchester M13 9PL</td>
</tr>
<tr>
<td>Email address</td>
<td><a href="mailto:dpak292@gmail.com">dpak292@gmail.com</a></td>
<td><a href="mailto:Cathy.Atkinson@manchester.ac.uk">Cathy.Atkinson@manchester.ac.uk</a></td>
</tr>
<tr>
<td></td>
<td><a href="mailto:dorota.martin@postgrad.manchester.ac.uk">dorota.martin@postgrad.manchester.ac.uk</a></td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td>0781 571 32 56</td>
<td>0161 275 3511</td>
</tr>
</tbody>
</table>

3. School contact (if applicable): The School/Institute Signatory will receive a copy of the outcome of the ethical review. If the School wishes anyone else to receive a copy, the relevant details should be entered here.

Name: Georgia Irving
Post: Ethics Administrator
Email address: ethics.education@manchester.ac.uk

4. Is this study, or any part of this study a student project? Yes/No.

If Yes what degree is it for?

Doctorate in Educational and Child Psychology

5. Please provide the names and email addresses of any academic staff or students involved, other than those named at 2 above:

N/A
SECTION B – Details of Project

6. When will the data collection take place? (If your research will be conducted outside the UK borders, please specify the duration for each country)

Start date: on obtaining ethical approval in Winter 2015/2016
End date: February 2017

7. What is the principal research question?

- What is the lived experience of Higher Education students of depression?
- What did the students find particularly supportive in their educational experiences during living with depression?
- What are the students’ perceptions of facilitators and barriers to accessing support?

8. What is the academic justification for the research? (Must be in language comprehensible to a lay person)

Although there is some research with regard to mental health promotion, frameworks of practice and capacity building at schools, the majority of it is pre-recession and prior to changes in the UK government legislation, policies and guidance. Due to the expansion of the Educational Psychologist’s (EP’s) role to work with children and young people (YP) age range 0-25, there is a need to explore the role of the EP with the Higher Education sector (HE). As significant number of YP experience depression it is important for practitioners and EPs to understand what are YP’s experiences of depression and what they have found supportive in educational settings whilst managing their depression. Most of the research on YP living with depression has been carried out within a medical model, and the proposed research is one of the very few that attempts to gain YP’s perspective within the context of the EP practice. The proposed research will help to investigate the HE students’ perceptions (lived experiences) of depression during their school years, perceived barriers and facilitators to YP accessing appropriate support. Gaining a better insight and deeper understanding of the reality faced by YP, in wider context of their lives, will help to raise awareness amongst professionals working with YP about support, management of depression and will help to inform future research in the area of post-16 educational practice. The proposed study aims to focus on the University of Manchester students (UoM) as representatives from HE sector.

9. Give a brief summary of the design and methodology of the planned research. It should be clear exactly what will happen to the research participant, how many times and in what order.

Describe any involvement of research participants, participant groups or communities in the design of the research. (This section must be completed in language comprehensible to the lay person and should be no longer than half a page. A research protocol is NOT a substitute for information provided on the UREC form. The committee will only read it when the UREC form refers to specific sections which explain, illustrate or expand on the information contained in the form. PLEASE DO NOT ATTACH GRANT PROPOSALS)

Project Design: This research will propose a qualitative, retrospective phenomenological approach, exploring the lived experiences of HE students (UoM students) who were living with depression during their school years.

Sampling: Purposive sampling will be used to allow for coherency of the design, method and analysis. It is anticipated that three participants will be interviewed, each to complete the three-interview series. Only three participants to complete the three-interview series will be needed, however, in case of participants’ withdrawal (or not completing the three-interview round – as this will be also an indicator of participants’ withdrawal), it is possible that more participants may be recruited to fulfil the sampling and study design criteria. One person will be interviewed at the time with the view to complete the three interviews, before interviewing another participant. Participants will be recruited via public advertisement (poster, Appendix 2), displayed in HE (UoM) venue, with permission of the Head of the School (Appendix 1). They will be given email address, should they be interested to find out more about the proposed study. The researcher then will arrange a meeting/or telephone conversation with the
interested prospective participant to discuss their motivation to participate in the research and to check their suitability. The participants would be aged 18-25, students in HE who had experience of depression during their school years. During the meeting/telephone conversation following initial participants’ response to the poster, further screening questions will be asked (see Appendix 5) to establish prospective participants’ suitability for the study. In case the prospective participants are not suitable, they will be thanked for the interest and signposted to relevant sources of support, if this is established during the initial conversation with the researcher. After checking suitability and further interest in the participation, they will be given participant information sheet, consent form and interview schedule to read. The researcher then will contact the prospective participants after a period of two weeks, to answer any questions regarding the proposed research and to check if they would like to continue their involvement. If yes, they will return signed consent forms and the first of three interviews will be arranged.

**Data Collection Methods:** Individual, open-ended interviews. This will allow for obtaining idiographic data, unique to the person being interviewed and rich in descriptions. The advantage of open-ended interviews is that these will allow for more exploratory, in-depth investigation. The three-interview series (Seidman, 2013) will be used to allow for building rapport and time to reflect upon experiences. Participants will be fully briefed and debriefed after each of the interviews. The first interview will explore the participant focused life story, before they lived with depression and their schooling experiences in particular. The second interview will be asking participants to reconstruct what it was like to live with depression and to tell a story about one day in life when they were living with depression, from waking up to getting to bed/to falling asleep, what it was like to be at school then and what they found particularly helpful. The third interview will focus on present times, and participants’ reflections upon, and meaning-making of depression at present. The interviews will be spaced between 3 days up to a week apart (subject to participants’ availability), allowing for some reflection and time to build rapport with the researcher, whilst at the same time not taking over participants’ lives. Each interview will last between 60-90 minutes.

**Method(s) of Analysis:** The study will employ Interpretative Phenomenological Analysis (IPA) to analyse the interviews. The IPA will use double hermeneutics: that is researcher’s interpretation of the participants’ own meaning-making of depression. Each interview will be analysed separately before moving onto the next interview. The analysis will follow a set of steps including: data familiarisation, transcription, and generation of initial codes, identifying emergent themes, clustering the emergent themes into higher-order codes and then moving onto the next interview. When all steps are repeated for the next interview, a stage of identifying patterns / idiosyncrasies across both interviews will follow, presenting themes in a master table. The researcher’s role will be interpretative, analysing and conceptualising the themes, acknowledging her own role in this iterative process and keeping a reflective diary. Participants will be asked if they would like to see the transcripts, to clarify/amend any information during the data analysis. Participants will be also asked if they would like to see completed analysis, findings and/or final research report.

10. **How has the scientific quality of the research been assessed?** *(Tick all that apply)*

- [x] Internal review (e.g. involving colleagues, academic supervisor)
- [ ] Review within a multi-centre research group
- [ ] Independent external review
- [ ] Review within a commercial company
- [ ] None external to the investigator
- [ ] Other, e.g. in relation to methodological guidelines *(give details below)*

*If relevant, describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:*
11.1 Does the research involve the administration of any physically invasive procedures, physical testing or psychological intervention (apart from the administration of standard psychological tests)?

☐ Yes ☒ No

If No, proceed to 11.2 If Yes, please ensure you complete Section F

11.2 Does the research involve human blood or tissue samples? If you are unsure, please see here for guidance relating to HTA.

☐ Yes ☒ No

If No, proceed to 11.3

11.3 Does the research involve interviewing participants or focus groups?

☒ Yes ☐ No

If No, proceed to 11.4

If Yes, please describe briefly how they will be conducted

The interviews will be carried out individually, in a private and quiet space at the HE venue, at the time convenient to participants. The participants will give their informed written consent to take part in the research, and this will be checked on the day of the interview in form of their verbal consent. The participants will be given a schedule for the interview beforehand and they will have an opportunity to ask questions regarding the research. The participants will be reminded of their right to withdraw at any time, up to the point of data analysis. Each participant will be interviewed three times, with each interview lasting about 60-90 minutes. If the participant shows signs of any distress or upset, the interview will be stopped and the participant will be offered help/signposting to help. After the interview, the participant will be debriefed.

11.4 Does the research involve the administration of questionnaires?

☐ Yes ☒ No

If No, proceed to 11.5

If Yes, please describe the process of delivery and collection

11.5 Is statistical sampling relevant to this research?

☐ Yes ☒ No

If No, proceed to 11.6

If Yes, please answer the following questions:

11.5.1 Has the protocol submitted with this application been the subject of review by a statistician independent of the research team? Select one of the following:

☐ Yes – copy of review enclosed

☐ Yes - details of review available from the following individual or organisation (give contact details)

☐ No – justify below

11.5.2 If relevant, specify the statistical experimental design and why it was chosen.
11.6 If you are not using statistical sampling how was the number of participants decided upon?

Purposive sampling will be used to allow for coherency of the design, method and analysis. It is anticipated that three participants will be interviewed. The participants will be HE students, age 18-25, who meet the inclusion criteria for: having a history of medical treatment or psychological support/diagnosis of depression, their condition being stable for at least twelve months prior to their participation in the research, no history of suicidal behaviour and no communication needs (fluent English speakers), with access to ongoing/existing support network/group and no currently under care of any outside agency. The sample size is sufficient for carrying out qualitative IPA analysis, to understand what it is like to live with depression and attend school. As the participants will be interviewed three times each, this will also serve as validation of their accounts.

This number of participants will result in nine interviews, allowing for rich data and finding patterns/themes amongst the participants. The purpose of the research is to gain an understanding of unique experiences of the individuals, and not to produce universally generalisable results. The number is in line with the recommended IPA guidelines for professional doctorates (Smith, Flowers, & Larkin, 2009).

11.7 Describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

Qualitative analysis, using IPA – Interpretative Phenomenological Analysis. The IPA will use double hermeneutics: that is researcher's interpretation of the participants’ own meaning-making. Each interview will be analysed separately before moving onto the next interview. The analysis will follow a set of steps including: data familiarisation, transcription, and generation of initial codes, identifying emergent themes, clustering the emergent themes into higher-order codes and then moving onto the next interview. When all steps are repeated for the next interview, a stage of identifying patterns / idiosyncrasies across both interviews will follow, presenting themes in a master table. The researcher's role will be interpretative, analysing and conceptualising the themes, acknowledging her own role in this iterative process and keeping a reflexive diary.

12.1 What do you consider to be the main ethical issues which may arise with the proposed study?

Potential sensitivity of the topic. There is a small chance of participants becoming upset. This will be monitored during the interviews, and if a participant shows any sign of upset or distress I would pause or terminate the study (please see the distress policy, Appendix 7 and answer to question 29.2) as appropriate and offer signposting to support, if needed.

The nature of the research (design, methodology, data collection and analysis), issues of confidentiality and anonymity will be explained on the participant information sheet, prior to undertaking the research. This will be also discussed on the day of the data collection, and participants will be debriefed after the interviews. They will be informed about their right to withdraw and if that was the chosen option, that their data will be securely destroyed.

The participants will be giving up their valuable free time. The researcher will try to alleviate this by arranging the interviews at the time/place most convenient for the participants.

Avoiding coercion - All participants will be taking part voluntarily and will be fully informed about the study and their right to withdraw without any consequences and without the need to explain why they would like to withdraw.

Venue for interviews – at a Higher Education Institution, ensuring a quiet, private and safe place to carry out the interviews. Alternatively, should finding a place proves to be difficult, I will ask for permission to use learner’s support room.

My position as a researcher. I do not anticipate to work at any HEIs involved in the research as a Trainee Educational Psychologist at the time of data collection (i.e. the research will not involve University of
Manchester students), therefore the duality of the role and any potential ethical issues arising from this are not applicable.

12.2 What steps will be taken to address the issues raised in question 12.1?

Please see the answers to 12.1 (above).

12.3 What qualifications/experience do the researchers have relevant to the conducting of this research? (For details about requirements for specific types of research click here)

I am currently in my second year of initial doctoral training as a Trainee Educational Psychologist. As part of the training, I have attended the relevant methodology seminars. Prior to this, I have completed my undergraduate dissertation in 2013, exploring the lived experiences of parent carers of disabled children/young people with regard to person-centred planning, support and quality of life. My dissertation design and methodology used Interpretative Phenomenological Analysis (IPA) and open-ended, semi-structured interviews.

During my first year of the doctoral training, I have carried out a pilot study exploring lived experiences of professionals working with post-16 learners with mental health needs, using IPA. I feel that this have prepared me well for undertaking another IPA study and getting to know the methodology well.

My doctoral research includes training in counselling and therapeutic interventions, and I have completed casework with children and young people whilst on placements within North West Local Authorities.

13. Has this or a similar application been previously considered by a Research Ethics Committee in the UK, the European Union or the European Economic Area?

- Yes
- No

If Yes give details of each application considered, including:

Name of Research Ethics Committee or regulatory authority:
Decision and date taken:
Research ethics committee reference number:

SECTION C – Details of participants

14. How many participants will be recruited? (If there is more than one group, state how many participants will be recruited in each group. For international studies, say how many participants will be recruited in each country and in total. Please ensure you clearly state the total number of participants)

Three

15. Age range of participants:

18-25

16. What are the principal inclusion criteria for participants? (Please justify)

Students in HE, age range 18-25, who experienced depression in the past, during their schooling, and who have had period of stability of condition for at least past twelve months, managing/overcoming their depression. They should not have history of suicidal behaviour, not undergoing major changes in their lives (other than attending university). They should have an ongoing access to support group/support
network, for example, accessing support group/counselling service/HE pastoral support with no outside agencies’ involvement.

Fluent English speakers, with no communication needs (other than written communication needs), to be able to reflect back on their experiences of depression and impact on schooling.

17. **What are the principal exclusion criteria for participants? (Please justify)**

As opposed to response provided to answer 16. History of suicidal behaviour, unstable condition and undergoing major changes in their lives. Involvement of outside agencies, other than attending support groups/having access to support network, etc.

18.1 **Will the participants be from any of the following groups? (Tick all that apply)**

- Adult healthy volunteers (i.e. not under medical care for a condition which is directly relevant to the application)
- Children under 16
- Adults with learning difficulties
- Adults who have a terminal illness
- Adults with mental illness (particularly if detained under mental health legislation)
- Adults with dementia
- Adults in care homes
- Adults or children in emergency situations
- Prisoners
- Young offenders
- Those who could be considered to have a particularly dependent relationship with the researcher, e.g. students taught or examined by the researcher.
- Other vulnerable groups

**Please note:** If an adult participant is not able to give informed consent (e.g. through mental capacity or is unconscious) or if a prisoner or young offender is involved in health related research ethical review should be undertaken by an appropriate NHS Research Ethics Committee.

18.2 **If you will be using participants other than healthy volunteers please justify their inclusion:**

The study aims to explore students’ lived experiences of depression. That means the inclusion criteria for participants will be to have experience of managing or overcoming depression. If the participants are still managing the depression and their condition has been stable for at least past twelve months, they had no history of suicidal behaviour, they can still participate in the study. It would not be realistic to ask healthy individuals who never experienced mental health difficulties to talk about their experiences of depression. Conversely, healthy individuals at the present might have experienced depression in the past, hence meeting the inclusion criteria.

19. **How will the potential participants be identified, approached and recruited? (Where research participants will be recruited via advertisement, please append a copy to this application)**

Please see the appended advertisement poster (Appendix 2). Initially, the participants will be self-selected from a public advertisement poster, displayed at HE venues. They will be requested to email the researcher, who on receipt of the email, will arrange to contact participants with further information and to check inclusion criteria. Should the potential participants meet the inclusion criteria (see above), they will meet with the researcher who will give them information about the study, consent forms, interview guides to read and then they could decide about taking part in the study (Appendices 3–6).

20. **Will individual research participants receive reimbursement of expenses or any other incentives or benefits for taking part in this research?**

- Yes
- No
As participants will be giving up their valuable time on three different occasions as a way of thank you, a £20 Amazon voucher will be offered to participants who will complete all three interview rounds. The value of the voucher will not be disclosed on the poster (as this can be seen as coercion).

21. What is the expected total duration of participation in the study for each participant? For ethnographic research focussing on one or more groups rather than individual participants, indicate the approximate period of time over which research will focus on particular groups.

Each participant will be interviewed three times, and the interviews may be spaced between 3 days and a week apart. On average, total duration of participation in the study for each participant will be 3 weeks (up to a month).

22. What is the potential benefit to research participants?

Feeling listened to without being judged. Being able to tell about and share own perceptions and experiences. The participants’ stories will give an insight into lived experiences and perceptions of YP with depression. They will be contributing to research and to others’ understanding of depression. This may potentially increase awareness and further understanding of issues the practitioners face whilst working with YP.

23. Will any benefit or assistance, which the participant would normally have access to, be withheld as part of the research?

☐ Yes ☒ No

(If yes, give details and justification)

SECTION D – Consent

24.1 Will informed consent be obtained from the research participants?

☒ Yes ☐ No

If Yes, give details of how consent will be obtained. Give details of your experience in taking consent and of any particular steps to provide information to participants before the study takes place eg information sheet, videos, interactive material.

If participants are recruited from any of the potentially vulnerable groups listed in Question 19.1, give details of extra steps taken to assure their protection. Describe any arrangements to be made for obtaining consent from a legal representative.

If consent is not to be obtained, please explain why not.

Yes, the consent will be obtained in both written and verbal form. The participants will be fully informed about the study, given information sheets, interview guides/debrief sheet and would have an opportunity to ask any questions regarding the study. Please see the appended consent forms and participant information (Appendices 3-6). To ensure additional protection of the participants, a plan of action in case of participant getting upset/distressed will be also discussed prior to taking part in the interview, to enable the participant fully informed consent. See Appendix 7 for a distress policy.

The researcher has experience in seeking informed consent from participants during her undergraduate studies, and during her current doctoral training where she carried out a pilot study to the proposed thesis research.

24.2 Will a signed record of consent be obtained?

☒ Yes ☐ No
Please find the appended consent form (Appendix 4).

25. How long will the participant have to decide whether to take part in the research? (If less than 24 hours please justify)

The participant will have time to read information, consent forms, interview guides and will have the opportunity to ask any questions regarding the research two weeks prior to making her/his decision whether or not to take part in the research.

26. What arrangements have been made for participants who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? (e.g. translation, use of interpreters etc.)

Due to the nature of the research, interested participants with communication needs will be excluded from taking part in the research.

The participants will be given the appropriately worded information prior to the study. They will be also given the opportunity to receive the information (information sheet, consent form, interview guide) in an alternative format (large fonts, coloured paper and other media).

SECTION E – RISKS AND SAFEGUARDS

27. Activities to be undertaken (This should be in the form of a brief list, such as answering a questionnaire, being interviewed)

Responding to an invitation to research poster, asking questions about research, taking part in three individual, face-to-face interviews.

28. Where will the research/data collection take place?

Higher Education venue (The University of Manchester)

29.1 What are the potential adverse effects, risks or hazards for research participants, including potential for pain, discomfort, distress, inconvenience or changes to lifestyle for research participants? Are they any greater than those that would arise from normal social interaction?

The participants will be giving up their valuable free time. The researcher will try to alleviate this by arranging the interviews at the time/place most convenient for the participants.

Change of normal routine – the participants will be giving up their free time to take part in the proposed study. This may involve cancelling some appointments/ or missing on a physical activity. The researcher will try to alleviate this by arranging the interviews at the time/place most convenient for the participants.

29.2 Could individual or group interviews/questionnaires raise any topics or issues that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could take place during the study (e.g. in the application of screening tests for drugs)?

☒ Yes ☐ No

If yes, provide your distress policy/give details of procedures in place to deal with these issues:

There is a small chance that the interviews may cause upset to the participants due to the sensitive nature of the proposed study. The participants may want to share some of their experiences they have not dealt with well and may feel they were not supported/not prepared for. The risk of bringing in difficult feelings and emotions during interview will be discussed. The participants will be given interview guide, to
prepare themselves/assess if they could proceed with the study, together with debrief information about additional sources of support (Samaritans helpline, Mind infoline). Please see appended Interview Guides and Debrief Sheet (Appendix 6).

The likelihood of being distressed and an action plan what to do in case of distress will be also discussed with the participants prior to commencing the study (see Appendix 7 for distress policy, cf. Hunter, 2011).

Should the participants become upset it would be checked with them if they need a break or they would like to withdraw from the study. Prior to the interviews, the participants will be asked what they would like to happen in the event they are upset/distressed during/after any of the interviews. An action plan will be agreed with the participant and depending on the level of the distress; the following will be offered/discussed:

If the event of distress, the researcher will ask the participants if they would like to have a break or stop the interview (Cowles, 1988). Should any additional advice be required, the supervisor will be contacted as appropriate.

In the event of distress the researcher will endeavour to stay with the participant until s/he feel better or the participant’s preferred trusted person/agency/GP will be contacted/or meet them, using a tiered approach, including:

- Friends/family
- GP
- Key worker/ or counsellor (As the research is intended to take place at a HE venue, there should be an access to learner/pastoral support in situ. This will be also checked by the researcher prior to meeting with the participant, to enable swift response, should that be needed).
- a mental health professional

The participant will be given time to reflect after the interview to say how s/he feel and will be given the researcher’s contact details, together with a list of useful contacts at the end of the interview. The researcher will ask if there is a need for any further support, checking if the participant would like to continue with the second/third interview or not. The researcher’s supervisor will be informed and kept up to date about any difficulties arising during /after the interviews.

29.3 What precautions have been taken to minimise or mitigate the risks identified above?

The participants will be ensured about their right to withdraw, to ask for a break/to shorten the interview. They will be assured that their data will be fully anonymised but their right to confidentiality may be withdrawn in case of child protection issues. See also 29.2 above on the steps taken to minimise the risks and distress policy (also Appendix 7). The participants will be debriefed and signposted to appropriate sources of support, if needed (see also Appendix 6).

30.1 What is the potential for adverse effects, risks or hazards, pain, discomfort, distress, or inconvenience to the researchers themselves? (If any)

Fieldwork risk assessment has been carried out and no risks were identified as there are no plans to carry out the interviews off UoM premises (please see Research Risk and Ethics Assessment Form in Appendix 9). Due to the sensitive nature of the interview, the researcher may feel uncomfortable/upset but this could be discussed/addressed during supervision with the University Tutor. A protocol for dealing with the researcher’s distress has been appended (Distress policy for the researcher in Appendix 8). The researcher may be dealing with participants’ distress (Distress policy for the participant in Appendix 7). Please see also answer to question 30.2.
30.2 What precautions have been taken to minimise or mitigate the risks identified above? (If the research means working alone in a location which is not public, semi-public or otherwise risk-free, please describe your lone worker policy or append a copy)

The interviews will be conducted in core office time and whenever possible, in the familiar UoM building (Ellen Wilkinson Building) where staff resources for supporting the researcher in the event of any issues arising will be available. The researcher will make sure there will be people around to support her/link with the office in case of any participant distress to manage that situation.

Any difficult feelings that would emerge for the researcher during her work could be discussed during regular supervision sessions with the University Tutor (see also Appendix 8 for distress policy for the researcher). In addition, the researcher practises mindfulness as a way of relaxation and keeping well.

31. ☒ I confirm that any adverse event requiring a radical change of method or design, or even abandonment of the research, will be reported to the Committee.

SECTION F – MEDICAL INTERVENTION

This section need only be completed by applicants whose project involves any form of medical or other therapeutic intervention or any physically invasive procedures, physical testing or psychological intervention (apart from the administration of standard psychological tests) (i.e. you answered 'Yes' to question 12.1)

32. Drugs and other substances to be administered (if applicable)

Indicate status, eg full product licence, CTC, CTX. Attach: evidence of status of any unlicensed product; and Martindales Pharmacopoeia details for licensed products

<table>
<thead>
<tr>
<th>DRUG</th>
<th>STATUS</th>
<th>DOSAGE/FREQUENCY/ROUTE</th>
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</table>

33. Procedures to be undertaken

Details of any invasive procedures, and any samples or measurements to be taken. and/or any psychological tests etc. What is the experience of those administering the procedures?

34. Will any procedures which are normally undertaken be withheld?

35.1 Will the research participants’ General Practitioner be informed that they are taking part in the study?

☐ Yes ☐ No

If No, explain why not

35.2 If you answered yes to question 35.1, will permission be sought from the research participants to inform their GP before this is done?

☐ Yes ☐ No
36. What are the criteria for electively stopping research prematurely?

SECTION G – Data protection and confidentiality

37.1. Will the research involve any of the following activities at any stage (including identification of potential research participants)? (Tick all that apply)

- Storage of personal data on any of the following:
  - Storage of personal data on manual files
  - Storage of personal data on laptops or other personal computers
  - Storage of personal data on University computers
  - Storage of personal data on NHS computers
  - Storage of personal data on private company computers
  - Use of audio/visual recording devices
  - Use of personal addresses, postcodes, faxes, e-mails or telephone numbers
  - Electronic transfer by magnetic or optical media, e-mail or computer networks
  - Examination of medical records by those outside the NHS, or within the NHS by those who would not normally have access
  - Sharing of data with other organisations
  - Export of data outside the European Union
  - Publication of direct quotations from respondents
  - Publication of data that might allow identification of individuals

37.2 Please provide details of how you plan to store and protect the study data as stated in 37.1 above.

The data will be fairly and lawfully processed, in line with the Data Protection Act and University Data Protection Policy (UDPP). The data will be processed for limited purposes as outlined in this application and only used in the way(s) for which consent has been given. It will be adequate for the purpose, relevant and not excessive, accurate and not kept longer than necessary. The data will be processed in accordance with the participant’s rights, only transferred to other settings if stored on an encrypted storage device. The publication of direct quotation from respondents will be anonymised and participants will be given pseudonyms to protect their identities.

My data and its storage will comply with the UDPP. The researcher will transcribe the interviews herself on an encrypted laptop. All data will be transferred to the researcher’s P drive or a secure UoM drive (and not stored on the laptop). Paper copies of data and encrypted storage devices will be stored in a locked draw or cupboard. On completion of my research, the data will be passed to my supervisor for archiving at the University for a period of 5 years after which it will be shredded/destroyed.
38. What measures have been put in place to ensure confidentiality of personal data? Give details of what encryption or other anonymisation procedures will be used and at what stage? Note: the University requires all personal data stored electronically to be held on wholly managed University servers or to be encrypted.

The participants’ personal information and the electronic files will be encrypted/password protected in a password protected laptop and the encrypted USB pen. The USB pen will not be used for long-term storage, the data will be transferred to the researcher’s P drive or a secure UoM drive. The data will be fully anonymised during transcription, analysis and reporting, to protect identity of the individuals/organisations. Audio recordings will be stored in a secured location (locked cabinet) and destroyed when no longer needed. All data will be destroyed when no longer needed for research, in line with the University requirements and guidelines. Please see also response to question 37 above.

39. Where will the analysis of the data from the study take place and by whom will it be undertaken?

The analysis of the data will be carried out by the researcher herself, at home or at the University. Initially, all analysis will be at the researcher’s home (access to private and safe place, with lockable cabinet to protect the data and with no unauthorised access to the data and analysis). This could be a pen and paper method or, in the later stage of the analysis, an encrypted laptop will be used (with possible use of Nvivo, data management software licensed for use by the UoM). Some of the transcripts with the handwritten notes/post it notes of the themes may be shown to the supervisor at the University to discuss the progress and to ensure transparency, validity and trustworthiness of the analysis.

40.1 Who will control and act as the custodian for the data? Note: for a student project this must be a supervisor or a permanent member of staff

Dr Cathy Atkinson, the researcher’s supervisor, will be the custodian of the data. The researcher will control the data.

40.2 Who will have access to the data and where are they based?

The student researcher will have access to the study data.

The student’s supervisor will have access to anonymised data.

40.3 Will the data be stored for use in future studies? If yes, has this been addressed in the consent process?

No.

41. For how long will the data from the study be stored?

5 Years

Note: the University requires non-medical data to be held for a minimum of 5 years and medical data to be held for a minimum of 10 years after the completion of the research. Some funding bodies require storage for longer periods.

42. What arrangements are in place to ensure participants receive any information that becomes available during the course of the research that may be relevant to their continued participation?

Should any information come to light that would be relevant to participants involvement with the study, this will be discussed with the participants to enable them to make informed decision. Should any information becomes available during the course of the research (for example, disclosure of intended harm) the study will be terminated and participants will be offered help. This will be also discussed with the University supervisor.
43. What arrangements are in place for monitoring the conduct of the research by parties other than the researcher?

The researcher’s supervisor will monitor the research.

Will a data monitoring committee be convened?

☐ Yes
☒ Not relevant

SECTION H – Conflict of Interest

44.1 Will individual researchers receive any personal payment over and above normal salary and reimbursement of expenses for undertaking this research?

☐ Yes  ☒ No

If Yes, indicate how much and on what basis this has been decided:

44.2 Does the principal researcher or any other investigator/collaborator have any direct personal involvement (e.g. financial, share-holding, personal relationship etc.) in the organisation sponsoring or funding the research that may give rise to a possible conflict of interest?

☐ Yes  ☒ No

If Yes, give details:

45. Will the host organisation or the researcher’s department(s) or institution(s) receive any payment of benefits in excess of the costs of undertaking the research?

☐ Yes  ☒ No

If Yes, give details:

SECTION I - Reporting Arrangements

46. How is it intended the results of the study will be reported and disseminated?

(Tick as appropriate)

☒ Peer reviewed academic journals
☐ Book or contribution to a book
☐ Other published outlets e.g. ESRC or Cochrane Review,
☒ Thesis/dissertation
☒ Conference presentation
☒ Internal report
☒ Other e.g. deposition in University Library

47. How will the results of research be made available to research participants and communities from which they are drawn?
48.1 Will dissemination allow identification of individual participants?

☐ Yes ☒ No

If No, proceed to 49

If Yes, indicate how these individuals’ consent will be obtained:

48.2 Will dissemination involve publication of extended direct quotations from identified participants and/or distribution of audiovisual media in which identified participants play leading roles?

☐ Yes ☒ No

If No, proceed to 49

If Yes, indicate how the participants’ possible Intellectual Property or Performance Rights in these outputs will be negotiated. Where relevant, attach a model of the release form that will be used.

48.3 Are special arrangements needed to provide indemnity and/or compensation in the event of a claim by, or on behalf of, participants on grounds such as libel, breach of confidence and infringement of Intellectual Property or Performance Rights?

☒ NO

SECTION J – Funding

49. Has external funding for the research been secured?

☐ Yes ☒ No

If Yes, give details of funding organisation(s) and amount secured and duration:

Organisation:

UK contact:

Amount (£):

Duration: Months

SECTION K – Confirmation of Application

Note: Student applications must also be signed by their supervisor

Signature(s) of applicant(s):
DOROTA IWONA MARTIN
TRAINEE EDUCATIONAL PSYCHOLOGIST

NAME AND POST OF APPLICANT (PLEASE PRINT)

Signature of supervisor (if applicable):

15.12.15

SIGNATURE (Electronic signature is required)

NAME AND POST OF SUPERVISOR (PLEASE PRINT)

Dr Cathy Atkinson, Curriculum Director, Doctorate in Educational and Child Psychologist

Please note: Once complete, please submit this application form and ALL supporting documentation to your signatory for review. Please DO NOT send directly to Research.Ethics@manchester.ac.uk or your application will be returned to you.
The Manchester Institute of Education is committed to developing and supporting the highest standards of research in education and its associated fields. The Research Risk and Ethics Assessment (RREA) resource has been created in order to maintain these high academic standards and associated codes of good research practice. The research portfolio within the Manchester Institute of Education (MIE) covers a wide range of fields and perspectives. Research within each of these areas places responsibilities of a differing nature on supervisors and students subject to course, level, focus and participants. The aim of the Research Risk and Ethics Assessment is to assist supervisors and students in assessing these factors.

The Manchester Institute of Education has determined three levels of Research Risk each of which has a number of associated criteria and have implications for the degree of ethical review required. In general, the research risk level is considered to be:

- **High** IF the research focuses on groups within society in need of special support, or where it may be non-standard, or if there is a possibility the research may be contentious in one or more ways.
- **Medium** IF the research follows standard procedures and established research methodologies and is considered non-contentious.
- **Low** IF the research is of a routine nature and is considered non-contentious.

The form guides you in assessing the research against each of these risk levels in turn. Agreement to proceed with research at each of these levels is provided by an appropriate University Research Ethics Committee, a MIE Research Integrity Committee member, or by the supervisor/tutor respectively.

**How to complete the Research Risk and Ethics Assessment (RREA) form.**

This form should be completed, in consultation with the MIE Ethical Practice Policy Guidelines, by Manchester Institute of Education students and their supervisors in all cases, except where a pre-approved assignment template currently exists. A separate Fieldwork Risk Assessment (FRA) form must be completed if you will be making fieldwork visits but are not able to agree with ALL the criteria in the LOW Risk Fieldwork Statement (Section C). This is so you can plan how safety issues will be responded to during fieldwork visits. The FRA

---

1 A reasonable person would agree that the study includes no issues of public or private objection, or of a sensitive nature.
2 [http://www.seed.manchester.ac.uk/studentintranet/miestudenthome/integrityethics/](http://www.seed.manchester.ac.uk/studentintranet/miestudenthome/integrityethics/)
3 For courses with approved templates see: [http://www.seed.manchester.ac.uk/studentintranet/miestudenthome/integrityethics/](http://www.seed.manchester.ac.uk/studentintranet/miestudenthome/integrityethics/)

144
form is available on the MIE ethics intranet. Instructions on this and subsequent stages of the RREA process are provided within each of the following sections.

**ANY student**

- Section A – Summary of Research Proposal (page 1)
- Section B – Description of Research (page 2)
- Section C – LOW risk Fieldwork Declaration (page 3)
- Sections D.0-D.1 – Criteria for HIGH risk research (page 6)
- Section D.2 – Criteria for MEDIUM risk research (page 7)
- Section D.3 – Criteria for LOW risk research (page 8)

**LOW Risk UG / PGT / Doctorate Pilot studies/Research Papers only**

- Section E.1 – Criteria for LOW risk ethical approval (page 10)

**Supervisors and tutor approvals of LOW risk student research**

- Section E.2 – Supervisor confirmation that research matches LOW risk criteria (page 11)

**Minor amendments to MEDIUM OR LOW risk approvals**

- Section F.1 – Minor Amendments to MEDIUM OR LOW risk approvals (page 12)

It may be appropriate for supervisors and students to review and discuss responses to these questions together from the outset.
### SECTION A - SUMMARY OF RESEARCH PROPOSAL

This section should be completed by the person undertaking the research.

<table>
<thead>
<tr>
<th>A1. Name of Person/Student:</th>
<th>Dorota Iwona Martin</th>
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<tbody>
<tr>
<td>A2. Student ID (quoted on library/swipe card):</td>
<td>9563168</td>
</tr>
</tbody>
</table>
| **A3. Email Address:** | dpak292@gmail.com  
dorota.martin@postgrad.manchester.ac.uk |
| A4. Name of Supervisor: | Dr Cathy Atkinson |
| **A5. Supervisor email address:** | Cathy.Atkinson@manchester.ac.uk |
| A6. Programme (e.g. PhD, MEd, MSc, PGCE, BA etc): | ProfDoc |
| A7. Year of Study | 2 |
| A8. Full/Part-time | Full time |
| A9. Course Code/Study type (tick) | EDUC / D.Ed.Ch.Psychol  
\(\checkmark\) |
| A10. Title of Project: | Students' own experiences of depression during their school years |
| A11. Project Submission Date: | 01/06/2017 |
| A12. Fieldwork visit dates | **Start Date:** on confirmation of ethical approval  
**Completion Date:** by February 2017 |
| A13. Geographic location(s) where | Higher Education Universities |
the project will be carried out:

<table>
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<tr>
<th>A14. Student Signature:</th>
<th>Dorota Martin</th>
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<tr>
<th>A15. Assessed Risk Level</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
<th>HRA reqd.</th>
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<th>A16. Supervisor Signature</th>
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<th>A17. Date</th>
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The following section to be completed by the SUPERVISOR

**SECTION B – DESCRIPTION OF RESEARCH**

This section should be completed by the person undertaking the research.

**B1.** Provide an outline description of the planned research (250 words max).
Principal Research Question(s):

- What is the lived experience of Higher Education students of depression?
- What did the students find particularly supportive in their educational experiences during living with depression?
- What are the students’ perceptions of facilitators and barriers to accessing support?

Academic justification: Although there is some research with regard to mental health promotion, frameworks of practice and capacity building at schools, the majority of it is pre-recession and prior to changes in the UK government legislation, policies and guidance. Due to the expansion of the Educational Psychologist’s (EP’s) role to work with children and young people (YP) age range 0-25, there is a need to explore the role of the EP within the Higher Education sector (HE). As significant number of YP experience depression it is important for practitioners and EPs to understand what are YP’s experiences of depression and what they have found supportive in educational settings whilst managing the depression. Most of the research on YP living with depression has been carried out within a medical model, and the proposed research is one of the very few that attempts to gain YP’s perspective within the context of the EP practice. The proposed research will help to investigate the HE students’ perceptions (lived experiences) of depression during their school years, perceived barriers and facilitators to YP accessing appropriate support. Gaining a better insight and deeper understanding of the reality faced by YP, in wider context of their lives will help to raise awareness amongst professionals working with YP about support, management of depression and will help to inform future research in the area of post-16 educational practice.

B2. The principal research methods and methodologies are (250 words max):

Project Design: This research will propose a qualitative, retrospective phenomenological approach, exploring the lived experiences of HE students who were living with depression during their school years.

Data Collection Methods: Individual, open-ended interviews. This will allow for obtaining idiographic data, unique to the person being interviewed and rich in descriptions. The advantage of open-ended interviews is that these will allow for more exploratory, in-depth investigation. The three-interview series (Seidman, 2013) will be used to allow for building rapport and time to reflect upon experiences.

Sampling: Purposive sampling will be used to allow for coherency of the design, method and analysis. It is anticipated that three participants will be interviewed.

Method(s) of Analysis: The study will employ Interpretative Phenomenological Analysis (IPA) to analyse the interviews. The IPA will use double hermeneutics: that is researcher’s interpretation of the participants’ own meaning-making. Each interview will be analysed separately before moving onto the next interview. The analysis will follow a set of steps, including: data familiarisation, transcription, and generation of initial codes, identifying emergent themes, clustering the emergent themes into higher-order codes and then moving onto the next interview. When all steps are repeated for the next interview, a stage of identifying patterns / idiosyncrasies across both
NB: If your research methods include collection of image or video data, you must complete the Video And Still image REsearch (VASTRE) document (regardless of research risk). See http://www.seed.manchester.ac.uk/studentintranet/miestudenthome/integrityethics/stillimageresearch/

B3. Please indicate which of the following groups are expected to participate in this research:

- [ ] Children under 16, other than those in school, youth club, or other accredited organisations.
- [ ] Adults with learning difficulties, other than those in familiar, supportive\(^4\) environments.
- [ ] Adults who are unable to self-consent
- [ ] Adults with mental illness/terminal illness/dementia/residential care home
- [ ] Adults or children in emergency situations
- [ ] Those who could be considered to have a particularly dependent relationship with the researcher
- [ ] Prisoners

\(^4\) The person with learning difficulties has appropriate support within the setting from accredited support workers or family members.
Young Offenders

Other vulnerable groups (please detail) Students who have experienced depression (received medical or psychological treatment/clinical diagnosis of depression) and are managing/overcoming depression, with no history of suicidal behaviour. Their condition should be stable for at least 12 months prior to engaging in the research and they should have access to ongoing support network/group, for example, learning support/counselling/other support. Current involvement from outside agencies would be exclusion criterion.

OR

None of the above groups are involved in this study

B4. Total number of expected research participants.

Number of different participant groups

(e.g. Teacher, parents, pupils = 3 groups requiring differentiated information/consent sheets)

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<thead>
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<th>Number of different participant groups</th>
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B5. The research will take place (tick all that apply):

<table>
<thead>
<tr>
<th>The research will take place (tick all that apply)</th>
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<tbody>
<tr>
<td>within the UK</td>
</tr>
<tr>
<td>within the researcher’s home’s country if outside the UK</td>
</tr>
<tr>
<td>wholly or partly outside the UK and not in the home country of the researcher*</td>
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</table>

* You must complete a separate Fieldwork Risk Assessment form

C. LOW Risk Fieldwork Statement and Declaration

If you are making fieldwork visits, BUT CANNOT TICK ALL the low risk fieldwork criteria in the Statement below, YOU MUST COMPLETE THE SEPARATE FIELDWORK RISK ASSESSMENT (FRA) FORM.

C.1 Fieldwork visits* (If you will not make any fieldwork visits, tick the alternative items in C.2)

Fieldwork Statement

5 The researcher’s ‘home country’ is defined as one in which (1) the researcher holds a current passport through birthright or foreign birth registration, (2) a country where the researcher has resident status, or (3) where the researcher holds a permit or visa to work, has a contract of employment, and is not a UK tax-payer.

6 Fieldwork visits involve travel to research locations off campus to collect data.
I confirm:

- I will not travel outside the UK or my home nation.
- I will not visit any country where the Foreign and Commonwealth Office has issued a warning against travel.\(^7\)
- The fieldwork does not require overnight stays in hotels or other types of public temporary accommodation.
- Public and private travel to and from the research location(s) are familiar to me and offer no discernable risk.
- I will not travel through, or work in research locations which have known hazards to health or safety such as unlit areas, derelict areas, cliffs, or local endemic diseases.
- I will carry only necessary personal items when travelling to, and within, research locations.
- No specific vaccinations are required / I have had specific vaccinations required to undertake this research.
- First aid provision and a trained first aider are available where appropriate.
- I will only operate machinery / electrical equipment / workplace vehicles, or handle / work with animals, at the research location(s) where I have clear competence to do so / will be under close supervision from a qualified person.
- The fieldwork will be carried out within normal working hours\(^8\) at a time convenient to participants.
- I will not give out personal telephone information to participants, or owners of secondary data resources, in relation to the research project.
- I am fully aware of, and sensitive to cultural and religious practices of participant groups, and will act accordingly.
- This research will not involve fieldwork visits to private homes, other than to those of friends or relatives.
- This research will not involve fieldwork visits to organisations’ premises, other than those with which I have an existing established relationship through placement, employment or volunteering.
- I will provide a regularly updated fieldwork visit schedule to a nominated University contact, unless visits only involve travel to the homes of friends or relatives.
- I will carry a Manchester Institute of Education Emergency Contact Information Card during all fieldwork visits, unless visits only involve travel to the homes of friends or relatives.

---


\(^8\) For example, in the UK normal working hours are between 8am and 6pm Mon-Fri inclusive.
C.2 No Fieldwork visits

☐ this research does not involve fieldwork visits of any kind

☐ I will not give out personal telephone information to participants, or owners of secondary data resources, in relation to the research project

Fieldwork Statement
I confirm:
**LOW Risk Fieldwork Declaration:**

Students and Supervisors please complete C.3 / C.4 respectively

<table>
<thead>
<tr>
<th>C.3 Student Declaration:</th>
</tr>
</thead>
<tbody>
<tr>
<td>By signing this declaration, I declare that the completed statement above is accurate to the best of my knowledge and that I will complete any actions that I have indicated I will complete.</td>
</tr>
<tr>
<td>Signature:</td>
</tr>
<tr>
<td>DOROTA MARTIN</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C.4 Supervisor Declaration:</th>
</tr>
</thead>
<tbody>
<tr>
<td>By signing this declaration, I confirm that I have reviewed the health and safety aspects of this research with this student and that the completed statement above is accurate to the best of my knowledge.</td>
</tr>
<tr>
<td>Signature:</td>
</tr>
<tr>
<td>Name (in capitals):</td>
</tr>
</tbody>
</table>
### SECTION D – RESEARCH RISK ASSESSMENT

The following sections should be completed by the person undertaking the research in discussion with their supervisor/tutor.

#### D.0 – Criteria for research classified as **HIGH RISK** – Health Research Authority (HRA) review

- The study involves primary research with adults who are unable to self consent
- The study involves primary research with NHS patients
- The study involves primary research with prisoners/young offenders

**Students** - If any of these options apply, you should complete an HRA application. See your supervisor for further guidance.

**Supervisors** – Forward this RREA form to ethics.education@manchester.ac.uk when you are satisfied that the project requires approval through the HRA operated Integrated Research Application System (IRAS).

#### D.1 – Criteria for research classified as **HIGH RISK** (tick any that apply)

I confirm that this research:

- [x] involves vulnerable or potentially vulnerable individuals or groups as indicated in B3
- [x] addresses themes or issues in respect of participant’s personal *experience* which may be of a sensitive nature (i.e. the research has the potential to create a degree of discomfort or anxiety amongst one or more participants)
- cannot be completed without data collection or associated activities which place the participants at personal risk
- requires participant informed consent and/or withdrawal procedures which are not consistent with accepted University practice
- addresses an area where access to personal records (e.g. medical), in collaboration with an authorised person, is not possible
- involves data collection on an area of public or social objection (e.g. terrorism, paedophilia)
- makes use of video or other images captured by the researcher, and/or research study participants, where the researcher cannot guarantee controlled access to authorised viewing.

**If ONE OR MORE of the HIGH risk criteria have been selected** DO NOT COMPLETE FURTHER SECTIONS OF THIS FORM. Ethical approval must be sought from a UREC committee. In all other cases, go on to Section D.2.

---

9 For full details see [http://www.hra.nhs.uk/resources/applying-for-reviews/]
**ACTIONS – HIGH RISK RESEARCH**

1. You and your supervisor should first agree this risk assessment.
2. You should then complete the University Research Ethics Committee (UREC) form (available on the MIE (RIC) ethics intranet site) and all supporting documents, and give these to your supervisor for review and feedback.
3. When satisfied with the application, your supervisor will submit:
   1. This completed RREA form
   2. Your completed UREC form – appending ALL supporting documents.
   3. Your completed and approved Fieldwork Risk Assessment (FRA) form - where indicated

**These documents should be submitted by your supervisor to:**

E
c
th
c
e.s
c.t.u
c.a.c.u.k

In doing so, supervisors confirm that they have agreed the assessed risk level and that the documents are complete and correct. The Ethics Administrator will arrange School authorisation for your documents to be submitted to UREC.

---

10 [http://www.seed.manchester.ac.uk/studentintranet/miestudenthome/integrityethics/](http://www.seed.manchester.ac.uk/studentintranet/miestudenthome/integrityethics/)

11 ‘Supporting documents’ include recruitment adverts/emails, draft questionnaires / interview topic guides, information sheets and consent forms.
D.2 – Criteria for research classified as MEDIUM RISK (tick any that apply)

I confirm that this:

- is research involving children or other vulnerable groups which involves direct contact with participants\(^\text{12}\).
- study is on a subject that a reasonable person would agree addresses issues of legitimate interest, where there is a possibility that the topic may result in distress or upset in rare instances.
- is research which involves substantial direct contact\(^\text{13}\) with adults in non-professional roles (e.g., parents).
- is research which focuses on data collection from professionals responding to questions outside of their professional concerns.
- is research with practitioners involving topics of a sensitive nature which are not personal to these participants.
- involves visits to site(s) where a specific risk to participants has been identified, and the researcher may not be closely supervised throughout.

If ONE OR MORE of the MEDIUM risk criteria have been selected, DO NOT COMPLETE FURTHER SECTIONS OF THIS FORM. Ethical approval must be sought from the Manchester Institute of Education (MIE) Research Integrity Committee (RIC). In all other cases, go on to Section D.3.

**ACTIONS – MEDIUM RISK RESEARCH**

1. You and your supervisor should first agree this risk assessment.
2. You should then complete the MIE Ethical Approval Application form (available on the MIE Ethics Intranet)\(^\text{14}\) and all supporting documents\(^\text{15}\), and give these to your supervisor for review and feedback.
3. When satisfied with the application, your supervisor will submit:
   1. This completed RREA form
   2. Your completed MIE form – appending ALL supporting documents.
   3. Your completed and approved Fieldwork Risk Assessment (FRA) form - where indicated

These documents should be submitted by your supervisor to:

Ethics.Education@manchester.ac.uk

In doing so, supervisors confirm that they have agreed the assessed risk level and that the documents are complete and correct. The Ethics Administrator will arrange review of your documents to be undertaken by a member of the MIE Research Integrity Committee and approval against our UREC Ethics Templates.

---

\(^{12}\) This does not include research in locations where children are present if they are not the focus of the research.

\(^{13}\) For example in focus group or one to one interview in private locations, and not ‘market research’ which is characterised by brief interaction with randomly selected individuals in public locations.

\(^{14}\) This document and guidance can downloaded from http://www.seed.manchester.ac.uk/studentintranet/miestudenthome/integrityethics/

\(^{15}\) ‘Supporting documents’ include recruitment adverts/emails, draft questionnaires / interview topic guides, information sheets and consent forms.
D3 – Criteria for research classified as LOW RISK

D 3.1  NO human participants
I confirm that this research (tick as appropriate):

☐ is Secondary research (i.e. it will use material that has already been published or is in the public domain).

☐ is Secondary data analysis (i.e. it will involve data from an established data archive)

If you have ticked one of the options in D3.1 above, and D3.2 does not apply, you should now complete section D3.3 below.

D3.2  Human participants
I confirm that this (tick as appropriate):

☐ research does not constitute high nor medium risk to the participants, as indicated by the criteria provided in sections D.0, D.1 and D.2 respectively.

☐ a reasonable person would agree that the study addresses issues of legitimate interest without being in any way likely to inflame opinion or cause distress\(^{16}\)

☐ is research on my practice (involving data collection on issues relating to my professional role, or for comparison against national or other targets or standards) in a setting where I am employed or on a placement.

☐ is research on the professional practice of others in professional roles and is conducted in my work / placement setting.

☐ is Market research (i.e. the research may involve data collection from the general public approached or observed in public locations for the purposes of market investigation).

☐ is research using a questionnaire completed and returned by participants who will have no direct contact with me.

☐ is part of a research methods course and participant groups are limited to peers, colleagues, family members and friends.

☐ is a Pilot Study

D 3.3  Research context
I confirm (tick as appropriate):

√ I am not in a position to coerce potential participants/secondary data owners

☐ the research involves no vulnerable group (as indicated in question B3).

\(^{16}\) A reasonable person would agree that the study includes no issues of public or private objection, or of a sensitive nature.
If ONE OR MORE of the LOW risk criteria above have been selected, ethical approval must be sought from the Manchester Institute of Education (MIE) Research Integrity Committee (RIC).

**ACTIONS – LOW RISK DOCTORAL RESEARCH**

1. You and your supervisor should first agree this risk assessment.
2. You should then complete the MIE Ethical Approval Application form (available on the MIE Ethics Intranet)\(^ {17}\) and all supporting documents\(^ {18}\), and give these to your supervisor for review and feedback.
3. When satisfied with the application, your supervisor will submit:
   1. This completed RREA form
   2. Your completed MIE form – appending ALL supporting documents.
   3. Your completed and approved Fieldwork Risk Assessment (FRA) form - where indicated

*These documents should be submitted by your supervisor to:*  
[Ethics.Education@manchester.ac.uk](mailto:Ethics.Education@manchester.ac.uk)

In doing so, supervisors confirm that they have agreed the assessed risk level and that the documents are complete and correct. The Ethics Administrator will arrange review of your documents to be completed by a member of the MIE Research Integrity Committee for approval against our UREC Templates.

---

\(^{17}\) This document and guidance can downloaded from [http://www.seed.manchester.ac.uk/studentintranet/miestudenthome/integrityethics/](http://www.seed.manchester.ac.uk/studentintranet/miestudenthome/integrityethics/)

\(^{18}\) *Supporting documents* include recruitment adverts/emails, draft questionnaires / interview topic guides, information sheets and consent forms.
### SECTION E. Ethical Approval Application for LOW risk research

**UG / PGT Research OR Doctorate Pilot Studies/Research Papers**

Section E.1 to be completed by students. Section E.2 to be completed by supervisors/tutors

#### E.1 Research ethics criteria

Tick as appropriate and/or indicate NA against items in bold where they do not apply to this research.

I confirm:

**Codes of Practice**

- [x] I have read and understood the Manchester Institute of Education Ethical Practice and Policy Guidelines
- [x] I will abide by the Manchester Institute of Education’s Ethical Protocol detailed therein
- [x] I am aware of and will abide by any organisation’s codes of conduct relevant to this research

**Researcher skills/checks**

- [x] All necessary training procedures for this research have been completed
- [ ] All appropriate permissions have been obtained to use any database or resource to be analysed in Secondary research
- [x] All relevant enhanced DBS or other checks have been completed
- [x] I will inform the Ethics Administrator if my DBS (or related) status changes
- [ ] Permission to be on the site to conduct research has been received (to follow)

**Rights of participants**

- [x] Participant information sheets (PIS), consent forms, questionnaires, and all other documentation relevant to this research have been discussed with supervisor/tutor named in A.5
- [x] PIS and consent forms have been confirmed with the supervisor named in A.5, as covering required headings illustrated in the MIE Participant Information and consent templates, AND that they are written in an accessible way for each proposed participant group.
- [x] I understand the Data Protection Act and the University Data Protection Policy and all data will be handled confidentially and securely, including storage on encrypted devices.

**Research Integrity**

- [x] No data will be collected before ethical approval of the study is confirmed by my supervisor/tutor
- [x] I will immediately report any issues arising during the course of the study that conflict with the MIE protocol, to my supervisor who has signed the ethics approval, and suspend data collection pending advice from that supervisor/tutor
I will immediately report any issues arising during the course of the study that conflict with the MIE protocol, to my supervisor who has signed the ethics approval, and suspend data collection pending advice from that supervisor/tutor.

I will report any proposed deviation from the research specification outlined in this assessment to my supervisor/tutor to update the current assessment or clarify any need for further approvals BEFORE such changes are made.

Research output

the only publication/output from this research on my practice or research methods study will be my assignment or dissertation.

the only publication/output from this research on professional practice / market research / questionnaire survey will be my assignment or dissertation unless consent has been obtained from participants for further dissemination.

ACTION: LOW RISK RESEARCH

1. You should email your final, completed RREA form (with ALL required supporting documents appended to it, including your research proposal, or equivalent document giving full details of the research) to your supervisor.

2. Your supervisor will first agree that this is LOW risk research. They will then, confirm that your proposed research matches our LOW RISK ethics criteria and that in doing so, that it is approved under our UREC ethics templates.

3. Your supervisor will send you an email to confirm this assessment.

4. The ethics administrator will send formal confirmation of approval once all relevant documents have been received.
E.2 Supervisor confirmation that research matches LOW risk criteria above.

When satisfied that the assessment is correct, supervisors should complete this section.

**SUPERVISOR: LOW RISK RESEARCH**

1. **Confirm** items in **bold** by ticking or marking as **NA** if not applicable to this research, and one or more of the specific research criteria as appropriate.

   I confirm:

   - This submission has been discussed and agreed with the student undertaking the research.
   - The student has had appropriate training and has the skills to undertake this study, or has close, qualified supervision in place.
   - The research activities outlined in the proposal involve **no substantive risks to the student researcher or potential participants**.

   **AND** one or more of the following as appropriate:

   - This research will not address issues of public or social objection, or of a sensitive nature.
   - Information giving and consent taking processes follow Manchester Institute of Education guidance.
   - Where fieldwork visits do not correspond to ALL items in the LOW Risk Fieldwork Declaration, a separate Fieldwork Risk Assessment form has been completed and approved.
   - This secondary research assignment/project has appropriate resource or database access permissions.
   - I will act as custodian for data used for any study that results in a publication (Masters/PhD dissertation or other output) and will arrange for archiving of data with MIE for a minimum period of 5 years.

**Confirm** that the proposed research matches the low risk ethics criteria (indicated in E.1) and that the documents supplied are complete and correct.

<table>
<thead>
<tr>
<th>Please specify:</th>
<th>Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number submitted</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Completed RREA form</td>
</tr>
<tr>
<td>1</td>
<td>Student research proposal, or equivalent, on which the assessment is based</td>
</tr>
</tbody>
</table>

Fieldwork visits involve travel to research locations off campus to collect data.

For audit purposes, a person unfamiliar with the research outlined in Section B must be able to ascertain the full details of the student project, therefore the study proposal or an equivalent document giving full details (eg assignment description) is required.
Completed and approved **Fieldwork Risk Assessment** form - where indicated

<table>
<thead>
<tr>
<th>Supporting documents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Draft questionnaire / interview topic guide / other data collection tools</td>
</tr>
<tr>
<td>1 Recruitment email / advertisement</td>
</tr>
<tr>
<td>1 Participant Information Sheet / page / letter (PIS) for each group</td>
</tr>
<tr>
<td>1 Consent form (or alternative) for each participant group</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supervisor's signature:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Signature]</td>
<td>15/12/15</td>
</tr>
</tbody>
</table>

3. **Submit** for confirmation of Approval to [ethics.education@manchester.ac.uk](mailto:ethics.education@manchester.ac.uk):

To validate this confirmation of approval a full set of documents must be submitted electronically for archiving and audit.

**NB:** The Ethics Administrator **can only provide formal confirmation** of ethical approval via email to both student and supervisor when a **complete set** of documents are supplied. Copies of all documents should be retained by the supervisor.
F.1 Minor amendments to LOW risk research design

Any minor amendment to low risk approved research submissions should be detailed below.

LOW risk research amendments should be checked and agreed by the supervisor as constituting a ‘minor’ change then signed-off below. Substantial changes to research will require a reassessment and revised ethical approvals. This revised copy of the RREA showing the approved amendments, and any amended/additional supporting documents, should be forwarded electronically to the ethics administrator at ethics.education@manchester.ac.uk.

The Ethics Administrator will provide formal acknowledgement of approval of the change by email. A copy should be retained by the supervisor.

To be completed if/when applicable:

<table>
<thead>
<tr>
<th>Minor amendment to assessed research agreed (1):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Details of amendment</td>
</tr>
</tbody>
</table>

This section will record any applications made during the life time of the Project regarding minor changes from what was approved.

---

21 Minor deviations from previously approved research submissions are defined as those which neither change the nature of the study nor deviate from any participatory research groups previously identified. Supervisors should contact a member of the MIE Research Integrity Committee for advice if in doubt.
Supervisor’s signature:  

Date:
Appendix C2: Invitation to participate in the study poster

Invitation to participate in research:

_Students’ own experiences of depression during their school years_

This Project Has Been Approved by the University of Manchester’s Research Ethics Committee 2 [UREC reference: ethics/15500]

**Are you a person who has experienced depression in the past during your school years and is currently managing it well?**

Are you a student aged between 18-25 who speaks fluent English?

If you would like to share your experiences what it is like to live with depression as a young person, what it is like to attend school and receive help to manage/overcome depression, please get in touch.

If you are interested in contributing to the study, please contact me on: 
[contact email]

This Project Has Been Approved by the University of Manchester’s Research Ethics Committee 2 [UREC reference: ethics/15500]
Appendix C3: Request for permission to carry out the research in Higher Education

Dear …..(Principal),

My name is Dorota Martin and I am a Trainee Educational Psychologist studying at the University of Manchester. I am currently planning to undertake a research, as part of my training, around the students’ own experiences of depression during their school years, prior to starting at your university. This research will form a part of my Doctorate in Educational and Child Psychology.

I am writing this email to ask for your consent to advertise the research publicly on your premises and to carry out the research with students who express their interest. The study will investigate issues of identifying needs, access and sources of support for students with depression; barriers and facilitators of the process and what students found particularly supportive in their educational experiences during coping with depression.

The study will be useful for increasing awareness, understanding perceived impact of depression on students, schools, and practitioners working with them.

The study will involve a series of three interviews, each lasting no longer than 90 minutes and the student will be using his/her own free time to participate. Participation of the study is voluntary and the participant will be free to withdraw at any time during the study. The interview will be audio-recorded and transcribed. The participant and your university will be anonymised throughout the study (from the transcription to the final report). Confidentiality will be adhered to unless there is a disclosure of a risk of harm issue that I would have to report. Please see below the content of the participant information sheet for more details:

Who will conduct the research?

Dorota Martin – Trainee Educational Psychologist

Contact details:

The University of Manchester, Manchester Institute of Education, School of Environment Education and Development (SEED), Ellen Wilkinson Building, Oxford Road, Manchester, M13 9PL

Title of the Research

Students’ own experiences of depression during their school years.

What is the purpose of the research?
This research aims to investigate experiences and perceptions of students in Higher Education, who lived with depression during their school years and are currently managing it well. This will be useful for informing further research and interventions/practice, understanding perceived impact of depression on learners, schools, and practitioners working with them.

Why have I been chosen?

You have been invited to participate in the study as you have received medical or psychological support for depression in the past although it has not caused you problems in the last 12 months. You have a very valuable perspective on and insight into what it is like to deal with depression and you can contribute to professionals’ understanding of depression in young people and its impact on all areas of life, particularly on education.

What would I be asked to do if I took part?

You would be asked to take part in a series of three interviews over the period of up to three weeks, to be held at your Higher Education University, at a mutually agreed quiet and private place at the time convenient to you, sometime in Winter 2015/2016. The interviews will focus on your life before living with depression (first interview), the details of the experience of depression (second interview) and reflections on the meaning of overcoming/managing depression (third interview). Please see the attached interview guide for more details.

What happens to the data collected?

The data will be collected on a digital recorder, transcribed, and then analysed. The analysis will look for themes emerging during the interview and the researcher will interpret these in the light of her own experiences and knowledge. This will be then written up for an academic journal, to enable professionals to understand more about young people’s perspectives on depression. Although some of the anonymised quotes may be used to illustrate this interpretation of your experiences, I will make sure that all personal details are changed so that there is no way in which you can be identified by readers of the journal paper.

How is confidentiality maintained?

The data will be transcribed and anonymised and any digital recording will be deleted when no longer needed. Any potentially identifiable information will be changed to protect your identity and you will be given a pseudonym. All personal data stored electronically will be encrypted/password protected and stored until it is no longer needed. On completion of the research, the data will be archived at the University of Manchester for a period of five years, after which it will be destroyed.

What happens if I do not want to take part or if I change my mind?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time until I anonymise your data during the transcription without giving a reason and without detriment to yourself and any of your data collected up to this point will be destroyed. You may find some parts of the discussions upsetting but if this
happens, you can stop at any time. I will make sure you are safe and I will stop, asking what you would like me to do. I will arrange for someone you know and trust to meet you, as we would have agreed prior to the interview. After the interview, I will ask you how you are and if you need any further support and check if you would like to continue with the second/third interview or not.

**What is the duration of the research?**

Your participation in the research will take place over a period of three weeks and will consist of three interviews, lasting 60-90 minutes each. If you wish or need to shorten the interview, you will be free to do so.

**Where will the research be conducted?**

The interviews will be conducted in your place of study (Higher Education University) at a mutually agreed quiet and private place, at a time and date convenient to you.

**Will the outcomes of the research be published?**

The outcomes of the research may be published, presented at future conferences and will form a part of the researcher's doctoral thesis that will be due for completion in 2017.

**Who has reviewed the research project?**

The project has been reviewed by the University of Manchester Research Ethics Committee 2 (UREC reference: ethics/15500).

**What if something goes wrong?**

You should contact the persons named above in the first instance. If you are upset or distressed during the interview, I will pause to see if you would like to take a break, carry on or withdraw from the interview. You may find some parts of the discussions upsetting but if this happens, you can stop at any time. I will make sure you are safe and I will stop, asking what you would like me to do. If you are distressed, I will arrange for someone you know and trust to meet you, as we would have agreed prior to the interview. After the interview, I will ask you how you are and if you need any further support and check if you would like to continue with the second/third interview or not.

If you would like some help and advice, please see below some contact details for organisations that may offer appropriate assistance:

Samaritans: 08457 90 90 90 or email: jo@samaritans.org

Mind Infoline: 0300 123 3393 or email: info@mind.org.uk

**What if I want to complain?**

If there are any issues regarding this research you should contact the researcher in the first instance:
However, if you would prefer not to discuss with members of the research team, please contact the principal supervisor:

Dr Cathy Atkinson E-mail: Cathy.Atkinson@manchester.ac.uk with whom you could talk about the study.

If you wish to make a formal complaint about the conduct of the research you can contact a Research Governance and Integrity Manager, Research Office, Christie Building, University of Manchester, Oxford Road, Manchester M13 9PL, by emailing: research.complaints@manchester.ac.uk, or by telephoning 0161 275 2674 or 275 8093.

How can I contact you?

Contact for further information:

Dorota Martin E-mail: dorota.martin@postgrad.manchester.ac.uk
Supervisor: Dr Cathy Atkinson E-mail: Cathy.Atkinson@manchester.ac.uk

This Project Has Been Approved by the University of Manchester's Research Ethics Committee 2 [UREC reference: ethics/15500]

What are the next steps?

If you agree for me to carry out the interview on your premises, please email your confirmation to: (dorota.martin@postgrad.manchester.ac.uk). Please do not hesitate to contact me or my university supervisor if you have any queries or you would like to discuss this study in more detail: e-mail: dorota.martin@postgrad.manchester.ac.uk

Supervisor: Dr Cathy Atkinson, e-mail: Cathy.Atkinson@manchester.ac.uk

Thank you for reading this. I look forward to hearing from you.

Kind regards,

Dorota Martin
Trainee Educational Psychologist
Appendix C4: Preliminary questions to establish participants’ eligibility

Students’ own experiences of depression during their school years

Participant’s Data Collection Sheet

Participant ID number/ pseudonym chosen:

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

Age: .................................................

Programme of study:

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

Type of help (medical/psychological) received:

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

Age when experiencing living with depression: .................................

Are you currently experiencing depression or suicidal thoughts?

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

Are you currently managing these conditions?..........................................................
Are you currently receiving care from any outside agencies?

What support networks are available to you?
Appendix C5: Participant information sheet

**Students’ own experiences of depression during their school years**

**Participant Information Sheet**

You are being invited to take part in a research study exploring your own experiences of managing/overcoming depression during your school years. The study will investigate issues of identifying needs, access and sources of support for students with depression; barriers and facilitators of the process and what students found particularly supportive in their educational experiences during coping with depression. This research will form a part of a Doctorate in Educational and Child Psychology.

Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take your time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for taking the time to read this.

**Who will conduct the research?**

Dorota Martin – Trainee Educational Psychologist

**Contact details:**

The University of Manchester, Manchester Institute of Education, School of Environment Education and Development (SEED), Ellen Wilkinson Building, Oxford Road, Manchester, M13 9PL

**Title of the Research**

Students’ own experiences of depression during their school years.

**What is the purpose of the research?**

This research aims to investigate experiences and perceptions of students in Higher Education, who lived with depression during their school years and are currently managing it well. This will be useful for informing further research and interventions/practice, understanding perceived impact of depression on learners, schools, and practitioners working with them.

**Why have I been chosen?**

You have been invited to participate in the study as you have received medical or psychological support for depression in the past although it has not caused you problems in the last 12 months. You have a very valuable perspective on and insight into what it is like to deal with depression and you can contribute to professionals’ understanding of depression in young people and its impact on all areas of life, particularly on education.
What would I be asked to do if I took part?

You would be asked to take part in a series of three interviews over the period of up to three weeks, to be held at your Higher Education University, at a mutually agreed quiet and private place at the time convenient to you, sometime in Winter 2015/16. The interviews will focus on your life before living with depression (first interview), the details of the experience of depression (second interview) and reflections on the meaning of overcoming/managing depression (third interview). Please see the attached interview guide for more details.

What happens to the data collected?

The data will be collected on a digital recorder, transcribed, and then analysed. The analysis will look for themes emerging during the interview and the researcher will interpret these in the light of her own experiences and knowledge. This will be then written up for an academic journal, to enable professionals to understand more about young people’s perspectives on depression. Although some of the anonymised quotes may be used to illustrate this interpretation of your experiences, I will make sure that all personal details are changed so that there is no way in which you can be identified by readers of the journal paper.

How is confidentiality maintained?

The data will be transcribed and anonymised and any digital recording will be deleted when no longer needed. Any potentially identifiable information will be changed to protect your identity and you will be given a pseudonym. All personal data stored electronically will be encrypted/password protected and stored until it is no longer needed. On completion of the research, the data will be archived at the University of Manchester for a period of five years, after which it will be destroyed.

What happens if I do not want to take part or if I change my mind?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time until I anonymise your data during the transcription without giving a reason and without detriment to yourself and any of your data collected up to this point will be destroyed. You may find some parts of the discussions upsetting but if this happens, you can stop at any time. I will make sure you are safe and I will stop, asking what you would like me to do. I will arrange for someone you know and trust to meet you, as we would have agreed prior to the interview. After the interview, I will ask you how you are and if you need any further support and check if you would like to continue with the second/third interview or not.

What is the duration of the research?

Your participation in the research will take place over a period of three weeks and will consist of three interviews, lasting 60-90 minutes each. If you wish or need to shorten the interview, you will be free to do so.

Where will the research be conducted?
The interviews will be conducted in your place of study (Higher Education University) at a mutually agreed quiet and private place, at a time and date convenient to you.

Will the outcomes of the research be published?

The outcomes of the research may be published, presented at future conferences and will form a part of the researcher’s doctoral thesis that will be due for completion in 2017.

Who has reviewed the research project?

The project has been reviewed by the University of Manchester Research Ethics Committee 2 (UREC reference: ethics/15500).

What if something goes wrong?

You should contact the persons named above in the first instance. If you are upset or distressed during the interview, I will pause to see if you would like to take a break, carry on or withdraw from the interview. You may find some parts of the discussions upsetting but if this happens, you can stop at any time. I will make sure you are safe and I will stop, asking what you would like me to do. If you are distressed, I will arrange for someone you know and trust to meet you, as we would have agreed prior to the interview. After the interview, I will ask you how you are and if you need any further support and check if you would like to continue with the second/third interview or not.

If you would like some help and advice, please see below some contact details for organisations that may offer appropriate assistance:

Samaritans: 08457 90 90 90 or email: jo@samaritans.org
Mind Infoline: 0300 123 3393 or email: info@mind.org.uk

What if I want to complain?

If there are any issues regarding this research you should contact the researcher in the first instance:

Dorota Martin E-mail: dorota.martin@postgrad.manchester.ac.uk

However, if you would prefer not to discuss with members of the research team, please contact the principal supervisor:

Dr Cathy Atkinson E-mail: Cathy.Atkinson@manchester.ac.uk with whom you could talk about the study.

If you wish to make a formal complaint about the conduct of the research you can contact a Research Governance and Integrity Manager, Research Office, Christie Building, University of Manchester, Oxford Road, Manchester M13 9PL, by emailing: research.complaints@manchester.ac.uk, or by telephoning 0161 275 2674 or 275 8093.
How can I contact you?

Contact for further information:

Dorota Martin E-mail: dorota.martin@postgrad.manchester.ac.uk

Supervisor: Dr Cathy Atkinson E-mail: Cathy.Atkinson@manchester.ac.uk

This Project Has Been Approved by the University of Manchester’s Research Ethics Committee [UREC reference: ethics/15500]
Appendix C6: Participant consent form

Students’ own experiences of depression during their school years

CONSENT FORM

If you are happy to participate please complete and sign the consent form below

Please
Initial
Box

1. I confirm that I have read the attached information sheet on the above project and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.

2. I understand that my participation in the study is voluntary and that I am free to withdraw at any time until data anonymisation during the transcription without giving a reason and without detriment to myself.

3. I understand that my data will remain confidential.

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

5. I agree to the use of anonymous quotes.

6. I agree that any data collected may be published in an anonymous form in academic books or journals.

I agree to take part in the above project

Name of participant ___________________________ Date ______________ Signature ___________________________

Name of person taking consent ___________________________ Date ______________ Signature ___________________________
Appendix C7: Distress protocol for participant

Students’ own experiences of depression during their school years
Distress Policy

Prior to the interviews, the participant will be asked what they would like to happen in the event they are upset/distressed during/after any of the interviews. An action plan will be agreed with the participant and depending on the level of the distress; the following will be offered/discussed and agreed:

If the event of distress, the researcher will ask the participant if they would like to have a break or stop the interview (Cowles, 1988). Should any additional advice be required, the supervisor will be contacted as appropriate.

In the event of distress the researcher will endeavour to stay with the participant until s/he feel better or the participant’s preferred trusted person/agency/GP will be contacted/or meet them, using a tiered approach, including:

- Friends/family
- GP
- Key worker/ or counsellor (As the research is intended to take place at a HE venue, there should be an access to learner/pastoral support in situ. This will be also checked by the researcher prior to meeting with the participant, to enable swift response, should that be needed).
- a mental health professional

The participant will be given time to reflect after the interview to say how s/he feel and will be given the researcher’s contact details, together with a list of useful contacts at the end of the interview. The researcher will ask how the participant feels and if there is a need for any further support, checking if the participant would like to continue with the second/third interview or not. The researcher’s supervisor will be informed and kept up to date about any difficulties arising during /after the interviews.

(cf. Hunter, 2011)
Appendix C8: Distress protocol for the researcher

Students’ own experiences of depression during their school years

Distress Policy for the Researcher

Pre-data collection
- Considering potential psychological and physical impact on the researcher of the participants’ description of life experiences
- Considering how many interviews could be undertaken in a week (on a case-by-case basis)
- Awareness of possible emotional impact and physical exhaustion

Data collection stage
- Potentially sensitive topic – the researcher is trained in working with vulnerable children/young adults and their parents/carers. The researcher practises mindfulness and is aware of her emotional states and where to find help if required.
- Ensuring that the supervisor is accessible by phone on the day of the interviews to enable a prompt response and advice from her if needed. In the event that the supervisor cannot guarantee availability, ensure contingency support arrangements are in place with co-supervisor, or another member of the Doctorate in Educational and Child Psychology programme team
- The supervisor (or member of the programme team) will be contacted straight after the interview for a quick debrief. This will also enable her to establish the researcher’s emotional state and suggest further help if required.
- Regular debriefing sessions with the researcher’s supervisor (the named person from the Doctorate in Educational and Child Psychology programme).
- Researcher recording her thoughts and feelings as part of the research process and reflexivity. This will be also useful in raising
awareness how the research and the participant-researcher cooperation influenced the researcher’s interpretation and subsequent interviews

- Access to regular supervision within university and placement
- Access to supervisor at all times via telephone and email contact

Data transcription
- Researcher working in a safe and private environment (from home)
- Ensuring frequent rest breaks
- Recognising that immersion in the data may bring repeated exposure to potentially difficult feelings. The researcher is aware of these processes through the training and experience she gained during her previous research and work with vulnerable children/young adults
- Regular debriefing sessions with the supervisor
- Prompt access to sources of support, including debriefing, supervision and mentoring
- Recording thoughts and feelings as part of the research process and reflexivity

Analysis
- The researcher through data collection stage will have already been aware of potentially “difficult” interviews
- Regular debriefing sessions with the supervisor
- Recording thoughts and feelings as part of the research process and reflexivity

Follow up
- Recognising a need to additionally access a research mentor within the programme if the researcher experiences increased distress/upset in the hours/days following transcription
- Engaging in self-care strategies, including availability of peer and counselling support

(Edward & Witham, 2015; McCosker, Barnard & Gerber, 2001; Woodby et al., 2011)
Appendix C9: Interview guide and Participant debrief sheet with sources of support

Students’ own experiences of depression during their school years

Interview Guides and Debrief Sheet

These are the types of questions I might be asking you during the interview and can be used a guide. If there is anything else that you feel is important and you would like to share it with me, please feel free to do so.

Introductions

Thank participants for coming, checking consent and explaining about the approximate duration of the interview.

Interview 1: Focused life story before depression

Duration: 60-90 minutes

Please could you tell me about your life experiences of being at school before you felt you were living with depression/received diagnosis/treatment for depression?

Prompts: What was it like? /What about relationships with peers/teachers? /Personal/home circumstances? /What was important to you at the time? /What was your life at school then? /Support at school? /Hopes and dreams?

Interview 2: Details of experience

Duration: 60-90 minutes

Checking if there is anything else to add from the previous interview/clarifying meanings if required.

Please could you tell me what your first experiences of living with depression were like?

What was it like to live with depression whilst you were at school?
Prompts: Tell me more/ What happened then?

Can you reconstruct a day in your life, from the moment you woke up until you fell asleep when you were living with depression?

Prompts: At school/after school/community/relationships, etc.

Could you tell me about the support you had at school then?

Prompts: During the experienced depression? Who helped? How?

What was helpful in coping/managing the depression during your school years?

Prompts: At school?/ Home?/Other places?

Interview 3: Reflection on the meaning

Duration: 60-90 minutes

Checking if there is anything else to add from the previous interview/clarifying meanings if required.

Given what you have said about your life before you were living with depression, and about your experiences of living with depression during your school year/s, how do you understand depression in your life?

What would it mean to you to manage/overcome the depression?

Prompts: Looking back now, as a student/after school/community/relationships, etc.

What sense does it make to you now the support you had then at school?

Is there anything else you would like to add?

Thank you very much for your time.
Debrief Sheet

Talking about experiences of psychological distress can be helpful but can be also upsetting, bringing in difficult emotions and feelings. This could be a normal response, but if you feel you would like to talk to me about the interview, please email me: dorota.martin@postgrad.manchester.ac.uk.

Or alternatively, please contact other sources of existing support at your Higher Education University.

Other sources of support:

Samaritans: 08457 90 90 90 or email: jo@samaritans.org
Mind Infoline: 0300 123 3393 or email: info@mind.org.uk

If you have any thoughts about harming yourself, you can seek help immediately at your nearest hospital, Accident and Emergency (A&E) or ring 999.
Appendix D

Appendix D1: Stages of analysis in IPA
Appendix D2: Representation of stages of analysis process of an interview
Appendix D3: Examples of higher-order (superordinate) themes from one participant – stage four of the analysis
Appendix D4: Examples of interrogative themes applied to each interview (an example from one participant)
Appendix D5: Representation of stages of analysis across interviews
Appendix D6: Representation of final themes with subthemes
Appendix D7: Master table – example of one master theme with subthemes
Appendix D8: Final interrogative themes examples across all interviews
Appendix D1: Stages of analysis in IPA
Adapted from Smith et al. (2009)
Appendix D2: Representation of stages of analysis process of an interview

First stages: exploratory comments and emergent themes annotations
Emergent themes on post-it notes, annotated with line numbers (stage three of the analysis)
Process of grouping into higher order themes (stage four of the analysis)
Appendix D3: Example of higher-order (superordinate) themes from one participant – stage four of the analysis

<table>
<thead>
<tr>
<th>Superordinate theme (in bold) consisting of themes (in italics)</th>
<th>Line number/s</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Victimised</strong></td>
<td>257-259</td>
<td>I haven’t done anything but (...) when you’re [sighs] a victim or something like that, you feel like it’s your fault</td>
</tr>
<tr>
<td></td>
<td>311-314</td>
<td>I was (...) absolutely broken as a person and I think as a child. I felt at that time I was robbed of a lot of a year of my childhood, most definitely.</td>
</tr>
<tr>
<td></td>
<td>79-85</td>
<td>It was really like hell on Earth, it was really awful (...) you’re just in a completely different world, in a completely different mindset, you just cannot enjoy your life at all (...) erm, it was (...) it was really terrible.</td>
</tr>
<tr>
<td><strong>Hurting inside</strong></td>
<td>112-116</td>
<td>I felt very lonely a lot, and then I felt better, and if anybody left me on my own I’d just get really terrified, just really scared of something, it was sort of like living in a constant, constant dread (...) of nothing (...) [sighs] so difficult to understand why you just can’t snap [sighs], I don’t know, why can’t you just [sighs] make yourself better</td>
</tr>
<tr>
<td></td>
<td>505-510</td>
<td>I wanted to cry all the time but it wouldn’t come out, you know? I don’t know if you’ve ever felt this level of despair, where you (...) so (...) scared (...) that you just want to cry and scream and it doesn’t come out and it’s so much worse, ‘cos like when you’re crying, you sort of get it out of you but when you’re holding in it’s just (...) just deeply, deeply depressing, everything was just,- (...) everything was just really terrible to me.</td>
</tr>
<tr>
<td></td>
<td>539-540</td>
<td>Still really scared and really, really, really hurting inside (...) but nobody could do anything for me.</td>
</tr>
<tr>
<td></td>
<td>117-121</td>
<td>When I went to school I was quite distracted, but actually, I didn’t feel as much effect, I felt a bit more normal (...) ‘cos I needed to get on with my work and erm, but if I was left on my own I would just feel terrible.</td>
</tr>
<tr>
<td><strong>Distractions welcomed</strong></td>
<td>189-194</td>
<td>I feel it was partially due to the fact that I had all this time and nothing to do, but back to my first experience I was actually in school at that point so erm (...) I feel like when I was in school it was [SIGH] obviously you know, ‘cos you can get easily distracted and I really liked school, I liked doing</td>
</tr>
</tbody>
</table>
my work and whatnot, I (.) can’t remember that well but (.) I do remember feeling better, ‘cos I wasn’t thinking about it

| 498-500 | Would’ve then probably came home from school and always tried to turn the TV on, I always needed to hear someone’s voice, erm, because I just could not be alone with my thoughts for a minute |
| 801 | It was constant distraction that helped me a bit |
| 51-52 | Just existing (.) just being,- I was (.) just so disengaged from a real life, I just didn’t have the same emotions as normal people |

**Disengaged**

| 93-97 | Like me getting into a state where I’m just not connecting with the real world at all (.) and (.) it’s a very, very painful experience and (.) I’m happy I don’t have got it anymore but It’s just really, really awful at the time |
| 168-173 | I got such in a bad way that I was not, I could not be thrilled, I could not understand why people are happy, why they could love in this life, or not, be miserable, I was not, not in a good way... *(pause)*. I mean when you’re depressed you’re not, you’re not there, you’re just existing, you’re just existing till the next day, even then, I was,- just really wanted to go to sleep |

**“No one here is helping me out”**

**Lack of understanding at school**

| 577-578 | Like obviously these teachers don’t (…) understand what the hell post (. ) trauma is (…) |
| 645-652 | I think teachers hold a lot of more responsibility to help children than what they realise (…) but I think that every child goes through some sort of trauma, whereas I talked to people, (…), ‘cos if a parent, or someone else does die it’s still like “oh, you should get over that” that the teachers do not do anything, I think it’s different in secondary school (…) but they don’t do anything for children. |
| 861-863 | No one’s going to help me, (…) and no one here is helping me out, it was all very (.) rubbish |
| 129-132 | I could have really done with counselling at that age you know, I could have somebody who might have been able to,- I was never referred to a psychiatrist, nothing like that, they should’ve,- there should be a procedure when someone gets told |
| 658-659 | The school has to have more responsibility to refer the child to get psychological help |
Appendix D4: Examples of interrogative themes applied to each interview (an example from one participant)

<table>
<thead>
<tr>
<th>Interrogative themes</th>
<th>Line number/s</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Temporality</strong></td>
<td></td>
<td>Note: Symbol (...) signifies text omitted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Symbol [word] signifies added comment/non-verbal communication</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Underlined words are spoken louder</td>
</tr>
<tr>
<td></td>
<td>6-8</td>
<td>I said last week or last time before Easter, erm, about times when I’ve been like really happy</td>
</tr>
<tr>
<td></td>
<td>86-87</td>
<td>I remember literally being there in first year</td>
</tr>
<tr>
<td></td>
<td>133</td>
<td>I remember being at school</td>
</tr>
<tr>
<td></td>
<td>279</td>
<td>for two years before I came here</td>
</tr>
<tr>
<td></td>
<td>291</td>
<td>to turn up every day and do (...) like five hours of work every day</td>
</tr>
<tr>
<td></td>
<td>376</td>
<td>during the evenings</td>
</tr>
<tr>
<td></td>
<td>459</td>
<td>part time, so, oh no it was full time</td>
</tr>
<tr>
<td></td>
<td>538</td>
<td>period of very intense work</td>
</tr>
<tr>
<td></td>
<td>655</td>
<td>slowly</td>
</tr>
<tr>
<td></td>
<td>717</td>
<td>[about future plans:] I’m definitely going to try and do a Masters</td>
</tr>
<tr>
<td></td>
<td>825</td>
<td>You get half an hour and off then half nine</td>
</tr>
<tr>
<td></td>
<td>918</td>
<td>every week</td>
</tr>
<tr>
<td><strong>Spatiality</strong></td>
<td>5</td>
<td>I’m going to go in at the deep end</td>
</tr>
<tr>
<td></td>
<td>30-31</td>
<td>Having a desk is like, quite a big thing symbolically. It’s a place. It’s a home almost, a home from home</td>
</tr>
<tr>
<td></td>
<td>120</td>
<td>You’re in a bad place and then about kind of working your way back up</td>
</tr>
<tr>
<td></td>
<td>220</td>
<td>the state of the halls is just abysmal</td>
</tr>
<tr>
<td></td>
<td>372</td>
<td>Two tours of Afghanistan</td>
</tr>
<tr>
<td></td>
<td>542</td>
<td>I literally just went and sat on the naughty step</td>
</tr>
<tr>
<td></td>
<td>719-720</td>
<td>I’m going to go to the South again I think I’ve had enough of the North</td>
</tr>
<tr>
<td></td>
<td>780</td>
<td>In California</td>
</tr>
<tr>
<td></td>
<td>810</td>
<td>Where 60 boys live in a house together</td>
</tr>
<tr>
<td></td>
<td>819</td>
<td>you to chapel</td>
</tr>
<tr>
<td>Page</td>
<td>Text</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>844</td>
<td>If I’m given a structure to lean on</td>
<td></td>
</tr>
<tr>
<td>844</td>
<td>woah, this is actually quite scary</td>
<td></td>
</tr>
<tr>
<td>182</td>
<td>kind of entropy</td>
<td></td>
</tr>
<tr>
<td>448</td>
<td>to get on the phone and bloody apply</td>
<td></td>
</tr>
<tr>
<td>537</td>
<td>it’s kind of hard to not to be consumed by it</td>
<td></td>
</tr>
<tr>
<td>603</td>
<td>Understanding the kind of mindset</td>
<td></td>
</tr>
<tr>
<td>704-705</td>
<td>just feel proud because the first few times it actually aches quite a lot</td>
<td></td>
</tr>
<tr>
<td>758</td>
<td>I need to feel good about myself I need to eat loads of ice cream</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>I prefer to like be alone</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Page</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>82</td>
<td>Some of my friends at home</td>
</tr>
<tr>
<td>217</td>
<td>nobody really cares</td>
</tr>
<tr>
<td>310</td>
<td>there’s no community</td>
</tr>
<tr>
<td>388</td>
<td>what’s the difference between him and me?</td>
</tr>
<tr>
<td>646-647</td>
<td>then people like Nietzsche and Kierkegaard</td>
</tr>
<tr>
<td>750</td>
<td>I’ve never done it in front of other people</td>
</tr>
<tr>
<td>817</td>
<td>not having your family around</td>
</tr>
<tr>
<td>887-888</td>
<td>I didn’t really know that many people and the people I did know weren’t going</td>
</tr>
</tbody>
</table>
Appendix D5: Representation of stages of analysis across interviews
Appendix D6: Representation of final themes with subthemes

Master themes represent big circles with subthemes grouped in smaller circles.
Appendix D7: Master table – example of one master theme with subthemes

Table of **master theme** (in **bold red**) and **sub-themes** (in **dark blue**) from the analysis of the interviews with Lucy (quotes in black), James Cared (quotes in green), and Jules (quotes in blue).

<table>
<thead>
<tr>
<th>Master theme (in bold) consisting of sub-themes (in italics)</th>
<th>Line number(s) / Interview number</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No one here was helping me out?</strong></td>
<td>853-863/3</td>
<td>There wasn’t really any. That’s the thing. There was meant to (...) in halls like a pastoral tutor (...) we were kind of on our own and then with our halls there was meant to be like a-, like a community there like a society for our halls. I only found out about it like a month before the end of term (...) I was like I didn’t even realise we had one? And the person that was selected never did anything about it so we never had any events</td>
</tr>
<tr>
<td></td>
<td>725-732/2</td>
<td>the thing about the university is that it offers some really good services like the counselling and the disability support office and library courses and wellbeing things and stuff, but they’re really hard to access if you don’t know they’re there and there’s no way to easily get to them without...really needing to reach out for something...yeah...and I think...like it...it seems obvious now...that of course the university provides these you know, things because that’s, that’s just what you should do but, you know, it’s not obvious when you’ve, when you’ve never been to a university before</td>
</tr>
<tr>
<td></td>
<td>921-932/3</td>
<td>the University provides a lot of support but you have to go out of your way to find it. (...) actually it was just very hard to kind of access it at first and it’s like, (...) we provide this support for students but actually it’s not, it’s not about necessarily the support it’s about the accessibility and it was just like</td>
</tr>
</tbody>
</table>

**Note:** Symbol (...) signifies text omitted, symbols (.) and (..) signify short hesitations
Symbol [word] signifies added comment/non-verbal communication
Underlined words are spoken louder
really hard to like it was so much effort to kind of admit to yourself that you have a problem and you have to go out of your way to find people who will help you.

all of that came with the realisation that I have an issue I have to deal with, so I think there is support there but it’s just sparse and it’s hard to access at first if you, if you’re not 100% sure that you have an issue then- and if you’re less inclined to seek help then yeah.

I know for a fact there was a support network that was supposed to be there...each flat had a...like a block tutor who was supposed to come round every month or two months and check on everyone, that everyone was OK and ours came for the first month and then we never saw (...) again for the rest of the year. (...) But...there wasn’t really any support network that the halls had set up.

[about support in the halls] I don’t know why the support stopped, (...) and it is frustrating that that stopped.

I went to a doctor and the doctor recommended me to the counselling service and then I ended up with a doctor, a counsellor, at one point a psychologist...and...I was put on medication and that’s when...sort of...a proper...support system got in place and...the university, the counselling service contacted my department and my department started getting involved and being like ‘do you need anything for lectures? Do you need any extra support in that kind of thing?’ (...)

it was a 9-5pm work week so I was in 9-5pm, so having somewhere...you know, the work wasn’t hard, (...) being around your family again and friends and that...you know, it was really good I think, but it was the regimentation of, of having a 9-5pm job, compared to like at uni (...) that was, that was important.

I actually made the tutorials most weeks because, because you know, there were people there to talk to and...and you had to go because you had to go for your course but lectures you didn’t have to go to.

I think maybe the thing about that was I always had really strong support networks in place before (...) before I came to uni.

I’m very like disorganised and stuff and just my character is a character that if, if I’m given a structure to lean on I will flourish (...) but I won’t like it, but I will do better and I did do better and I didn’t like it but I did do better.

I found out...later on...someone who was...one of the teachers was trained as a sort of as a counsellor and could talk about that kind of thing...but that wasn’t really something that was advertised as an option to students, it was sort of, if you went to them with a problem...they’d then...they’d then...sort of
there was another boy at school and I didn’t find out about this until later when I got friendly with one of his friends, but he’d gone through...not dissimilar experiences from what I could gather...and he’s not sort of...the type of person he was, he wasn’t massively academic, so he didn’t hang around in the library and that kind of thing, he wasn’t friendly with any teacher in particular and (...) he just ended up dropping out of the school and...sort of stopped turning up for school and I later found out it was just...he’d got depression quite badly and...couldn’t come to school anymore and...it...yeah...it wasn’t...it wasn’t something...like...I, I accessed the support and he didn’t, it was...just I got lucky with who I was and friendly with a teacher that I could...let know...that this was happening, but he didn’t really have that and then didn’t have anyone...in particular

Yeah, it is...difficult knowing it could have...could have very easily turned out...very differently and...I didn’t massively have control of which way it turned out, it just fell down to chance...which is scary to think about

because by sixth form I was aware that the system should have been there but wasn’t...or rather was but I didn’t know it was there, but at secondary school I didn’t know that the system should have even been there so it wasn’t...as frustrating at the time

[during sixth form] having the group of friends that I eventually ended up with, which were really supportive

[about a concerned friend] for 5 months they persisted and were really (...) really kind and helpful about making me...or encouraging me to go, so not...not being angry when I didn’t go just...just...keeping sure that they knew I was (pause) like alive (...) for (...) want of a better word, but keeping asking the questions and keeping asking was I OK, asking what I’d done that day or since I’d last talked to them and...not...not giving up...

[about not being aware of mental health difficulties] the people I, I...hung around with in school time weren’t really very aware...they were just as unaware of it as I was...

I think what really disgusted me about it was my mum actually told the teachers and at that time they didn’t do anything or nothing was done about it, like I (...)
<table>
<thead>
<tr>
<th>645/2</th>
<th>I think teachers hold a lot of more responsibility to help children than what they realise.</th>
</tr>
</thead>
<tbody>
<tr>
<td>861-863/2</td>
<td>No one’s going to help me (...) and I’m upset, and no one here is helping me out, it was all very (...) rubbish.</td>
</tr>
<tr>
<td>208-209/2</td>
<td>Yeah. It was (.) pretty, erm, pretty upsetting, erm (.) but they didn’t do anything about that, no.</td>
</tr>
<tr>
<td>327-329/3</td>
<td>I was so isolated (...) when I made friends with this, erm, new girl, this new friend Polly, that obviously brought me out of it, a good,- I felt a lot better...</td>
</tr>
<tr>
<td>412-415/3</td>
<td>first experience of depression, erm, there was no help from school whatsoever even though they were aware what had happened. Nobody talked to me, nobody said anything, nothing was done, I wasn’t changed class, wasn’t offered any counselling, any support whatsoever.</td>
</tr>
<tr>
<td>84-85/2</td>
<td>The only reason I could understand eventually ‘cos my (...) was like “oh, you have this so called anxiety, you’re depressed or something”</td>
</tr>
<tr>
<td>892-898/2</td>
<td>My Year Head was very sympathetic towards me and I feel like, she in some respect, she helped me to emasculate the whole experience, ‘cos she would’ve been like, very considerate and she would’ve been very considerate of my personal life (...) although it was completely different to what I felt in primary school</td>
</tr>
<tr>
<td>927-931/2</td>
<td>But I do feel that some teachers in my school were very sympathetic to that (...) even if they did get involve in my personal life, they didn’t blame me</td>
</tr>
<tr>
<td>207-213/1</td>
<td>At secondary school...sort of...there wasn’t a support system in place, it was more sort of a teacher noticing...and sort of...being like...if you need to talk to someone you can come and talk to me...because...I think we were supposed to have a school nurse because of the sort of size of the school (...). So there wasn’t really a support system in place for that school.</td>
</tr>
<tr>
<td>824-825/1</td>
<td>we’d not found out about this other classroom that was a safe space</td>
</tr>
<tr>
<td>203-206/2</td>
<td>The work side of things...not massive amounts of help, I was offered special consideration in AS levels because of...some of the illness that had gone with it, but that was really as far as the help went. Yeah, there wasn’t much...</td>
</tr>
<tr>
<td>545-551/2</td>
<td>No, I never had...learning support through...through either secondary or sixth form, erm, there were a few teachers who...in...definitely in secondary school...some...were aware that it was at the very least happening...and made an effort to [sighs] not necessarily prevent it...but...either make it more...durable or make the times when it wasn’t happening better, so teachers who’d...try and give...enjoyable things</td>
</tr>
</tbody>
</table>
to do when possible and it wasn’t being a problem or…that kind of thing

| 161-165/3 | all the support there came from…unofficial routes, so just a teacher who you happen to be friendly with and felt you could talk to, rather than...there being a system where...if you fell down there was a set person you could properly talk it through |

Nobody noticed?

| 73-74/2 | much later that people started asking ‘are you OK? Is there something wrong?’ And that was...it never really came from the same group of people, |

| 103-105/2 | they were among the ones who sort of noticed this and sort of...recommended that I do something about it because it was clearly having a big effect on me |

| 155-159/2 | I started going for...sort of...kind of like therapy sessions at the local hospital and a teacher needed to be known because I’d had to leave his class half an hour early at the end of school to go and so that was the first time...that I think school had been aware of the fact that there was something wrong. Up to that point they’d not really known me well enough to pick up on it |

| 697-708/2 | I didn’t really know the people in my flat well enough...so when I was in my room for a week and never came out...they never really noticed that I wasn’t there...and...on the actual night I was leaving...I sat down and told someone in the flat what had happened and...she said the weirdest thing which was...‘you know, I had a feeling a few months ago that something was wrong because there was some toast in the toaster that had just been left and no-one came and collected it.’ (...So even...even then people had noticed something was wrong, they didn’t feel like they knew me well enough to...ask what was wrong until I said to them. |

| 729-736/2 | other friends (...I didn’t feel able to explain it, they’d explained it for me and they...they played a really crucial part in making sure I felt OK and that other people could be there as well to support me and...sort of...) they formed a support network even though I wasn’t with...like they were all at universities all across the country and they weren’t around, but they could be there if I just needed someone to talk to. |

| 117-120/1 | Until you’re at uni when literally you know you could sit in a room for three weeks at a time and people probably wouldn’t notice you know? That’s the thing. And I think I spent a lot of first year doing that and nobody noticed– [sighs] |

| 328-333/2 | I remember one time like...they were just like...they were just like ‘right, tomorrow we’re going somewhere (...) and you’re gonna come...’ we didn’t go in the end for whatever reason but like...I think it
<table>
<thead>
<tr>
<th>I knew I needed help</th>
<th>163-166/2</th>
</tr>
</thead>
<tbody>
<tr>
<td>was bad enough that they kind of you know, they’re just students, like they didn’t have any obligation at all to me, erm, other than just being good people</td>
<td></td>
</tr>
<tr>
<td>94-96/3</td>
<td>I didn’t really understand much about the treatment options available, the, the therapy and the medication side, I wasn’t really...in the know</td>
</tr>
<tr>
<td>263-264/3</td>
<td>the support was there and I knew the support was there but I didn’t feel able to use the support because I was too ill or not too ill but...I didn’t feel able to do it because of the illness</td>
</tr>
<tr>
<td>279-280/3</td>
<td>it was more...more me not accessing it and...a problem with me as an individual than...anything bigger</td>
</tr>
<tr>
<td>221-224/2</td>
<td>it was very difficult during secondary school getting other people to understand what was happening, especially because (. ) I’d not really been introduced to the idea of depression and the idea of anxiety and sort of forming the language to describe what I was feeling to other people was difficult and (. ) for the most part I just didn’t bother trying to tell other people about it</td>
</tr>
<tr>
<td>233-237/2</td>
<td>It was frustrating I think (. ) and (. ) just (. ) got more frustrating (. ) frustrating that I couldn’t tell anyone and frustrating that I couldn’t even really understand (. ) myself (. ) what was wrong with it. And...frustrating that this was happening everywhere so I couldn’t talk to people at school about it, I couldn’t really talk to people at home about it</td>
</tr>
<tr>
<td>257-259/2</td>
<td>on top of the not being able to talk about feelings, it was ‘I can’t share this with anyone because...this is a scary thing as well’ and a lot of fear stemmed from that rather than the not being able to tell people</td>
</tr>
<tr>
<td>266-272/2</td>
<td>as I got older learned more about this kind of thing...sort of learned about depression, anxiety, ( . ) and sort of reflecting back and thinking...’oh, it’s not this way, it’s this way round, ‘ so it became easier to talk about what was happening. But even though I was sort of talking with those people, it still became very difficult to talk about that with my parents and even more so with people like teachers...and sort of doctors and that kind of thing</td>
</tr>
</tbody>
</table>
| 228-238/2           | ’cause the thing is is that it’s hard to like...express what it’s like when you’re not ( . ) there ( . ) do you know what I mean? You kind of...like...this is the thing about going and asking for help from people is that you know, people tend not to like ( . ) you know, they look at you and they see you as someone, you know, who’s outgoing and happy enough to be asking for help from someone and they see that and they think,
<p>| | |</p>
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<tbody>
<tr>
<td>479-487/2</td>
<td>it’s quite hard to like...I guess part of it, you know, being a bloke and that, like you’re meant to be like,-you have this thing about being strong, you know, you’ve got to be successful and all that kind of thing and like, you know, you don’t need help, you don’t ask for directions, you know, all that kind of thing...you don’t (. ) you know (. ) you’ve got a headache, you know, you don’t go to the doctors, you just you know, whatever like, you know, it’s like you cope by yourself and that so...there’s that as well which is another layer of (. ) you know (. ) you know (. ) trying to convince yourself that you’re fine and that you don’t need help...so yeah...so yeah, there was that</td>
</tr>
<tr>
<td>679-680/3</td>
<td>I knew I needed help I just didn’t know how to do it and I found straight up admitting my issue shameful so I couldn’t do that.</td>
</tr>
<tr>
<td><strong>Wellbeing treatment</strong> 147/2</td>
<td>When I was a teenager, I was offered all the counselling</td>
</tr>
<tr>
<td>415-422/1</td>
<td>I said, it never helped me, it’s just did not work. I (. ) don’t even know how helpful people are (...) If that worked for another people, I think that’s great, but it really did not work for me. Like some women [laughs] were just getting so desperate and one of them was like: ‘oh well, you know, if you cannot do anything else, just say a prayer to God’ [laughs], and I’m just saying: ‘well, thanks for all of the suggestions, but you know, it’s not very practical right now [laughs] at the moment’</td>
</tr>
<tr>
<td>706-710/2</td>
<td>I really wanted antidepressants just to help me to get over it and (...) I didn’t get them (...) I think that, the fact that they understood me and (. ) they understood what I was going through helped me.</td>
</tr>
<tr>
<td>729-731/2</td>
<td>But it was nice that I had someone who recognised what my illness,- and actually made me feel much better about it, made me feel like I was a normal person for it</td>
</tr>
<tr>
<td>744-750/2</td>
<td>Yeah, but I think that although that experience wasn’t as beneficial to me when I was seventeen, I think it would have been extremely beneficial if I got it as a child, ‘cos I would’ve a lot less understanding of my condition and... it would have really helped me a lot. And just to have someone, especially when you’re a child, just to have someone who is really nice, and gentle, and sympathetic, and caring, that (. ) that really would make me feel a lot better about my condition as well</td>
</tr>
<tr>
<td>390-394/3</td>
<td>through sort of the year or so after I started seeing help... on to the medication and sort of that helped stem things getting worse, I... went through a lot of therapy with a lot of different people and a lot of different methods, like CBT and mindfulness and just normal counselling as well, erm, it let me... improve on a lot of the things that had been negatives in my life for quite a while</td>
</tr>
<tr>
<td>400-403/3</td>
<td>it’s been a big help in... maintaining... the... so the happiness that came from getting treated and... getting better and becoming a happier person sort of... fixing all of the other little things around it has helped maintain that happiness afterwards</td>
</tr>
<tr>
<td>410-413/3</td>
<td>when I did start receiving treatment, I thought it would be mostly receiving the treatment and just fixing the depression and the anxiety but it was... much more of a well-rounded improving wellbeing treatment and I think it was a much more positive thing</td>
</tr>
<tr>
<td>458-464/3</td>
<td>I called the counselling service and... I was like ‘yeah, I have an issue, can I come and talk?’ I think they were quite busy around then because it was running up to the exams, but they saw me and I think... I’d seen them briefly before, but... I found it a bit strange because I found it quite hard to talk about things, so I didn’t think I was quite ready when I went before. I didn’t go again. But I did go (.) but when I asked this time, which was the second time, and I did actually and I’ve been going ever since and it does help (.)</td>
</tr>
<tr>
<td>192-195/2</td>
<td>the therapy didn’t end... really when I left... the therapy didn’t really come to a natural close, I sort of went from therapy and just came to university afterwards, they ended a few months before I think because I’d got exams and things. But it was more (.) more (.) we didn’t have like the opportunity to carry on with it</td>
</tr>
<tr>
<td>129-132/2</td>
<td>I could have really done with counselling at that age you know, I could have somebody who might have been able to, - I was never referred to a psychiatrist, nothing like that, they should’ve, - there should be a procedure when someone gets told</td>
</tr>
<tr>
<td><strong>I wish I had...</strong></td>
<td>But I really wanted some justice done. Yeah, but nothing happened and no one did anything, not my dad, not my mum and no one was there like, oh, actually, we should do something about this...</td>
</tr>
<tr>
<td>593-595/2</td>
<td>The school has to have more responsibility to refer the child to get psychological help</td>
</tr>
<tr>
<td>658-659/2</td>
<td>if someone had just like come in and like shaken my shoulders like that and you know... if I could go back I would... I’d be like ‘right, you know, stop, stop trying to be you know... like... stop you know, stop trying so hard to pretend that everything’s alright because it’s not alright, you know, things are getting worse,</td>
</tr>
</tbody>
</table>
but they’re only getting worse because you’re allowing them to get worse’ and stuff like that, you know

I do wonder maybe if there’d been someone I could just go to...informally and just be like...there isn’t...there’s potentially an issue here, like I’m not coping properly like I should be

I think potentially having lectures that I’d have had to have gone to (.) you know, and even like smaller seminar groups that were more like important and more regular, like (.) would have been good, you know.

You get there and they sweep you off and they’re like ‘right, you know, let’s show you the ropes’ and all that kind of thing and it’s like wow I wish, I wish that I’d had that in my- because that would have really helped.

it was good to have those sort of caring people around me as things got worse because...if the same thing had happened at an earlier point, I think it would have probably turned out very differently just because at secondary school I didn’t have the support network there

I should have taken more of those breaks and longer (…) rather than just...doing it to deal with the symptoms and then...going back straight into it...so (.) it was more (.) doing what I needed to do to keep going rather than...trying to fix it.

even before sort of the support, it would...a knowledge of what was happening would have been a step I’d have needed before I could access the support, so the schools I was in never run...we had sort of citizenship (…), but there was never sort of a class on...mental health or that kind of thing and even within courses that I did, like biology, it was never something that was touched on, so (.) I really would have liked that kind of thing because then...I would have been a lot quicker in associating with that kind of thing and then (..) being able to...ask...for support (…) I didn’t know that there should have been someone at the school to talk about it with....and yeah, it would have been nice if there was...yeah, just some...some teaching about that kind of thing (pause).

And at secondary school when things were pretty bad...just...any sort of official support system...so...a permanent nurse on site or a...a counselling system or a teacher
### Appendix D8: Final interrogative themes examples across all interviews

Interrogative themes from the interviews with Lucy (in black), James Careed (in green), and Jules (in blue)

<table>
<thead>
<tr>
<th>Interrogative themes</th>
<th>Line number(s) / Interview number</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Temporality</strong></td>
<td></td>
<td>Note: Symbol (…) signifies text omitted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Symbol [word] signifies added comment/non-verbal communication</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Underlined words are spoken louder</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Symbol (.) signifies a short hesitation</td>
</tr>
<tr>
<td>57/3</td>
<td></td>
<td>I’ve had a lot of time to reflect</td>
</tr>
<tr>
<td>75-77/1</td>
<td></td>
<td>You’d have like a day schedule that went from 8 o’clock in the morning till about half 9 at night and that would be every day Monday to Saturday</td>
</tr>
<tr>
<td>96/3</td>
<td></td>
<td>I was what seventeen at that point</td>
</tr>
<tr>
<td>100/1</td>
<td></td>
<td>getting my SATS results</td>
</tr>
<tr>
<td>118/1</td>
<td></td>
<td>You could sit in a room for three weeks at a time</td>
</tr>
<tr>
<td>182/3</td>
<td></td>
<td>In around Year 9</td>
</tr>
<tr>
<td>187/2</td>
<td></td>
<td>It will last for over, period of months</td>
</tr>
<tr>
<td>194/1</td>
<td></td>
<td>as I got a bit older</td>
</tr>
<tr>
<td>206/2</td>
<td></td>
<td>I could possibly have extra time in exams</td>
</tr>
<tr>
<td>288-289/3</td>
<td></td>
<td>once every…week or two</td>
</tr>
<tr>
<td>322/3</td>
<td></td>
<td>When I had my second spell of depression</td>
</tr>
<tr>
<td>334-335/1</td>
<td></td>
<td>I just ended up staying in school for like three hours a day, every day for like a month</td>
</tr>
<tr>
<td>343/1</td>
<td></td>
<td>Yeah, fifteen years later!</td>
</tr>
<tr>
<td>382/2</td>
<td></td>
<td>Over that summer I got a job</td>
</tr>
<tr>
<td>382/3</td>
<td></td>
<td>if I had a time machine</td>
</tr>
<tr>
<td>458/2</td>
<td></td>
<td>I think he was retired from work then</td>
</tr>
<tr>
<td>459/3</td>
<td></td>
<td>part time, so, oh no it was full time</td>
</tr>
<tr>
<td>461/1</td>
<td></td>
<td>I last spoke to someone in January</td>
</tr>
</tbody>
</table>
I was robbed of a year of my childhood
We all went to work 9-5 pm
Break times and dinner times
I just don’t remember a lot of memories from my childhood
It’s like (…) two years ago, three years ago (…) I was only sixteen or seventeen
[about future plans:] I’m definitely going to try and do a Masters
for as long as possible
The second time when I was depressed
You get half an hour and off then half nine
that moment was the moment
I’m going to go in at the deep end
it was a small primary school near where I live
we would stay at this old house, he, he lived near big city, so he would take us every weekend, take us to the play park, take us to the shopping centre
it just follows me around
You had to go to church
In a downwards spiral
I volunteered at a charity shop
It wasn’t about ticking boxes or jumping through hoops
The way the flat was laid out…. physically
Things went downhill from there I guess
there was this library…that I could go to every day and just take a book out
Two tours of Afghanistan
I think being in a house is nice compared to being in the halls because it’s kind of being in halls you open door and you’re on the street even though you’re inside
There was a common room that they built in the science department
I locked myself in the bathroom
Space in between… and then locked the doors from the inside of the school

Spatiality
<table>
<thead>
<tr>
<th>Page</th>
<th>Text</th>
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</thead>
<tbody>
<tr>
<td>529/2</td>
<td>What happened in my sister’s room, I’d look and really can’t go in</td>
</tr>
<tr>
<td>544/1</td>
<td>The school is on the south coast. But yeah it was a long way</td>
</tr>
<tr>
<td>582/2</td>
<td>on the opposite side of the road was their sixth form</td>
</tr>
<tr>
<td>589/2</td>
<td>Theatre at Roslyn</td>
</tr>
<tr>
<td>613-615/2</td>
<td>My friend lived opposite this house so I had to walk past his house every day and he would be out in the garden</td>
</tr>
<tr>
<td>743/2</td>
<td>straight from there to the counselling service</td>
</tr>
<tr>
<td>765/1</td>
<td>there was a kid in the corner with a Bunsen burner</td>
</tr>
<tr>
<td>775/2</td>
<td>’Cos they were living in Australia</td>
</tr>
<tr>
<td>819/3</td>
<td>you go to chapel</td>
</tr>
<tr>
<td>862-863/3</td>
<td>knocked down the school and they rebuilt the school with a new name</td>
</tr>
<tr>
<td>884-885/2</td>
<td>He brought me into his office</td>
</tr>
<tr>
<td>23-24/3</td>
<td>I’d always been quite a nervous, anxious person</td>
</tr>
<tr>
<td>53-54/3</td>
<td>I didn’t understand fear – I didn’t have many fears</td>
</tr>
<tr>
<td>74/2</td>
<td>It’s a slap in the face really</td>
</tr>
<tr>
<td>134/1</td>
<td>I was always a bit odd</td>
</tr>
<tr>
<td>171/2</td>
<td>blackouts, like my vision would just go and I’d just fall over, not…quite fainting</td>
</tr>
<tr>
<td>184-188/1</td>
<td>she must have some sort of psychological problem that I don’t know what it is [SIGHS]</td>
</tr>
<tr>
<td>219-220/2</td>
<td>[about his visit to the doctors:] Quite groggy and didn’t have any motivation to do stuff and…I was just a bit… and they thought I had carbon monoxide poisoning</td>
</tr>
<tr>
<td>245/3</td>
<td>I feel rotten, I feel rotten for hours afterwards</td>
</tr>
<tr>
<td>249/1</td>
<td>Getting a tough skin</td>
</tr>
<tr>
<td>265/3</td>
<td>I didn’t feel able to do it because of the illness</td>
</tr>
<tr>
<td>302-304/3</td>
<td>Didn’t realise I had dyslexia and like thinking about it now I do actually struggle reading a lot</td>
</tr>
<tr>
<td>321-322/2</td>
<td>I felt so guilty</td>
</tr>
<tr>
<td>374/3</td>
<td>I’m on the whole a happier person and a calmer person</td>
</tr>
<tr>
<td>449-450/3</td>
<td>I don’t know, maybe she’s got some sort of psychopathic tendencies</td>
</tr>
<tr>
<td>474/1</td>
<td>I wasn’t ever very sporty</td>
</tr>
</tbody>
</table>
just feeling so (...) powerless (...) and just...sad
it’s kind of hard to not to be consumed by it
I don’t think I was overreacting, I felt extremely violated by that
I can still remember it really clearly, like how it...the feeling
I’d feel weird in my, in my head
I couldn’t motivate myself to make proper food
sending us to school with greasy hair with an oil in it, we must looked so strange but she didn’t care
[about reading books] I just loved that
I’ve got personal stigma about anxiety and depression, it’s not illness, it’s not real, erm, I should be strong enough to get through it
when she brushed my hair, she never like, hold it, so she would like, brush it and then (.) it would be like so painful (...), pull it and I will be like crying in pain and telling her to stop (..) She was just horrible about it (...) she traumatised me so much by nearly ripping the hair off my scalp
I need to feel good about myself I need to eat loads of ice cream
it was more sort of...physical and psychological bullying
I had good relationships with people
There’s no kind of person who you can even go to (...) like you know, I’m not having a good day today you know?
She told my dad, erm, and she told (..) the woman who was looking after me (.). who would’ve been a family friend, and I think she told my teachers as well
We’ve got good relationship
one of the teachers was trained as a sort of as a counsellor
I do appreciate that experience if I want to help other people
he wasn’t friendly with any teacher in particular
I was taken away from family and stuff (...) it did feel like horribly lonely just being by yourself
Lonely but lonely with other people around me
He could just give me that support and that love that I needed and he’s,– if I didn’t have him, would I have got through it?
<table>
<thead>
<tr>
<th>Line</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>310/3</td>
<td>there’s no community</td>
</tr>
<tr>
<td>392/3</td>
<td>with a lot of different people</td>
</tr>
<tr>
<td>466/1</td>
<td>he would always help me out, that’s why I got closer to him</td>
</tr>
<tr>
<td>517-519/1</td>
<td>Not like they were the teacher but they were like your peer and they were just helping you out and you know it was nice, it was a good relationship</td>
</tr>
<tr>
<td>523/2</td>
<td>The other people who got involved were sort of her friends</td>
</tr>
<tr>
<td>529-530/3</td>
<td>it’s very difficult to explain to other people for them to understand</td>
</tr>
<tr>
<td>545-546/1</td>
<td>Luckily my grandparents lived fairly close so they’d come and see me but I think a lot of time I was just there by myself</td>
</tr>
<tr>
<td>578-579/1</td>
<td>I do remember feeling a bit jealous, ‘cos their mother was so lovely and I thought ‘oh, why can’t I just have their life?’</td>
</tr>
<tr>
<td>586/1</td>
<td>children of friends of my parents</td>
</tr>
<tr>
<td>638/1</td>
<td>it’s been a much closer relationship with my mum</td>
</tr>
<tr>
<td>703/2</td>
<td>There was meant to be a pastoral tutor in halls, he didn’t do anything</td>
</tr>
<tr>
<td>750/3</td>
<td>I’ve never done it in front of other people</td>
</tr>
<tr>
<td>756/1</td>
<td>these things that ostracised me from other people</td>
</tr>
<tr>
<td>797/2</td>
<td>I think that meeting that girl and my friend, I think that helped me, umm</td>
</tr>
<tr>
<td>803-804/2</td>
<td>I don’t blame the teachers for not getting involved and I’m just thankful for the ones who could.</td>
</tr>
<tr>
<td>887-888/3</td>
<td>I didn’t really know that many people and the people I did know weren’t going</td>
</tr>
<tr>
<td>926-928/2</td>
<td>She was very, very interfering in my life, she’s very controlling, you see. But I do feel that some teachers in my school were very sympathetic to that</td>
</tr>
</tbody>
</table>
Appendix E: Slides from pilot study findings presentation

“A stitch in time saves nine”
Lived experiences of professionals supporting the mental health of post-16 learners

A pilot study
In part written for the Doctorate in Educational and Child Psychology
University of Manchester

Dorota Marlin
Supervisor: Dr. Cathy Timmons

July 2016

Background

- “One in ten children and young people (10 per cent) aged 5-16 had a clinically diagnosed mental health disorder” (K theaters, McLaughlin, McGee, Ford & Goodheart 2005, p.4)
- The UK government agenda on delivering mental health support in school (DfE, 2015)
- and the new SEND Code of Practice (DfE, & DCSF, 2014)
- encompass a wider age range 0-25
- Proposed framework of practice for training EPs (Akinsi, Durrman, Lang, & Wright, 2015)

Literature

- The literature on mental health for post-16 learners: lacking in contrast to the body of knowledge of promoting mental health in primary and secondary schools.
- Existing frameworks of practice promoting wellbeing and mental health at schools (st. Monica and Thomas, 2003; West et al., 2006; White, 2015) and how to deal with pupils’ crises (First, 1990)
- Young people’s (YP) needs only became recognised when their mental health difficulties become serious, missing the opportunity for earlier interventions (Korth, & Leaver, 2005)
- Teachers felt challenged in their roles when providing support for CYP with mental health needs (Connelly et al., 2008)
- There is often misidentification of mental health difficulties as behavioural issues and misconception about mental health needs in FE colleges (Warwick et al., 2008)

Contribution to knowledge

- Contribute to bridging the knowledge gap about the mental health needs of post-16 students relevant to the expanding role of the educational psychologist
- Insight into professionals’ experiences of working with YP
- Barriers and facilitators to accessing help
- Building upon Warwick et al (2006, 2008) research with the reference to current climate and legislative changes

Research Questions

- What is the lived experience of the professionals supporting the mental health of post-16 learners?
- What are the professionals’ perceptions of facilitators and barriers to supporting post-16 learners with mental health difficulties?

Methodology

- Qualitative study
- Phenomenological stance: exploring the participants’ perceptions and lived experiences of their work with students with mental health needs and the participants’ own meaning-making, interpreted by the researcher (Lungbridge, 2007; Smith, Flowers, & Larkin, 2009)
- Purposive sampling
- Open-ended, semi-structured interviews (duration between 60-90 minutes)
How does it fit together?

- Lived experiences rich, complex and multi-faceted
- Impact on staff and students
- Influence of personal skills, experience and beliefs and attitudes towards inclusion
- Facilitators and barriers prominent in themes: Service for students and Part of the whole
- Shared understanding amongst staff and between agencies important part as is collaborative work
- Training needs
- Findings can be situated within existing frameworks for promoting mental health in schools (cf. Horbury & Atkinson, 2003; Wearne, 2015)

Limitations

- Findings contextual-bound
- Small sample size – participants representing “good practice colleges”
- Idiographic findings (however, with theoretical transferability)
- Experience analysed through language therefore socially constructed (Willig, 2013)
- One interview only, further explorations might have shed more light on issues participants were faced with, no triangulation

Implications

- Raising awareness amongst EPs about the mental health needs of post-16 learners
- Developing and delivering training for college staff re mental health needs/practice (cf. Wearne, 2015)
- Developing resiliency trainingframeworks for staff in post-16 provisions
- Role of EP in post-16 provisions – what can be done and how to work effectively with EPs
- Developing communities of practice in multi-agency teams

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References


References


