

How Can Qualitative Investigations into Adolescent  
Experiences of Stressors, Risk Factors and Protective Factors  
Further Our Understanding of Mental Well-Being and the  
Prevention of Psychopathology During Adolescence  
in England?

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Thesis submitted for the degree of Doctor of Philosophy (PhD)

2020



## Declaration

I, Amelia Irena Eisenstadt 'Mia', confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature:

Mia Eisenstadt

Date: 1<sup>st</sup> September, 2020



## Abstract

**Background aim:** This thesis explored how qualitative investigations into adolescent experiences of stressors, risk factors and protective factors can further understanding of mental well-being and psychopathology prevention in England.

**Methodology:** (1) A narrative review explored research on adolescent mental well-being and the risk of psychopathology, stressors, and protective factors in adolescence. (2) A qualitative study considered types of stressors and effects on mental well-being in a sample of 54 10- to 16-year-olds in 12 selected geographies across England. (3) A scoping review explored current literature on types of protective factors associated with increases in adolescent mental well-being and the reduction of psychopathology. (4) An ideal-type analysis was applied to examine patterns in reports of protective factors in relation to mental well-being and the risk of psychopathology of 9- to 12-year-olds. (5) A qualitative study explored change in reported protective factors in relation to mental well-being and psychopathology risk over one year for the above sample of 10- to 13-year-olds.

**Results:** (1) The literature review highlighted a lack of qualitative research on the thesis topic in the English context. (2) A thematic analysis identified six overarching types of stressors experienced by adolescents: negative mental states, peer difficulties, bullying, behaviour difficulties, school difficulties and family difficulties, with a total of 32 reported stressors. (3) The scoping review identified 104 protective factors presented in an updated framework. (4) An ideal types typology of protective factors comprised: adolescents with 'Uncertain Sources of Support' (USS,  $N = 35$ , 55.55%), 'Self-Initiated Forms of Support' (SIFS,  $N = 7$ , 11.11%), and those with 'Multiple Sources of Support' (MSS,  $N = 21$ , 33.33%). (5) Exploration of changes in reported protective factors over one year found both continuity and change. Of those that shifted ideal type, 24 participants (40%) moved in a positive direction towards more effective protective factors and (10%) moved towards fewer and less effective protective factors.

**Conclusion:** The qualitative investigations in this thesis identified adolescent perceived protective factors in relation to mental well-being and psychopathology risk. Group-level patterns in protective factors showed continuities and shifts in reports of stressors and protective factors over time. These patterns of stasis and change may have implications for the identification of adolescents at risk of poor mental well-being.

## Impact Statement

By highlighting the heterogeneity in the experiences of stressors and protective factors that adolescents themselves suggest, new opportunities for interventions and approaches arise to support adolescent mental well-being and the prevention of psychopathology. The first implication of the thesis is that examining a broad range of stressors that adolescents report to experience is important in the design and theory of preventative approaches. Interventions that aim to address singular stressors may fail for adolescents that report a high stressor load, occurring in multiple, interacting domains. Second, the focus is shifted not towards *what* support is already in place or risks that can be measured, but towards what support adolescents *perceive* to be effective in relation to *adolescent-reported* stressors. This entails a possible approach towards risk identification that is adolescent-centric and can be combined with findings from the wider literature, and other types of risk assessment. The ideal types typology presents a novel method to study change in patterns of reported protective factors in relation to stressors. Use of the typology can, in theory, identify those adolescents who perceive that they have had least effective and most uncertain support, as well as those who report a deterioration. The ideal types typology was published as a study within the report *Shining a Light on Risk and Protective Factors* (Eisenstadt, Stapley & Deighton, 2020).

The findings of the changes in ideal types study from the thesis have been presented at the International Association for Youth Mental Health (IAYMH) in Brisbane, Australia in 2019 and Children and Young People's Mental Health and Wellbeing: Communities, Families, Resilience and Resistance conference held in Stirling, Scotland 2019. These conferences provided an opportunity to receive feedback on the typology from academics, mental health professionals and young people attending the sessions. The author presented her findings to undergraduates in psychology at London South Bank University as part of a course on qualitative methods; colleagues at the Evidence Based Practice Unit and from clinical services in the Anna Freud Centre; doctoral students on the Clinical Psychology doctorate program at UCL (for two consecutive years); and teachers and sixth form students at a sixth form college in North London.

The candidate was invited to present her thesis findings on a podcast for the Association of Child and Adolescent Mental Health (ACAMH, 13 May 2020). A blog entitled “What young people think matters; a qualitative approach to the study of protective factors for mental well-being” which was recently published by the ACAMH blog synthesised the findings of the studies and has been widely disseminated online. The candidate is committed to the communication of the findings from the literature to the wider public and has communicated many ideas from the thesis and ideas in relation to adolescent mental well-being on her Medium blog. Two of the candidate’s articles were disseminated by Medium in April and August 2020 after selection by Medium curators for the Psychology and Mental Health section.

In 2019, the candidate had the opportunity to facilitate a meeting with youth leaders on the topics of increasing young people’s participation in decision making at EU and local government levels. Later in 2019, she co-facilitated a meeting of leading researchers in the field of risk and protective factors with a young person from a Native American community and a leading researcher in the field of child and adolescent mental health at Leading Minds on the topic of the future of mental health research. Leading Minds was organised by UNICEF and UNICEF Office of Research-*Innocenti*, held in October 2019.

The candidate had the opportunity to peer review journal submissions on the topic of qualitative approaches to stressors and has submitted a paper on the types of stressors adolescents report and effects on mental well-being. In July 2020, the candidate was invited to join as a panellist for the AI for Mental Disorders workshop (Webinar) (<https://www.ai4mh.com>) during the IEEE World Congress on Computational Intelligence 2020 (<https://wcci2020.org>). This interdisciplinary panel explored the promise of AI: the candidate brought in her interest of the promotion of mental well-being and reduction of psychopathology through subjectively reported stressors and protective factors to the discussion.

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## List of Abbreviations

ACAMH	Association for Child and Adolescent Mental Health
AFNCCF	Anna Freud National Centre for Children and Families
APA	American Psychiatric Association
CAFCASS	Child and Adolescent Family Court Advisory and Support Service
CAMHS	Child and Adolescent Mental Health Services
CR	Common Room, a coproduction organisation
CR	Critical Realism
CR	Cumulative Risk
EBPU	Evidence Based Practice Unit
ECA	Extra-Curricular Activities
ES	Emily Stapley
EOI	Expression of Interest
GP	General Practitioner
HS2	HeadStart Phase 2
HS3	HeadStart Phase 3
IAYMH	International Association for Youth Mental Health
JD	Jessica Deighton
LCA	Latent Class Analysis
LG	Lauren Garland
LGBTQI	Lesbian Gay Bi Transgender Queer Intersex
MH	Mental Health
MSS	'Multiple Sources of Support'
MWB	Mental Well-Being
MW	Miranda Wolpert
PE	Physical Education
QLS	Qualitative Longitudinal Study
QRT	Qualitative Research Team
RA	Research Assistant
RT	Rosa Town
SES	Socio-Economic Status

SIFS	'Self-Initiated Forms of Support'
SOG	Safeguarding Oversight Group
TNLCF	The National Lottery Community Fund
UNICEF	United Nations International Children's Emergency Fund
UK	United Kingdom
USS	'Uncertain Sources of Support'
WB	Well-being
WHO	World Health Organization
YA	Young Advisor (from Common Room)

## **Declaration of the Candidate's Role in Each of the Studies**

Guidance was provided for each of the studies by Prof. Jessica Deighton, Dr Emily Stapley, and Prof. Miranda Wolpert.

### **Chapter 1. Adolescent Mental Well-being, Psychopathology, and Experiences of Stressors, Risk Factors, and Protective Factors: A Broad Overview of the Literature**

All work is the candidate's own.

### **Chapter 2. Research Design and Context**

All work is the candidate's own.

### **Chapter 3. What Types of Stressors do Adolescents Report to Experience and What are the Perceived Effects on Their Mental Well-being and Risk of Psychopathology**

The work is the candidate's own. Coding in NVivo and final themes were reviewed for accuracy and consistency by Emily Stapley and Jessica Deighton. The candidate conducted a proportion of the interviews as part of the evaluation of HeadStart phase 2 in 12 areas of England led by the Evidence Based Practice Unit.

### **Chapter 4. What Types of Protective Factors Have Been Associated with Increases in Adolescent Mental Well-Being and a Reduction in the Risk of Psychopathology in Current Research? A Scoping Review.**

The work is the candidate's own. Prof Jessica Deighton reviewed the scoping review protocol and search terms. Lauren Garland screened 20% of the article titles and abstracts according to inclusion and exclusion criteria. Lauren Garland and the candidate reviewed any differences to achieve consensus.

## **Chapter 5. What Patterns Exist in Adolescents' Experiences and Reports of Protective Factors in Relation to Mental Well-Being and the Risk of psychopathology? An Ideal Type Typology of Protective Factors**

Dr Emily Stapley (ES) reviewed the initial types and assisted with the type formation. Finalised types were checked by Rosa Town and by a Young Advisor for their accessibility for young people. Type descriptions were reviewed by Emily Stapley. Detailed explanation of each of these roles is provided within the chapters.

The candidate was involved in inputting into the design of the interview schedule and conducted a proportion of the interviews as part of HeadStart phase 3 in three of the six areas: Cornwall, London Borough of Newham, and Kent. Transcripts were checked by Ola Demkowicz, Emily Stapley, and the candidate.

## **Chapter 6. A Qualitative Study of Changes in Reported Experiences of Protective Factors in Relation to Mental Well-being and the Risk of Psychopathology over the Course of One Year for 10- to 13-year-olds.**

All work is the candidate's own. Initial research proposal was reviewed by Emily Stapley and Jessica Deighton. Case reconstructions were sorted into types by Dr Emily Stapley.

## **Chapter 7. Thesis Discussion**

All work is the candidate's own.



# Publications and Presentations Associated with the Thesis

## Journal Articles and Reports

Eisenstadt, M., Stapley, E., Deighton, J & Wolpert, M., (2020). Adolescent Stressors and Their Perceived Effects on Mental Wellbeing: A Qualitative Study. *Mental Health and Family Medicine*, 16, 992-1001 Retrieved from

<http://www.mhfmjournal.com/pdf/adolescent-stressors-and-their-perceived-effects-on-mental-well-being-a-qualitative-study.pdf>

Eisenstadt, M., Stapley, E., & Deighton, J. (2019). Learning from young people in Headstart: a study of young peoples reported protective factors in relation to risk factors and wellbeing. Retrieved from [https://www.ucl.ac.uk/evidence-based-practice-unit/sites/evidence-based-practice-unit/files/evidence\\_briefing\\_6\\_january\\_2020.pdf](https://www.ucl.ac.uk/evidence-based-practice-unit/sites/evidence-based-practice-unit/files/evidence_briefing_6_january_2020.pdf)

Stapley, E., Demkowicz, O., Eisenstadt, M., Wolpert, M., & Deighton, J. (2019). Coping with the stresses of daily life in England: A qualitative study of self-care strategies and social and professional support in early adolescence. *Journal of Early Adolescence*. <https://doi.org/10.1177/0272431619858420>

Hayes, D., Cortina, M. A., Labno, A., Moore, A., Edbrooke-Childs, J., Moltrecht, B., Eisenstadt, M., Dalzell, K., & Deighton, J. (2020). Social Prescribing in Children and Young People: A review of the evidence. [https://www.ucl.ac.uk/evidence-based-practice-unit/sites/evidence-based-practice-unit/files/review\\_social\\_prescribing\\_in\\_children\\_and\\_young\\_people\\_final\\_0.pdf](https://www.ucl.ac.uk/evidence-based-practice-unit/sites/evidence-based-practice-unit/files/review_social_prescribing_in_children_and_young_people_final_0.pdf)

Liverpool, S. Eisenstadt, M. Pereira, B, Prescod, J, & Edbrooke-Childs, J. (2020). The emotional experiences of parents making child mental health decisions: A synthesis of qualitative evidence. [Submitted for publication]

Eisenstadt, M., Merrick, H., Town, R & Dutta, S., (2021). A Brief Review of Culturally Specific Protective Factors for Positive Mental Health, *Mental Health and the Coronavirus Research Bite Number 3*. Retrieved from

[HTTPS://WWW.ANNAFREUD.ORG/MEDIA/13430/CORONAVIRUS-RESEARCH-BITE-6-PROTECTIVE-FACTORS.PDF](https://www.annafreud.org/media/13430/coronavirus-research-bite-6-protective-factors.pdf)

## **Presentations**

Eisenstadt, M. (2016, November 29). *Risk factor research: Opportunities for research and practice*. [Presentation to HeadStart partnerships and Learning Team] HeadStart Workshop, Anna Freud Centre, Maresfield Gardens, London.

Eisenstadt, M. (2017, March 29). *What stressors do adolescents face and what are the effects on their well-being?* [Poster presentation]. University College London, Faculty of Brain Sciences Fifth Annual Postgraduate Research Symposium, London, United Kingdom.

Eisenstadt, M. (2017, April 25). *What is evidence and to whom? Epistemological approaches to psychology*. [Presentation to EBPU PhD students]. Evidence Based Practice Unit, London.

Eisenstadt, M., Demkowicz, O, & Stapley, E. (2019). *Coping with the stresses of daily life in England: Self-care strategies in early adolescence* [Paper presentation]. CORC Members Forum.

Eisenstadt, M. (2018, August 13<sup>th</sup>). *A qualitative study of changes in reported protective factors over the course of one year for 10- to 13-year-olds* [Paper presentation]. Presentation to the Evidence Based Practice Unit as part of the Text Talk series.

Eisenstadt, M. (2019, September 5-7<sup>th</sup>). *A qualitative study of changes in reported protective factors over the course of one year for 10- to 13-year-olds* [Paper presentation]. Children and Young People's Mental Health and Wellbeing: Communities, Families, Resilience, and Resistance Conference, Stirling, Scotland.

Eisenstadt, M. (2019, October 27-28th). *A qualitative study of changes in reported protective factors over the course of one year for 10- to 13-year-olds* [Paper presentation]. 5th International Conference on Youth Mental Health, Brisbane, Australia.

Eisenstadt, M. & Wolpert, M. (2019, May 10th). *Making Evidence Practice a reality: Navigating the swampy lowlands*. Presentation to Clinical Psychology Doctoral students, UCL, London.

Eisenstadt, M. (2019, November 7th). *Interviews with Children and Young People*. [Presentation for first year PhD Students], Evidence Based Practice Unit, London.

Eisenstadt, M. (2020, January) *HeadStart and risk factor research*. iRisk – Young Champion Session, Kantor Centre for Excellence, London.

Eisenstadt, M. (2020, May 29th) *What can changes in young people's narratives over time tell us about mental wellbeing and reducing the risk of mental health disorders in adolescence?* [An online presentation and discussion]. Anna Freud National Centre for Children and Families.

Eisenstadt, M. & Wolpert, M. (2020, June 5th). *Making Evidence Practice a reality: Navigating the swampy lowlands*. Presentation to Clinical Psychology Doctoral students, UCL, London.

## **Blogs**

Eisenstadt, M. (2020). "What young people think matters; a qualitative approach to the study of protective factors for mental well-being" Association of Child Adolescent Mental Health.

<https://www.acamh.org/blog/qualitative-approach-to-the-study-of-protective-factors-for-mental-well-being/>

Eisenstadt, M. (2020). Life after lockdown: What can the science of coping tell us about young people's wellbeing? Medium blog. Distributed as part of their

psychology section. <https://medium.com/@mia.eisenstadt/life-after-lock-down-what-can-the-science-of-coping-tell-us-about-young-peoples-well-being-7348d690bfb3>

## **Podcast**

Podcast: "In Conversation: Mia Eisenstadt", ACAMH, 13 May 2020  
<https://www.acamh.org/podcasts/in-conversation-mia-eisenstadt/>

## Acknowledgements

Firstly, I would like to thank my fantastic supervisory team: Prof. Jessica Deighton, Dr Emily Stapley and Prof. Miranda Wolpert for their consistent, thorough, and patient support and encouragement throughout the PhD and the pandemic. Thanks to Jess for being a beacon of calm, wisdom, and inspiration. Heartfelt thanks and acknowledgement to Emily for support on site visits and enabling me to weave my studies as separate strands but integral aspects of the qualitative evaluation of HeadStart Phase 3. Thank you to Miranda for her sharp thinking that has provided clarity through “the swampy lowlands”. Thank you to the 117 young people who were interviewees in the qualitative studies. This research would not have been possible without both young people’s participation and their voices. I hope that the thesis does justice to the range of perspectives amongst the young people who were generous and kind with their time and sharing their lived experience.

Special thanks to The National Lottery Community Fund (TNLCF) HeadStart program for funding this PhD thesis. I am extremely grateful for the opportunity to situate this work within the cutting-edge research of the Learning Team led by the Evidence Based Practice Unit, a partnership between the Anna Freud National Centre for Children and Families and UCL. Heartfelt thanks to Lauren Garland and Rosa Town and the Young Advisors from Common Room for invaluable input and assistance. Thanks to supportive encouragement and sage guidance from Dr Julian Childs and Dr Dan Hayes. I am indebted to the HeadStart local partnerships in both Phase 2 and 3 of HeadStart and privileged to have witnessed the changes in HeadStart from inception. Much appreciation is due to the participating schools for enabling our visits to undertake interviews as part of the HeadStart Qualitative Longitudinal Study. Thanks to the HeadStart partnership staff for their support with the Qualitative Longitudinal Study and particular thanks to Valdeep Gil, Dr Simon Munk, and Richard Head. Warm thanks to staff at Camelford school in Cornwall who made me feel extremely welcome and supported and carefully arranged my visits there.

Special thanks for thought-provoking conversations with Prof. Val Curran, Prof. Michael Ungar, Dr Bettina Moltrecht, Dr Ola Demkowicz, Dr Shaun Liverpool, Nevicia Case, Dr Holly Bear, Dr Karolin Krause, Dr Sally O’Keeffe, Prof. George Patton, Benjamin Perks, Stefan Peterson, David Antony, Rosie Mansfield, Dr Tanya Lereya Dr Hannah Merrick, and Maddie Crease.

I would like to thank my parents, Marc, and Jacqueline, for their love and unflinching support, and particularly with offering essential childcare during the PhD program, academic conferences, and field visits. Thank you to Naomi, Mick, Robert, and Sylvia for your kindness and continued interest. Special thanks to my youngest brother, Leo and wife, Hannah, for support throughout the PhD journey. Thank you to Zaid for the encouragement, generosity, and moral support. Thanks for your support to Nathan, Charlotte and Jascha. Thanks for the unwavering long-distance support from Eric and Bess Eisenstadt. Deep gratitude to: Angela and Rich, Roz, and Mez Combes, Dharmesh Mistry, Katie Chalcraft, and Oliver Thomas. Thank you for your warmth, friendship, and accommodation during my field visits to East London to Katy Lock, Lily Heinemann and Wasi Rizvi, and Zenoby Orsten-Butler.

Thanks to Mark, Bex for friendship and emotional support in the ebbs and flows of life. Further thanks for friendship, adventure, understanding, and kindness is due to Rasheed and Shagufta Turabi, Faraz Hassan, Oliver MacDonald, Grace Gatera, Victor Antony Lopez-Carmen, Anca Gilga, Tina Slade, Sophia Cope Tylee, Dr Becky Keller, Michael Manley, Oliver Benjamin, Dr Jack Woods, Dr Ben Brast-Mckee, and Batian Nieuwerth. Special thanks to Myrna Lewis, Manish Jain, and Courtney Carlsson. Thanks to Joel and Lucy Bassuck and family.

Finally, thanks to my son, Ashar Zak Hassan, for the inspiration, songs, and laughter, and watching my journey with interest.

*In loving memory of Brian Coombe, Tony Parsons, Red Grant, Jack Watson, Betty Watson, Adele Eisenstadt and Joseph Eisenstadt.*

## **Statement of Funding**

This PhD was funded by The National Lottery Community Fund as part of the evaluation of HeadStart Phase 3 led by the Evidence Based Practice Unit, a partnership between the Anna Freud National Centre for Children and Families and University College London.

The data used in this thesis were collected as part of HeadStart Learning Programme and supported by funding from The National Lottery Community Fund. The content of the thesis is solely the responsibility of the author and it does not necessarily reflect the views of The Fund.

# Glossary

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Construct	Definition applied within the thesis
<b>Mental Well-being (MWB)</b>	<p>I am using the definition proposed by Ryan &amp; Deci (2001) that states:</p> <p>“Evidence from a number of investigators has indicated that well-being is probably best conceived as a multidimensional phenomenon that includes aspects of both the hedonic and eudaimonic conceptions of well-being.” (p.148)</p> <p>Hedonic well-being includes happiness, pleasure, and positive feelings. Eudaimonia describes attaining meaning in life, congruence between values and activities and realising potential in activities such as achievements in school or outside of school (Ryan &amp; Deci, 2001; Waterman, 1993).</p>
<b>Psychopathology</b>	<p>Within the thesis, psychopathology is equated with mental disorders. The APA definition of mental disorder (APA, 2000) stipulates it as:</p> <p>“a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one of more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.” (American Psychiatric Association, 2000, p. xxxi)</p> <p>The term “clinically significant” is taken to mean that level of dysfunction that reaches thresholds for concern or intervention (recognising that different studies employ different thresholds to determine clinical significance) (Clark, Cuthbert, Lewis-Fernández, Narrow, &amp; Reed, 2017; Jacobson, Follette, &amp; Revenstorf, 1984).</p> <p>Throughout the thesis, the interest is limited to adolescent-onset psychopathology, rather than psychopathology that presents before or after adolescence (e.g., childhood or adulthood).</p>
<b>Risk factor</b>	<p>“A risk factor is defined as a characteristic, experience, or event that, if present, is associated with an increase in the probability (risk) of a particular outcome over the base rate of the outcome in the general (unexposed) population” (Kazdin, et al., 1997, p. 377).</p> <p>I am considering risk factors for the outcomes of poor mental well-being and/or psychopathology (as defined above).</p>
<b>Stressor</b>	<p>For the purposes of the research within the thesis, the definition of stressors adhered to includes both environmental stressors (negative life events, traumatic experiences, daily hassles) and internal stressors (mental and emotional states, such as worry or trouble regulating emotions), that may be temporary, intermittent, or chronic, which are perceived to affect adolescent mental well-being from the adolescent’s point of view.</p>

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**Protective factor** A protective factor is defined as a variable that may change, interact with, improve, or influence an outcome, either in the context of a known risk factor or not. This draws on the definition by Kazdin that protective factors refer to: “antecedent conditions associated with a decrease in the likelihood of undesirable outcomes or with an increase in the likelihood of positive outcomes” (Kazdin, 1997, p. 377).

In light of this, I am considering protective factors to be variables that decrease the likelihood of the outcomes of poor mental well-being and/or psychopathology and increase the likelihood of positive mental well-being and the absence of psychopathology.

**Coping** In this thesis, the definition of coping from the transactional theory of coping is adhered to, in which Lazarus & Folkman (1984) define coping as the “constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (p. 141).

**Adolescence** “Given the concept that growth continues into the twenties, together with the delays in adopting adult roles, the idea has been proposed that adolescence might best be considered as ranging from 10 to 24 years” (Patton, et al., 2016, p. 375). Adolescence is then divided into early, middle and late adolescence (Braet, Vlierberghe, Vandevivere, Theuwis, & Bosmans, 2013). Definitions of the stages of adolescence vary between studies. In this thesis, samples are included that cover early (9 through 14 years of age) to middle adolescence (14 through 16 years of age) (Oberle, 2018). Late adolescence, the period beyond age 16, is beyond the thesis’ scope.

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Chapter 1: Adolescent Mental Well-being, Psychopathology,  
and Experiences of Stressors, Risk Factors, and Protective  
Factors: A Broad Overview of the Literature

# **1 Adolescent Mental Well-being, Psychopathology, and Experiences of Stressors, Risk Factors, and Protective Factors: A Broad Overview of the Literature**

## **1.1 Introduction**

The overall aim of this thesis is to examine how qualitative investigations into adolescent experiences of stressors, risk factors and protective factors can further our understanding of adolescent mental well-being and the prevention of psychopathology in the context of England. This aim is situated within a broader context of population-level research, which suggests that there has been a decline in mental well-being and rising rates of psychopathology amongst adolescents in the UK (Belfer, 2008; Collishaw, Maughan, Natarajan, & Pickles, 2010; Deighton, Yoon, & Garland, 2020; Deighton et al., 2019). Research indicates that being female increases the odds for emotional difficulties and being male increases the odds for behavioural difficulties amongst adolescents (Deighton et al., 2019; Fink et al., 2015). Research has suggested that as many as 50% of mental health disorders are thought to be established by age 14 (Kessler et al., 2007). An understanding of the subjective experience of the factors that may influence mental well-being and psychopathology is needed for a growing evidence base that mainly comprises quantitative studies. Research in this area has the potential to be applied to preventative efforts aiming to decrease the negative effects of risk factors and stressors for adolescents, in a wider context of rising rates of psychopathology and poor mental well-being.

The first chapter of the thesis will provide a broad overview of the current literature on stressors, risk factors and protective factors in relation to the outcomes of mental well-being and psychopathology. The chapter will also summarise key research issues that characterise the literature on risk factors for poor mental well-being and psychopathology, stressors, and protective factors in relation to mental well-being and reducing the risk of psychopathology. Finally, the chapter will highlight major gaps within the extant literature and opportunities to address these

gaps through empirical investigation and further evidence synthesis, as well as exploration of the potential benefits of such a contribution.

### **1.1.1 The context of adolescent mental well-being and risk of psychopathology**

The period of adolescence is characterised by rapid changes in biological, social, and psychological development, as children mature into young adults (Blum, Astone, Decker, & Mouli, 2014; Buitelaar, 2012; Oberle, 2018; Patton et al., 2018, 2016). During this time, rapid changes occur in a developing adolescent's brain, body, and behaviour (Fuhrmann, Knoll, & Blakemore, 2015a). Changes also unfold in adolescents' relationships with family, school, peers, and others (Fuhrmann et al., 2015a; Lester & Cross, 2015; Oberle, 2018). Whilst many of these changes are part of growing up and pubertal development, some can be experienced as stressors that pose threats to mental well-being and the risk of psychopathology (Benner, 2011; Eccles et al., 1993; Grant et al., 2003; Patton et al., 2018; Pellegrini, 2002). Indeed, a number of stressors and stressful events occur for the first-time during adolescence, such as the transition to secondary school (Benner, 2011; Eccles et al., 1993), which can have negative effects on mental well-being and the risk of psychopathology (Grant et al., 2003). Thus, it has been proposed that early adolescence is an important period of time to study the risk of psychopathology, and is a potentially significant period in which adolescents develop protective resources to manage new stressors (Hollenstein & Loughheed, 2013; Kim, Oesterle, Catalano, & Hawkins, 2015).

Whilst previous definitions of adolescence have typically defined this as the period of life between the ages of 10 and 18 years old in humans, more recent estimates suggest that it is in fact a longer period, ranging from age 10 to 24 (Patton et al., 2016, p. 375). Within psychological research, adolescence is typically divided into early, middle, and late adolescence (Blum et al., 2014; Braet et al., 2013; Meeus, Van De Schoot, Keijsers, Schwartz, & Branje, 2010). Precise estimates of these stages vary between studies; however within the thesis, early adolescence refers to 10 through 14 years of age and middle adolescence designates 14 through 16 years of age (Oberle, 2018). Late adolescence, the period from age 16 and beyond, is beyond the scope of this thesis, as the samples included in this thesis do

not include adolescents above age 16. The periods of early and middle adolescence are key periods within which to study adolescent mental well-being (Blum et al., 2014), given that research suggests that half of adults with psychopathology reported that they first experienced the symptoms of mental health difficulties before age 14 (Kessler et al., 2005).

### **1.1.2 The current context of adolescent mental well-being and psychopathology in the England and the United Kingdom**

Recent national survey data suggests that the mental well-being of adolescents in the UK has decreased since the year 2009 (The Children's Society, 2019). 1 in 9 young people reported having low life satisfaction and being worried about their own future as published in The Good Childhood Report (2019). The report also found age differences in the topics that adolescents were worried about. Drawing on data from the Children's Society Household Survey, early adolescents aged 10 to 13 years old reported worries about grades at school, rather than future employment, whereas older adolescents aged 14 to 17 years old were more concerned about employment and less about grades. Children living in poverty were more worried about their mental health and employment than going to university. When asked about worries towards broader issues, adolescents (aged 14 to 17 years old) were found to be more worried about the British economy, Brexit, crime, and information sharing online, whereas younger adolescents (aged 10 to 13 years old) were unsure about these issues and up to a third of these participants did not answer the questions on Brexit and wider political issues (The Children's Society, 2019). The authors theorised that adolescents in the younger age bracket may lack confidence and knowledge of such topics (The Children's Society, 2019). The survey also found that children who were found to have lower life satisfaction, had an increased risk of worry about their future mental health than their peers and they were also more likely to be worried about housing and employment (The Children's Society, 2019).

In the British context, the Office for National Statistics (ONS) has brought together data on the life satisfaction, feelings of worth and general happiness of children and adolescents since 2012. Findings suggest that there is a level of complexity in the overall wellbeing of British children and adolescents. Many children

are affected by topics such as bullying and feeling unsafe after dark (Department for Education, 2019). Drawing specifically from data from the Household Longitudinal Study (UKHLS) *Understanding Society* (collected in 2016-2017), it was found that 84.9% of early adolescents (10 to 15 years old) reported being “relatively happy with their lives”, and 5% were reported that they were relatively unhappy measured on a scale of 1-7 (Department for Education, 2019). The report found that 13- to 15-year-olds reported lower life satisfaction than their younger peers aged 10 to 12 years (Department for Education, 2019). The report also found that children were happiest with their families and friends and the bullying was a source of difficulty, reported by 17% of participants aged 10 to 15 years old (Department for Education, 2019).

When subject to international comparison with other developed countries, the UK has previously scored low or mid-range in terms of adolescent mental well-being (UNICEF, 2007). For instance, concerns were raised by a United Nations Children’s Fund (UNICEF) report card, which ranked the UK in the bottom third of developed countries for child well-being (UNICEF, 2007). The report card assessed five areas of children’s lives: material well-being, health, behaviour and risks, education, housing, and environmental safety (UNICEF, 2007). In an updated report card 11, the UK was ranked as 20th out of 35 countries for life satisfaction and 16<sup>th</sup> out of 29 rich countries assessed for child and adolescent well-being (UNICEF, 2013). The results of the UNICEF report cards have prompted a range of inquiries into understanding associations with, and threats towards, adolescent well-being in the UK (Booker, Skew, Sacker, & Kelly, 2014). Booker et al. (2014) argue that “It is important to understand why the UK youth are doing poorly” (p. 318), and this entails examination of which factors link to changes in well-being. Thus, opportunities exist for further research that explores how adolescents perceive and make meaning in relation to the factors affecting their well-being, and how this may relate to the risk of poor well-being.

As stated, evidence suggests that the rate of psychopathology is growing within the UK (Belfer, 2008; Deighton et al., 2020; Pitchforth et al., 2019). Estimates suggest that 1 in 8 (12.8%) 5- to 19-year-olds in the UK have at least one type of psychopathology (NHS Digital, 2017). This rise is in line with similar trends across developed countries, particularly in terms of increases in rates of anxiety and

depression (Collishaw et al., 2010; Thapar, Collishaw, Pine, & Thapar, 2012). Notably, emotional disorders have been found to increase in girls more than boys in the UK (Collishaw, 2015; Deighton, et al., 2020; Fink et al., 2015). Recent research from a quantitative longitudinal study using the HeadStart dataset of 10,889 young people (46% male and 54% female), that began in 2017 at age 11-12 and continued until 2019 (age 13-14), found that emotional difficulties increased by 17% between the ages of 11 and 14 (Deighton, Yoon, & Garland, 2020). However, as compared to female adolescents, male adolescents' emotional difficulties remained at similar levels, even reducing by 5% over the period (Deighton, Yoon, & Garland, 2020). Thus, the authors concluded that the period of early adolescence is a time when gender differences in the onset of psychopathology begin to emerge (Deighton, Yoon, & Garland, 2020).

Other research has found that young women had higher rates of emotional disorders and self-harm than other demographic groups (NHS Information Centre, 2018). Research found that 25.5% of 11- to 16-year-olds surveyed with a type of psychopathology had previously self-harmed or attempted suicide. This was compared to 3.0% of those without a diagnosis (NHS Information Centre, 2018). Furthermore, self-harm is not a standalone incident, children and adolescents who have self-harmed are 9 times more likely to die of unnatural causes and an increased risk of suicide and fatal acute alcohol or drug poisoning (Morgan et al., 2017). Research suggests that the demand for child and adolescent mental health services (CAMHS) in the UK has also been rising (Crenna-Jennings & Hutchinson, 2018). The number of referrals to specialist CAMHS services has increased by 26% in the last five years, yet a significant proportion of referrals continue to be rejected (Crenna-Jennings & Hutchinson, 2018). A recent report found that 24.2% of children and adolescents referred to CAMHS were rejected in their request for support and the authors estimate that at least 55,800 sought support from CAMHS but were not deemed eligible (Crenna-Jennings & Hutchinson, 2018).

Increases in adolescent psychopathology necessitate increased service provision and associated cost. Evidence suggests that child mental health services may be under a degree of strain and the cost of treatment per individual is high. Findings from the 2019 CAMHS benchmarking report demonstrated that the annual

operating cost per bed was £219,000 (NHS Benchmarking Network, 2019). The community costs of provision for adolescent mental health was £5.4 million per 100,000 (age 0-18) in the year 2018/2019 (NHS Benchmarking Network, 2019). In addition to the treatment of mental health services, a lack of service provision for those at risk of psychopathology can also pose a high cost to society with one possible outcomes of a lack of support resulting in antisocial behaviour and an associated with increased risk of crime (Scott, Knapp, Henderson, & Maughan, 2001). Evidence suggests that interventions to prevent adolescent psychopathology can contribute to cost savings later on (as adolescents become adults), including savings for related sectors, such as education, criminal and welfare systems (Scott et al., 2001; Skokauskas et al., 2018). Thus, the long-term sequelae raises a question about what support adolescents can, might and do access who are on the cusp of psychopathology and may report poor mental well-being and some symptoms of psychopathology. Additionally, there may be long-term economic savings from early intervention in mental health.

Psychopathology is equated within this thesis with the concept of types of mental disorders, in line with existing literature (Butcher & Hooley, 2018; Krueger & Markon, 2006; Moleiro, 2018). For the purpose of this review and the remainder of this thesis, a mental disorder refers to:

A clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one of more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. (American Psychiatric Association, 2000, p. xxxi).

In the above definition, the term “clinically significant” is taken to mean that the level of dysfunction reaches thresholds for concern or intervention (Clark et al., 2017; Jacobsen & Hofmann, 1997). This definition is also adopted within this thesis.

Throughout the studies in this thesis, the interest is limited to adolescent-onset psychopathology, rather than psychopathology that presents before or after adolescence (e.g., childhood or adulthood).

## 1.2 The study of adolescent mental well-being

The study of adolescent mental well-being is agreed to be important for society and public health (Rose et al., 2017). However, to date, the focus within the research and health community has been less on the study of positive well-being within psychology and more on alleviating the symptoms of psychopathology and dysfunction (Deci & Ryan, 2008a; Dray et al., 2017; Hamby et al., 2018; Huppert, 2009; Keyes, Shmotkin, & Ryff, 2002). This emphasis has been reflected in research and in the design of interventions aiming to reduce specific types of psychopathology (Rose et al., 2017; Suldo & Shaffer, 2008). However, since the 1960s a shift has occurred towards more psychological research focused on the promotion of happiness and well-being (Huppert, 2009; Rose et al., 2017). This shift occurred because the pursuit of well-being and positive mental health were increasingly being considered by researchers in this field as beneficial goals in their own right, as well as due to a growing understanding that increasing positive well-being may be a beneficial approach to decrease the risk of psychopathology (Huppert, 2014).

Over time, psychologists have increasingly sought to understand the determinates of positive mental health or positive well-being (Huppert, 2014). Jahoda (1958) was the first psychologist to put forward the notion of *positive mental health* (Huppert, 2014). Jahoda (1958) argued that positive functioning comprised 'attitudes of an individual towards his own self', 'self-actualisation', 'integration', 'autonomy', 'perception of reality', and 'environmental mastery'. More recent theorists have posited in a theory of self-determination that positive well-being is the result of fulfilling fundamental psychological needs, defined as 'autonomy', 'competence', and 'relatedness' (Ryan & Deci, 2001). Yet, despite increased emphasis on exploring the factors that promote well-being, confusion remains within the literature around the general term 'well-being' and it has proved difficult to operationalise empirically (Thomas, 2009). Some researchers have suggested that

well-being is “intangible, difficult to define and even harder to measure” (Thomas, 2009, p. 11). Others have described well-being as “conceptually muddy... [but] pervasive” (Morrow & Mayall, 2009, p. 221).

Whilst some theorists have focused on defining the generic concept of well-being, others have focused on defining a particular aspect, such as *psychological well-being*, *emotional well-being*, or *subjective well-being* (Chen, Jing, Hayes, & Lee, 2013). Subjective well-being focuses on an individual’s happiness and cognitive and affective appraisals of their life (Chen et al., 2013; Diener, 1984). Emotional well-being can be defined as the hedonic aspects of well-being, referring to positive affect and life satisfaction (Chen et al., 2013; Deci & Ryan, 2008b). Psychological well-being has been defined as the eudaimonic aspects referring to meaning, goal fulfilment and realising potential (Keyes et al., 2002; Ryff & Keyes, 1995). In this thesis, the interest is in both hedonic and eudaimonic aspects of well-being and thus for the present purposes, mental well-being is defined following Ryan and Deci (2001), as a: “A multidimensional phenomenon that includes aspects of both the hedonic and eudaimonic conceptions of well-being” (p.148). Hedonic well-being includes happiness, pleasure, and positive feelings (Ryan & Deci, 2001). Eudaimonia describes attaining meaning in life, congruence between values and activities, and realising potential in activities, such as achievements in school or outside of school (Ryan & Deci, 2001; Waterman, 1993). This thesis will focus on mental well-being and thus excludes physical well-being, which would likely be included in a general definition of well-being.

A precise definition of mental well-being is necessary to measure the construct accurately, as well as to differentiate mental well-being from related concepts of mental health and psychopathology. However, studies sometimes use the terms mental health or well-being interchangeably (Keyes, 2006), when the two constructs are, in fact, quite distinct (Patalay & Fitzsimons, 2016). For example, a definition of mental health proposed by Keyes (2006) posits that mental health refers to emotional, psychological, and social well-being, with well-being as the underlying construct. Moreover, the commonly cited World Health Organisation (WHO) definition of mental health views it as, “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work

productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2004). As more studies measure well-being, it is essential to be clear about how well-being is defined, measured and interpreted (Dodge, Daly, Huyton, & Sanders, 2012). However, beyond construct validity, the precise measure of well-being applied varies between studies, with some studies looking at related constructs, such as life satisfaction (Sharpe et al., 2016), rather than specifically at the construct of mental well-being. A recent study of a large community sample of 45,398 children and early adolescents (8 to 13 years old) in schools across England measured self-reported quality of life and symptoms of psychopathology using the Me and My School questionnaire, finding that of those participants who met the threshold for a type of psychopathology only 12% reported a high quality of life (Sharpe et al., 2016).

Evidence is increasing in favour of treating mental well-being and psychopathology (or mental health) as distinct, yet overlapping, constructs (Patalay & Fitzsimons, 2016; Sharpe et al., 2016). Research has found that individuals with psychopathology, such as depression, have lower reported well-being (Deci & Ryan, 2008a; Lucas, Diener, & Suh, 1996; Ozer & Benet-Martínez, 2006). Yet, studies also suggest that while mental well-being and psychopathology can be highly negatively correlated, some adolescents can have symptoms of psychopathology (e.g., depressive symptoms), but still have high levels of mental well-being (Sharpe et al., 2016). Conversely, adolescents could report no psychopathology but have low levels of mental well-being, as indexed by low levels of life satisfaction and quality of life (Greenspoon & Saklofske, 2001; Sharpe et al., 2016; Suldo et al., 2009). Thus, the absence of psychopathology does not necessarily entail the presence of positive well-being, such as life satisfaction (Cloninger, Salloum, & Mezzich, 2012), though highly linked.

Further empirical evidence on the topic of the distinction between psychopathology and mental well-being is provided by a study that examined predictors of both outcomes. Using data from the Millennium Cohort Study (MCS) in the UK, Patalay and Fitzsimons (2016) compared a range of predictors of psychopathology and subjective well-being. First, the study noted a modest correlation between psychopathology and well-being, which was (-0.2), indicating a

low overlap between these two domains (Patalay & Fitzsimons, 2016). Furthermore, the study found that predictors of symptoms of psychopathology at age 11 were not the same as predictors of positive well-being. Predictors of psychopathology included cognitive factors, home environment factors, and parental health. Risk factors identified were communication difficulties, chronic illness, peer relationship problems and frequent arguments with a parent. The main predictors for well-being, however, were social relationships and the wider environment, including perceived school connectedness, liking school and an absence of peer bullying (relating to school and peers). In sum, Patalay and Fitzsimons's (2016) study provides evidence of the different, yet overlapping, conceptual territory of psychopathology and mental well-being.

### **1.3 Risk factors for poor mental well-being and psychopathology in adolescence**

The study of threats to the mental well-being of adolescents and the risk of psychopathology has been approached through the study of risk factors. Researchers in the field of risk research aim to identify factors that predict a given negative outcome, often with the intention of identifying individuals most at risk and who could benefit from potential intervention (Kraemer et al., 1997). Studying risk factors has assisted with identifying the causes of different types of psychopathology (Kazdin, Kraemer, Kessler, Kupfer, & Offord, 1997). The causes of psychopathology are not straightforward, however; instead they are “complex and multifactorial” (Fairchild, 2011, p. 414). *Causal risk factors* have been described as the 'gold' of risk estimation due to the fact that they can be applied to “identify who is most at risk and inform the selection of variables to change within the context of interventions to prevent the outcome” (Kraemer et al., 2005, pp. 32-33). A causal risk factor is: “associated with a mental illness outcome, precedes the outcome, can be changed and its modification changes the outcome”, and thus is important for preventative intervention design (Furber, Leach, Guy, & Segal, 2017, p. 232). Risk factors can be fixed attributes, like gender (that cannot be easily changed through intervention), or, they can be *modifiable* factors that can be purposefully changed through

preventative interventions, such as modifying negative thought patterns in the context of an intervention (Kioumourtzoglou, 2019; Rice & Rawal, 2011).

Whilst risk factors increase the likelihood of a negative outcome occurring, there remains variability within populations of the extent to which a negative outcome will occur (Masten, 2011). Many different pathways contribute to a given outcome, such as mental well-being. Such pathways were previously described as part of development by psychoanalyst Anna Freud as 'developmental lines' (Freud, 1965; Luyten, Vliegen, Van Houdenhove, & Blatt, 2008). The term *equifinality* refers to the phenomenon that different developmental pathways may lead to the same developmental outcome (Cicchetti & Rogosch, 1996). For example, amongst adolescents who develop types of psychopathology, some will have experienced a range of different risk factors and experiences that led to the outcome, relative to others (Cicchetti & Rogosch, 1996). In contrast, *multifinality* is the notion that one risk factor, such as parental divorce, may lead to different developmental outcomes (positive, neutral, or negative) in the adolescent, depending on other influences, including the adolescent's perception of the stressor itself (Cicchetti & Rogosch, 1996; Luyten, Blatt, Van Houdenhove, & Corveleyn, 2006).

One implication of multifinality is that taking a person-centred approach to examining the relationships between risk factors or stressors and outcome is important, owing to the fact that contexts affect adolescents in different ways (Drabick & Kendall, 2010). Thus, how a context interacts with individual factors to contribute to an adolescent's mental well-being and risk of psychopathology is highly variable. How an adolescent perceives the context or a given stressor can arguably also have a role in determining the effects of a risk factor on outcomes. Thus, taking a qualitative, person-centred approach to examining variation in how stressors may be perceived by adolescents has potential benefits for the evidence base. Qualitative research can further understanding of the links between a stressor or a group of stressors and their contribution towards poor mental well-being or risk of psychopathology. Preventative interventions also need to account for the variation in the ways that adolescents perceive and respond to stressors (Stroud et al., 2009), as well as variation in which risk factors an adolescent experiences (Gladstone, Beardslee, & O'Connor, 2011). Interventions that may be too focused on one

pathway may not take into account multifinality and the range of responses that individuals can have to stressors (Luyten et al., 2008). Research on the variation in how risk factors and specific stressors link with outcomes of interest is therefore key to understanding who has a high level of risk and how interventions can reduce or eliminate risk of poor mental well-being and psychopathology.

At the level of the individual, a wide range of risk factors for the outcome of poor mental well-being in adolescents have been studied within the evidence base. Examples include a lack of perceiving that one's life has meaning (Rathi & Rastogi, 2007), negative schemas (cognitive frameworks that interpret events negatively) (Cherry & Lumley, 2019), low self-esteem (Donnellan, Trzesniewski, Robins, Moffitt, & Caspi, 2005) and body dissatisfaction (Durkin & Paxton, 2002; O'Dea, 2006). Normative biological and social transitions that occur during adolescence, such as puberty and the move to secondary school can also be a source of risk.

With regard to puberty, extensive research has explored the role of early pubertal development as a risk factor in girls for types of psychopathology, such as anxiety and depression (Graber, Lewinsohn, Seeley, & Brooks-Gunn, 1997; Kaltiala-Heino, Marttunen, Rantanen, & Rimpelä, 2003). However, the findings for boys in relation to this have been much less consistent (Pomerantz, Parent, Forehand, Breslend, & Winer, 2017). Whilst early maturation in girls is associated with risk of internalising symptoms. Older studies found that early maturation in boys was advantageous, or did not exert a negative effect, more recent studies have found that it is also linked with internalising symptoms, however, for late maturation the findings have been less clear (Pomerantz et al., 2017). Some studies find late maturation to be linked with internalising symptoms and others do not, and whether the data is self-reported or reported by parents or a physical exam (Dorn, Susman, & Ponirakis, 2003).

With regard to the move to secondary school, as young adolescents enter new settings, they have to contend with new rules, changes in peer groups, and new teachers, and confers a risk of a mismatch between social settings and individual development (Eccles et al., 1993), which can be a cause of distress (Benner, 2011). Negative life events, such as bullying or interpersonal issues, have also been linked

with poor mental well-being (Bryden, Field, & Francis, 2015; Grant, Compas, Thurm, McMahon, & Gipson, 2004), and increased risk of depression (Stikkelbroek, Bodden, Kleinjan, Reijnders, & van Baar, 2016). Moreover, the outcome of poor mental well-being itself can be a risk factor for particular types of psychopathology, such as depression and other internalising disorders (Watson & Naragon-Gainey, 2010).

Further, at the individual level, there is an extensive evidence base covering genetic risk factors for types of psychopathology (Arnau-Soler et al., 2019; Dick, 2011; Dunn et al., 2011; Krishnan et al., 2016; Thapar et al., 2012; Venables et al., 2017). Research has examined the interaction of genetic and environmental factors, described as the G x E (genes x environment) interaction, in contributing to an increased risk of psychopathology or towards specific types of psychopathology, such as depression (Dick, 2011; Dunn et al., 2011; Kendler & Eaves, 1986). Some types of psychopathology have been found to have a much stronger genetic component than others, such as depression (Shadrina, Bondarenko, & Slominsky, 2018; Thapar, Cooper, Eyre, & Langley, 2013). Adolescents vary in the extent to which they may have underlying genetic risk factors for psychopathology and the influence of genetic factors varies across development (Bartels, Cacioppo, van Beijsterveldt, & Boomsma, 2013). The examination of genetic factors contributing to mental well-being and risk of psychopathology is beyond the scope of this thesis, but it is important to reference this growing direction within the literature (see Arnau-Soler et al., 2019).

At the family level, risk factors for poor adolescent mental well-being include poor relationships with parents (Broberg, 2012; Gauze, Bukowski, Aquan-Assee, & Sippola, 1996), paternal criminality (Murray & Farrington, 2008), parental mental ill-health (Beardslee, Gladstone, & O'Connor, 2011; Halligan, Murray, Martins, & Cooper, 2007), parental subjectively perceived lower mental and physical health (Giannakopoulos et al., 2009), and higher parental psychological control (of the adolescent) and restrictions on the adolescent's autonomy (Barber & Harmon, 2002; Baumrind, 2005; Stafford, Kuh, Gale, Mishra, & Richards, 2016). Perceived insecure attachment (Doyle & Markiewicz, 2005), marital conflict (Doyle & Markiewicz, 2005) and living in a separated family (Hetherington & Kelly, 2002) are also risk factors for poor adolescent mental well-being, as well as parental divorce and parental distress

(Størksen, Røysamb, Holmen, & Tambs, 2006). Perceptions of a lack of open communication from parents by adolescents have also been found to be associated with poor mental wellbeing in adolescents (Bireda & Pillay, 2018), as well as difficult communication with parents (Levin & Currie, 2010).

Beyond the family, poor relationships with teachers have been found to be a risk factor for reduced mental well-being in adolescents, as has a lack of connection with peers at school (Bond et al., 2007; Moore et al., 2018). Bullying has been found to be associated with the risk of psychopathology across a range of studies, including social withdrawal, internalising problems, delinquency, self-harm, and psychotic symptoms (Arseneault et al., 2011; Bender & Lösel, 2011; Esbensen & Carson, 2009; Przybylski & Bowes, 2017; Rothon, Head, Klineberg, & Stansfeld, 2011). Cyberbullying is another risk factor found to correlate with poor well-being (Wigderson & Lynch, 2013). A systematic narrative review found that social media in general has been found to have mixed effects across studies, including negative, positive and neutral effects on well-being (Best, Manktelow, & Taylor, 2014). A lack of friends, as compared to having friends, has been found to correlate with adolescent distress (Wentzel, Barry, & Caldwell, 2004). However, a recent study by Moore et al. (2018) found a positive association between peer relationships and mental well-being, when support from friends was accompanied by support from family. In contrast, when support for friends was provided without close family relationships, individuals were more likely to have lower mental well-being and more likely to engage in risky behaviours (Moore et al., 2018).

At the community level, exposure to community violence has been associated with poor well-being and symptoms of psychopathology (Stansfeld et al., 2017), poor physical characteristics of the neighbourhood (such as dilapidated housing) are associated with the risk of depression, Attention Deficit Hyperactivity Disorder (ADHD) and disruptive behaviour (Butler, Kowalkowski, Jones, & Raphael, 2012). Neighbourhood poverty is another correlate of poor mental wellbeing (McBride et al., 2011). Neighbourhood disadvantage is linked with an increased risk of behavioural problems. In a review by Sellström & Bremberg (2006), several cross-sectional studies have found links with the social climate of neighbourhoods (social climate refers to levels of social support and control, crime rates, voluntary groups,

residential stability, neighbourhood cohesion, and collective efficacy and the risk of behavioural difficulties (Drukker, Kaplan, Feron, & van Os, 2003; Rankin & Quane, 2002). Low levels of connectedness to school have been found to be another risk factor in several studies, with an association with a range of outcomes such as poor well-being, risk of depressive symptoms, risky behaviour and reduced likelihood of completing school (Bond et al., 2007; Patalay & Fitzsimons, 2016).

Overall, threats to mental well-being and the onset of psychopathology have been found to have multiple causes through the interaction of genetic, biological, family and social factors (Kraemer, Lowe, & Kupfer, 2005). Yet, despite the interconnections between risk factors, many studies have focused their inquiries on a singular risk factor, rather than on multiple, co-occurring risk factors (Appleyard, Egeland, van Dulmen, & Sroufe, 2005; Evans, Li, & Whipple, 2013). The challenge with this approach is that adolescents often experience constellations of co-occurring risk factors (Masten & Wright, 1998). Indeed, multiple risk factors have been shown to have stronger combined effects on mental well-being and psychopathology than individual risk factors (Appleyard et al., 2005). Multiple risk factors tend to be a better predictor of the risk of psychopathology and other negative outcomes (Appleyard et al., 2005; Gutman, Sameroff, & Cole, 2003). Investigating multiple risk factors and the manner in which they interact to influence outcomes is thus vital (Raviv, Taussig, Culhane, & Garrido, 2010).

Cumulative risk analysis is performed by marking risks present or absent and summing the total number of risks (Evans et al., 2013; Gerard & Buehler, 2004; Hebron, Oldfield, & Humphrey, 2016). For example, cumulative risk studies suggest that three or more risk factors can have a significant negative effect on outcomes (Jones, Forehand, Brody, & Armistead, 2002; Morales & Guerra, 2006). It has been hypothesised that cumulative risks place a load on the individual that exceeds the biological and psychological capacities and systems to withstand stress, described as *allostatic load* (AL) (Danese & McEwen, 2012; McEwen, 2004). The notion of cumulative risk has predictive validity, as it becomes possible to predict adolescent outcomes based on level of risk exposure (Evans et al., 2013). However, a disadvantage of the CR approach is that it gives all risks the same weighting so it is not possible to understand which risks might be experienced as more salient than

others (Gerard & Buehler, 2004; McLaughlin & Sheridan, 2016). A recent study drawing on data from a large sample of children and adolescents found a significant relationship between cumulative family risk and poor mental well-being outcomes in adolescents (Lin & Seo, 2017). Risks included single parenthood, insecure parental employment, large family size, parental stress, low maternal education, and low maternal physical and mental health (Lin & Seo, 2017). When the level of poverty was also examined, the odds of deterioration in mental well-being was much greater (Lin & Seo, 2017). The authors concluded that children experiencing multiple sources of risk should be prioritised for intervention to prevent poor mental well-being (Lin & Seo, 2017). In summary, the cumulative risk hypothesis is highly relevant for understanding the effects of multiple risks on mental well-being and psychopathology in adolescents, but, owing to the fact that it focuses on the number of risks, it may not illustrate the wide range of processes and mechanisms by which factors interact to influence outcomes (McLaughlin & Sheridan, 2016).

#### **1.4 Stressors in adolescence**

Stressors represent a particular type of risk factor for psychopathology and poor mental well-being (Grant et al., 2003; Seiffge-Krenke, 2000). The terms 'stress' and 'stressor' are often used interchangeably across studies (Grant et al., 2003, 2004, 2014; Grant, McMahon, Duffy, Taylor, & Compas, 2011). Ambiguities (such as variation in definition of terms) have been noted with the use of the term (McEwen, 2004). Further conceptual issues with the definition of stressors have been raised in recent research, particularly whether to place the emphasis on the subjective or objective dimensions of stress (Aggarwal, Prabhu, Anand, & Kotwal, 2007; Christensen et al., 2019). Grant et al.'s (2003) definition of a stressor has been applied in a range of studies. In Grant's definition a stressor refers to "an environmental event or chronic condition that can objectively threaten the physical and/or psychological health or well-being of individuals of a particular age in a particular society" (p. 449). However, this definition is problematic due to it only focusing on objective stressors. For instance, a number of studies have distinguished between 'objective stressors' versus 'subjective stressors' (Christensen et al., 2019). Objective stressors refer to stressors that are understood to be inherently stressful for everyone and are measured through checklists of

events deemed stressful, such as a bereavement or a divorce (Christensen et al., 2019). Checklists include measures such as Stressful Life Events and the Life Events Checklist that have been adapted for different cultural contexts (Moya-Higueras et al., 2018; Zhang, Zhang, Zhang, & Guo, 2019). Studies that focus only on 'objective' stressors have been critiqued for ignoring the subjective appraisal of stressors. Crucially, an event that may be perceived as a stressor for one person, may not be perceived as a stressor for another, this is relevant for both life events as well as everyday stressors (Yeager, Lee, & Jamieson, 2016).

The role of subjective appraisal has been extensively investigated in studies that adopt a transactional theory of stress, which emphasises the role of perception in of a stressor and the cognitive and emotional process that are involved in giving meaning to a stressor (Biggs, Brough, & Drummond, 2017; Christensen et al., 2019). Such studies have focused on the role of the individual in cognitively appraising a given stressor and their capacity to cope with it (Lazarus & Folkman, 1984; Christensen et al., 2019). Appraisal is linked to an individual's classification of a stressor, as well as their response. When an individual perceives a stressor to lie within their capabilities to cope with it is a challenge, when it is beyond their perceived coping resources it is a threat. Research has found different physiological effects from perceiving a stressor as a threat or a challenge (Yeager et al., 2016). Due to being beyond scope, the physiological effects are not of concern but the subjective experiences of stressors as reported by adolescents are of primary import for the current research.

Placing an emphasis on the subjective experience of stressors can enable the study of how the experience and appraisal of stressors may vary between individuals. For example, researchers found that adolescents process the stressor of exposure to community violence differently, and the effects on adolescents' mental well-being is linked to how the threat is appraised (Kliwer & Lepore, 2015). Interestingly, whilst there is a long tradition of stressor research a number of gaps, concerning differences in appraisal of stressors still remain. The interest in this thesis focuses on how adolescents report effects on their mental well-being. Thus, if they perceive a stressor to exceed their coping capacities, this is included, and if

they discuss difficulties with a stressor impacting on their mental well-being (but do *not* mention coping), this is also included.

For the purposes of the thesis, the definition of stressors adhered to is broad and includes both environmental stressors (negative life events, traumatic experiences, daily hassles) and internal stressors (mental and emotional states, such as worry or trouble regulating emotions), that may be temporary, intermittent, or chronic, which are perceived to affect mental well-being by the individual concerned. Within the wider landscape of research, the study of environmental stressors is more common (Brook, Rubenstone, Zhang, Morojele, & Brook, 2011; McMahon, Coker, & Parnes, 2013; Parikh et al., 2019); however, a small minority of qualitative studies have included both external and internal stressors when seeking to understand what adolescents perceive as difficulties or problematic situations (see Farrell et al., 2007).

Mirroring the evidence base on risk factors, stressor research has frequently examined the effects of singular stressors on mental well-being and psychopathology. A range of specific stressors have been studied in bullying and peer victimisation, exam stress, interpersonal conflict, daily hassles, difficulties in romantic relationships and family stressors such as conflict and changes in family structure (Carver & Scheier, 1994; Denscombe, 2000; Forehand, Wierson, McCombs, Brody, & Fauber, 1989; Hamilton et al., 2016; Swearer & Hymel, 2015; Wadsworth & Compas, 2002). Fewer studies exploring the effects of a range of concurrent stressors (Bergman & Scott, 2001; Heizomi, Allahverdipour, Asghari Jafarabadi, & Safaian, 2015), unless under the topic of stressful life events or life events, or under a particular domain, such as interpersonal stressors (Collins & Laursen, 2004; Fiorilli, Grimaldi Capitello, Barni, Buonomo, & Gentile, 2019; Rudolph, 2002). However, it is unlikely that a single stressor is experienced in isolation and, in fact, evidence suggests that one stressor can prompt another, described as '*stress proliferation*' (Pearlin, Schieman, Fazio, & Meersman, 2005).

As discussed, within the study of stressors, an extensive range of population-level checklists and surveys have been developed to measure stressful life events or daily hassles (Grant et al., 2004). Such measures have been criticised, however,

because subscales are based on authors' preconceptions of stressors that limit the type, number, and duration of stressors captured (Duggal et al., 2000). Studies have measured the impact on adolescent mental well-being and risk of psychopathology of such stressors as daily hassles and minor stressors, including the routine challenges of daily life (e.g. being late for school or forgetting homework) (Asselmann, Wittchen, Lieb, & Beesdo-Baum, 2017; Cicognani, 2011), recent stressful events (Moya-Higueras et al., 2018), wider community stressors (such as exposure to neighbourhood violence) (McMahon et al., 2013), extreme traumatic events (such as natural disasters) (Mohay & Forbes, 2009), negative life events (Bryden et al., 2015), adverse childhood events (Balistreri & Alvira-Hammond, 2016), and cumulative life events (the additive effect of events and associations with outcomes in adolescence and later life) (Björkenstam et al., 2015; Bøe, Serlachius, Sivertsen, Petrie, & Hysing, 2018).

Gender similarities and differences in the perception of stressors have been established. For example, negative life events are a risk factor for depressive symptoms in both males and females, but it is also well studied that girls experience a greater range of stressors than boys and may be more emotionally affected by them, particularly conflict amongst peers (Bakker, Ormel, Verhulst, & Oldehinkel, 2010; Hankin, Mermelstein, & Roesch, 2007; Miloseva, Vukosavljevic-Gvozden, Richter, Milosev, & Niklewski, 2017). A prospective cohort study of 2,084 male and female early adolescents in the Netherlands found gender differences in reports of stressors (Bakker et al., 2010). Friendship loss and romantic break-ups were reported by girls and linked to externalising symptoms. Both genders reported the risk of bullying and sexual harassment as stressors, but female adolescents reported increased gossip and boys reported more violence. In line with many other studies, the study found that females had more internalising problems, and boys had more externalising problems (Bakker et al., 2010).

Prospective longitudinal studies have also been key to examining the links between stressors and outcomes (Seiffge-Krenke, 2000). This is because the long-term effects of stressors on mental well-being and psychopathology can be difficult to detect and measure in cross-sectional studies, and '*sleepers effects*' can occur where effects of stressors are not immediate but are picked up at future timepoints

(Seiffge-Krenke, 2000). For example, one study found no association between adolescents' reports of major stressful life events and anxiety and depression at the first data collection point, but at the second timepoint self-reports of negative events explained 5% of the variance in outcomes (Cohen, Burt, & Bjorck, 1987; Seiffge-Krenke, 2000). This study is a reminder that effects of a stressful life event may not be identified at specific times in data collection but may reveal themselves at a later date.

Studies have also found both mediating and moderating factors that influence the extent to which stressors can affect mental well-being (Bryden et al., 2015), or psychopathology (Snyder & Hankin, 2016). A *mediator* refers to an additional factor that intervenes in the relationship between a dependent variable and an independent variable (Baron & Kenny, 1986). Mediators play a less direct role in influencing an outcome of interest (Davis & Humphrey, 2014). For instance, avoidant coping has been found to mediate the association between a reduced emotional intelligence and higher levels of psychological distress (Chan, 2005; Davis & Humphrey, 2014). A *moderator* refers to variables that can make the relationship between two variables either stronger or weaker (Baron & Kenny, 1986; Jach, Sun, Loton, Chin, & Waters, 2018). For example, having a growth mindset has been found to partially moderate the positive effect of strength-based parenting on adolescent well-being (Jach et al., 2018). The study found that adolescents with a growth mindset, when receiving the strength-based parenting intervention, were more likely to use their strengths (Jach et al., 2018).

Research has found complex pathways linking particular moderators, stressors, and outcomes. For example, a study of the role of trait emotional intelligence (perceived competence in EI) as a moderator, found that in a sample of adolescents who had both high emotional intelligence and high self-perceptions of emotional intelligence, experienced fewer depressive symptoms (Davis & Humphrey, 2014). Interestingly, emotional intelligence by itself was not enough to protect adolescents from specific types of stressors. Instead both trait EI and ability EI were found to work in tandem to enable adolescents to reduce the effect of stressors on depression (Davis & Humphrey, 2014). Thus, the authors concluded that the moderators of trait EI and ability EI work together to ensure appropriate selection of

coping strategy and its effective implementation (without ability EI, a coping strategy would not be effective and the stressor would continue to have a negative effect (Davis & Humphrey, 2014).

Indeed, adolescents respond to and function in the context of stressors in heterogeneous ways (Hankin et al., 2011). A number of explanations for this variability exist. For example, the *diathesis–stress model* suggests that the onset of psychopathology results from the interaction of a predisposition to stress (*diatheses*) and exposure to stressors (stress) (Gazelle & Ladd, 2003). According to the diathesis-stress hypothesis, when an individual experiences a given stressor (such as a negative event), how they perceive the stressor will influence the extent to which they develop psychopathology (Swearer & Hymel, 2015). On the other hand, the *theory of differential susceptibility* postulates that different underlying susceptibilities (such as a genetic vulnerability) render some individuals more at risk of the effects of the environment than others in both a negative and positive direction (Belsky & Pluess, 2009; Boyce & Ellis, 2005). Therefore, certain individuals may be more responsive to either positive environments (e.g. environments with a lot of support) or negative environments, or may be similarly as responsive to both, described as a ‘for better, for worse’ fashion (Belsky, Bakermans-Kranenburg, & van IJzendoorn, 2007; Hankin et al., 2011). This theory also differs from the *dual risk model*, which theorises that some individuals are most vulnerable to a risk and then more negatively affected by a stressor than others, but when the stressor is absent they respond akin to others that are more resilient to a given stressor (Belsky & Pluess, 2009).

Many studies have also examined both stressors and adolescents’ responses to them through the lens of coping behaviour (Bryden et al., 2015; Seiffge-Krenke, 2000). In the current thesis, the highly cited definition of coping from Lazarus and Folkman’s (1984) transactional theory of coping is adhered to. Specifically, Lazarus and Folkman (1984) define coping as the “constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (p. 141). Coping has been identified as mediator and a moderator when studying the association between negative life events and mental well-being (Grant et al., 2006; Thompson, Lengua, &

Garcia, 2016). Perceiving a stressor as within the capability of the individual to respond to the stressor can reduce the negative effects of stressors on well-being, as can the selection of a specific coping strategy to reduce the effect of a stressor (Dijkstra & Homan, 2016; Horiuchi, Tsuda, Aoki, Yoneda, & Sawaguchi, 2018). Within the literature, a range of taxonomies of child and adolescent coping behaviour have been proposed (Ryan-Wenger, 1992; Thompson et al., 2010). For example, *emotion-focused* (reducing the emotional response) vs. *problem-focused* (addressing the problem/stressor) coping; and *approach* (directly addressing the stressor, such as through problem solving) versus *avoidance/withdrawal* (removal from exposure to the stressor) (see Skinner, Edge, Altman, & Sherwood, 2003, for a review).

Skinner et al. (2003) have argued that it is useful to distinguish among different forms of coping based on whether they are harmful or helpful. Some types of maladaptive coping strategies are linked to negative effects on mental well-being and heighten the risk of psychopathology (Seiffge-Krenke, 2000). For example, an association has been found between lower use of withdrawal coping strategies (removing one's self from the stressor, distraction and finding emotional outlets) and elevated levels of mental well-being in adolescents (Cicognani, 2011; Seiffge-Krenke, Aunola, & Nurmi, 2009). Other studies have found that approach-orientated coping is associated with positive mental well-being (Heckhausen, Wrosch, & Schulz, 2010). Conversely, avoidant coping has been found to be associated with both poor mental well-being (Ebata & Moos, 1991), and increased risk of psychopathology, such as high levels of depressive symptoms (Seiffge-Krenke & Klessinger, 2000).

## **1.5 The study of protective factors in adolescence**

Studies have demonstrated that of those adolescents exposed to risk and stressors, some individuals will adapt and others will be negatively affected by a stressor, prompting inquiries into what factors are associated with resilient individuals and positive outcomes (Garmezy, 1974; Luthar, 1991; Masten, 1985). The concept of *resilience* describes the process whereby individuals or systems overcome or adapt to exposure from a risk factor, stressor, or adverse event or

multiple stressors (Masten, 2011; Rutter, 2012; Ungar, Ghazinour, & Richter, 2013). Understanding the reasons for the variability in outcome amongst high-risk individuals is a major interest in resilience research (Garmezy & Masten, 1986; Masten, 2011; Rutter, 1979). Early resilience studies found that high-risk children of schizophrenic mothers did not necessarily develop schizophrenia, for example (Garmezy, 1974; Masten, Best, & Garmezy, 1990). Other early studies examined individual differences in outcomes at the group level, finding correlations between specific traits and resilience, such as autonomy and high levels of self-esteem and the outcome of resilience (Garmezy & Streitman, 1974; Luthar, Cicchetti, & Becker, 2000; Masten, 2011).

Later studies of protective factors have examined processes and change at the level of multiple, systems around the individual, drawing on Bronfenbrenner's (1998) *Social Ecological model*, which depicts an adolescent situated within concentric, external systems akin to a Russian doll (Lynch & Cicchetti, 1998; Ungar et al., 2013). The Social Ecological model was a significant conceptual contribution to the study of adolescent mental well-being, risk, and resilience because it encouraged analysis of complex interrelated systems (Ungar et al., 2013). Studies that adopt a Social Ecological model assume that adolescent is located within the centre of a complex, interrelated set of systems and that various systems shape the individual, described as *micro-*, *meso-*, *exo-*, *macro-*, and *chronosystem* levels (Cramer & Kapusta, 2017). As applied to the study of risk protective factors, research considers risk and protective factors at each of these levels. For example, as supportive family would be part of the *microsystem* that confers protection, and a strong welfare system would be present at the *macrosystem*. The microsystem, the adolescent, their home, school, and peer group are considered the most direct influences on the adolescent and may interact with the mesosystem (Cramer & Kapusta, 2017). The *exosystem* has an effect on a child or adolescents' life, such as the parents workplace, but rarely has a direct influence on the adolescent (Cross et al., 2015). In contrast, the macrosystem would be more distant, affecting the child through cultural, societal and political influences (Cross et al., 2015; Eriksson, Ghazinour, & Hammarström, 2018; Ungar et al., 2013). The *chronosystem* considers the role of time, bringing attention to specific events that are unique to a period of time, such as a financial crisis or in the UK context, Brexit. The Social Ecological model brough

attention to the complex interaction of the individual adolescent with the wider environment, theorising that interrelations between all the systems influence individual behaviour and outcomes (Hong & Garbarino, 2012). However, it could be questioned whether in reality the structure of protective factors fits neatly into nested systems as per the Social Ecological model and whether adolescents are always at the centre of surrounding systems, even though the breadth and complexity of the model is instructive. More contemporary definitions of resilience have also adopted a systems-centred view it as: “The capacity of a dynamic system to withstand or recover from significant challenges that threaten its stability, viability or development” (Masten, 2011, p. 494).

The construct of protective factors is integral to resilience research (Luthar, Sawyer, & Brown, 2006; Masten & Monn, 2015). The identification of protective factors can enable understandings of the differences between individuals who, due to protective factors and processes, adapt to difficult circumstances, as compared to those who do not (Garmezy, Masten, & Tellegen, 1984; Luthar et al., 2000). However, the definition, operationalisation and study of protective factors and processes has varied across studies (Cairns, Yap, Pilkington, & Jorm, 2014; Fergus & Zimmerman, 2004; Luthar & Zigler, 1991; Luthar et al., 2000). Luthar (2000) asserted that: “Researchers use terms such as “protective” or “vulnerability” factors in varied and inconsistent ways” (p. 6). Various terms have been applied in the literature to describe protective factors, including: *protective factors* (Grant et al., 2000; Luthar, 2003), *protective mechanisms* (Rutter, 1987) *promotive factors* (Sameroff, 2006; Zimmerman, 2013), *assets* (Oberle, Schonert-Reichl, & Zumbo, 2011; Scales, Benson, & Mannes, 2006), *protective resources* (Hjemdal, 2007), *resilience factors* (Black & Lobo, 2008; Fritz, et al., 2018), and *strengths* (Walsh, 2012). Some studies have differentiated between *promotive factors* and *protective factors*; promotive factors are variables that promote positive psychological well-being, as contrasted with protective factors that reduce the risk of psychopathology (Patel & Goodman, 2007). Within this thesis, a protective factor is defined as a variable that may change, interact with, improve, or influence an outcome in a positive direction, either in the context of a known risk factor or not. This draws on the much-cited definition by Kazdin (1997) that protective factors refer to:

“antecedent conditions associated with a decrease in the likelihood of undesirable outcomes or with an increase in the likelihood of positive outcomes” (p. 377).

In the current thesis, I am also considering protective factors to be variables that decrease the likelihood of the outcomes of poor mental well-being and/or psychopathology but increase the likelihood of positive mental well-being and the absence of psychopathology. In some studies, variables have only been considered protective if they operate in the context of risk (Grant, 2000, p. 391). However, more recent studies have incorporated factors that promote mental well-being, regardless of the presence of risk, as protective factors for individuals (Bowen, Lee, & Weller, 2007; Sameroff, 2000). Researchers have suggested that research is needed that considers both the correlates of poor well-being and positive well-being:

Few comprehensive studies have focussed on factors which influence adolescents' sense of wellbeing, and the literature is often divided into the risk factors that are associated with poor mental health, or the positive factors associated with wellbeing, with few studies addressing both (Lambert et al., 2014a, p. 101).

Research into protective factors has developed apace, despite a level of inconsistency in terminology and measurement across a vast number of studies (Luthar et al., 2000). As with risk research, protective factor research is critical to informing interventions aiming to prevent psychopathology in adolescence (Fergus & Zimmerman, 2004; Gladstone et al., 2011; Patel & Goodman, 2007). Research on the topic of protective factors has enhanced knowledge of how to protect adolescents against specific negative outcomes through the delivery of protective factor-informed clinical interventions (Cairns et al., 2014; Gladstone et al., 2011). For example, parental depression has been identified as a specific risk factor for adolescent depression (Cairns et al., 2014; Gladstone et al., 2011). Parenting training (PT) is an intervention that works with depressed parents of children and early adolescents to teach them parenting strategies and positive parenting, with the goal to changing parents' attitudes and behaviour, in order to potentially improve

parenting quality (Lundahl, Risser, & Lovejoy, 2006). Other interventions in this area include supporting parents to parent effectively whilst living with a mental illness, such as supporting the adolescent's friendships and out of school activities (Beardslee, Solantaus, Morgan, Gladstone, & Kowalenko, 2013). These variables - parenting quality and supporting adolescents in their extracurricular activities - are factors that have been identified as promoting adolescent mental well-being more generally (Jach et al., 2018; Ruvalcaba, Gallegos, Borges, & Gonzalez, 2017).

However, the mechanisms that underpin the ways protective factors function to influence outcomes vary and not all mechanisms are currently understood. Luthar et al., (2000) outlined six processes through which protective factors can operate. First, the *protective model*, where an attribute simply improves competence for overcoming adversity within both low- and high-risk conditions to the same extent (where there are many risk factors and where there are few). Second, the *protective-stabilising model*, where a protective factor increases the likelihood of a positive outcome despite high risk. Third, the *protective enhancing model*, where some level of stress increases the adaptation of the individual to the environment. Fourth, the *protective-reactive model*, where a protective factor has a benefit at low levels of stress but not at high levels. Fifth, the *vulnerable-stable model*, in this case, a particular factor renders an individual vulnerable, but this does not change with changes in levels of stress. Finally, the *vulnerable and reactive model*, where the overall disadvantage linked to a given variable increases under high stress conditions (Luthar et al., 2000). Fergus and Zimmerman (2005) later added the *challenge model*, whereby repeated exposure to a stressor strengthens resistance to it. For example, coping skills are developed that enable subsequent risks to be handled effectively (Zimmerman, 2013). Brook and colleagues (2001) also proposed a *protective-protective model*, where the effect of one protective factor has a positive effect on another factor, thus increasing the protective effect of a given variable (Brook, Brook, Arencibia-Mireles, Richter, & Whiteman, 2001).

Early studies of protective factors emphasised the interactions between the adolescents and their environment. As described, Bronfenbrenner (1979) brought attention to the interactions between systems within the surrounding ecological environment, described as the Social Ecological model (Ungar et al., 2013). Building

on this foundation, research from a range of contexts has brought attention to the ways that overcoming risk and adversity is located within culturally specific contexts and influenced by variables that are specific to different cultures and geographies (Seccombe, 2002; Ungar, 2006). Researchers have encouraged exploration of the social and political context which influences the extent to which supportive resources are available to adolescents (Seccombe, 2002). Some factors may be protective in one cultural setting but not in others (Fergus & Zimmerman, 2004), and so can be described as *culturally moderated* (Ungar et al., 2013).

Thus, many protective factors are dynamic and context-dependent in terms of their effects on mental well-being and reducing the risk of psychopathology (Luthar et al., 2000). For example, in some contexts, democratic decision-making within the family has been found to be protective. Yet, in a study of academic achievement amongst African American families in a high-risk setting, democratic decision-making increased the negative effect of other risk factors on outcomes (Gutman, Sameroff, & Eccles, 2002). In the study, within a high-risk environment, consistent discipline, such as parental monitoring was correlated with adolescent achievement, but democratic decision-making was not (Gutman et al., 2002). The authors concluded that in a high-risk environment, factors that promote autonomy can in fact increase risk, relative to lower risk environments where autonomy is part of normative adolescent development (Gutman et al., 2002). Thus, examining the cultural specificity of mechanisms is important (Fergus & Zimmerman, 2004; Ungar, 2003; Ungar, Brown, Liebenberg, Cheung, & Levine, 2008), as well as the types of risks associated with a given environment. For instance, neighbourhoods with higher levels of socio-economic disadvantage are likely to confer higher levels of risk (LeBrón, Schulz, Mentz, Israel, & Stokes, 2019).

Whilst sophisticated models of protective factors have been developed (Luthar et al., 2000), the evidence base is characterised by an absence of a commonly applied framework of resilience that facilitate organisation of the different types of protective factors identified and studied, based on all available evidence (Luthar et al., 2000). Hamby, Grych & Banyard have remarked, “there are few conceptual frameworks that organize the wide range of protective factors into a coherent model and consequently much of the work on protective factors has been atheoretical

(Hamby, Grych, & Banyard, 2017). Early research seeking to develop a framework of protective factors established three core categories: “1) dispositional attributes of the child; 2) family cohesion and warmth (e.g. supportive parenting; and 3) the availability and utilization by parent and child of external support resources” (Garmezy & Masten, 1986, p. 511). This model has been further extended by Masten and Powell (2003) and will be discussed in more detail in Chapter 3 of this thesis.

Synthesising and collating the extant evidence on protective factors is not straight-forward. The literature is hindered by both the *jingle and jangle fallacies*, where psychology was described as the ‘*jingle jangle jungle*’ (Block, 1995; Peck, 2004). In the *jingle* aspect, common terms refer to different underlying conceptions of a protective factor (Luthar et al., 2000). For example, researchers have observed that sometimes a protective factor denotes a factor that is only the opposite of a risk factor (Hamby et al., 2017), but in other studies, a protective factor is both a factor that can alleviate risk but can also promote mental well-being in the absence of risk (Hamby, Grych, & Banyard, 2017, p. 173). In the *jangle* aspect, different terms are used to describe common underlying conceptions (e.g., strengths, protective factors, resilience factors and promotive factors are all denoted as protective factors; Luthar et al., 2000). Given the breadth of research on protective factors, and the trend towards inconsistency of language across studies (Luthar et al., 2000). this points to a need for shared definitions across studies and the potential to amass the literature within a framework of identified protective factors. This would show where the research on specific protective factors is scarce or denser, or where factors may be protective for given age groups or genders but not for others.

Finally, within both the quantitative and qualitative literature in this area, few studies have examined how protective factors change over time (Kim, Oesterle, Catalano, & Hawkins, 2015; van der Put et al., 2011). Indeed, understanding the timing of changes in protective factors that are associated with positive outcomes, through longitudinal data, can inform the correct timing of preventative interventions in an adolescent’s life (Kim et al., 2015). Further, more specific knowledge of age differences in stressors and protective factors more widely is important so that

interventions to promote mental well-being and reduce the risk of psychopathology are age appropriate.

## **1.6 Qualitative studies of stressors, risk factors and protective factors**

There is an increasingly robust quantitative evidence base on the declining rates of mental well-being and increasing rates of psychopathology amongst adolescents in the British context (Deighton, Yoon & Garland, 2020; Pitchforth et al., 2019). However, a lack of clarity remains on the precise drivers underpinning this trend. There is somewhat limited evidence on how symptoms and drivers may be subjectively experienced by adolescents. Indeed, there has been a relative lack of qualitative studies that provide data on British adolescent perspectives on their experiences and the mechanisms that link stressors and protective factors in relation to their mental well-being, including what they perceive as threats to mental well-being and the links with the development of psychopathology. Ultimately, prominent resilience theorists have noted a striking absence of children's and adolescents' own views in the literature on the factors influencing their own mental well-being (Luthar, Sawyer, & Brown, 2006).

Qualitative studies of factors relating to mental well-being from adolescents' perspectives can elucidate what adolescents find important with regard to their mental well-being (Sixsmith, Gabhainn, Fleming, & O'Higgins, 2007). Adolescent conceptualisations may deviate from or expand upon adult- or researcher-developed measures and use of language around these concepts (Kirby, 2004). Moreover, the concept of mental well-being is highly subjective (Sharpe et al., 2016). Therefore, eliciting adolescent views on how they experience their own mental well-being is well suited to qualitative research methods that can illustrate individual subjective experience. It is fair to say that there remains a lack of clarity on the full range of processes and mechanisms behind the influence of stressors on adolescent mental well-being (Parikh et al., 2019; Sigfusdottir, Kristjansson, Thorlindsson, & Allegrante, 2017). This suggests opportunities for qualitative research on adolescents' experiences and perceptions on the topic (Neubauer, Witkop, & Varpio, 2019). In

addition to the research need, the importance of considering adolescents' views and experiences has been documented in the Children's Act and the UN Convention on the rights of the child; Article 12 states that children have a right to be heard (Cavet & Sloper, 2004).

Sixsmith and colleagues' (2007) study in Ireland has provided an example of a qualitative consideration of adolescent perspectives on mental well-being. Early adolescents aged 10 to 12 years old were consulted on the factors that they associated with their well-being, with the aim of incorporating the results into national well-being indicators (Sixsmith et al., 2007). The study found that participants made connections between many factors that interacted to influence their mental well-being, such as relationships (including with parents and friends), and the effect that these had on their 'sense of belonging' and 'feeling loved' (Sixsmith et al., 2007). The authors noted a gap between what adolescents identified as good for their well-being, as compared to what parents and teachers identified as important for adolescent well-being (Sixsmith et al., 2007). This serves as a reminder of the importance of elucidating specifically adolescent perspectives on their mental well-being to understand the construct of well-being in full. Thus, there is a research imperative, an international convention, and a public policy impetus that all contribute to the rationale behind efforts to understand adolescents' views, perspectives, and perceptions towards their well-being.

Clearly then, qualitative studies can make a unique contribution to stressor and protective factor research (Smokowski, Reynolds, & Bezruczko, 1999; Ungar, 2003). Ungar (2003) has outlined five benefits of qualitative resilience research:

Qualitative methods are shown to be particularly relevant to the study of resilience in five ways. They are well suited to the discovery of unnamed processes; they study phenomenon in very specific contexts, their trustworthiness strengthened by the thickness of the description of that context; they elicit and add power to minority 'voices' which account for unique localized definitions of positive outcomes; they promote tolerance for these localized

constructions by avoiding generalization in favour of transferability; and, they require researchers to account for the bias inherent in their social location. (p. 86).

Qualitative studies can elevate the voices of adolescents, as well as investigate 'disjuncture' (Smith, 1990). Disjuncture refers to possible differences between how a phenomenon, such as stressors, is experienced subjectively, as compared to how the phenomenon is described within the academic literature (Smith, 1990). Qualitative research can identify mechanisms as they are individually experienced (Ungar, 2003). For example, a young person can explain how or why a risk factor leads to changes in their lived experience of mental well-being or symptoms of psychopathology. Data on the subjective experience of mechanisms is an important complement to statistical research that shows the strength of an association between a risk factor and an outcome (but may not show how or why the association exists) (Ungar, 2003).

Qualitative studies have the potential to provide evidence of change over time. For example, a study examined life events and psychological symptoms in 532 adults using semi-structured interviews over two years (Thoits, 1995). The study applied both quantitative and qualitative methods and found that qualitative research could account for some of the complexity that was undetected in the quantitative study. Thoits stated, 'quantitative analyses (which used counts of generic events, as in most conventional studies) could not capture such nuances in meaning' (Thoits, 1995, p. 79). Further, qualitative studies of stressors can identify contextually relevant stressors and protective factors and intervention design (Parikh et al., 2019). Arguably then, qualitative research into what stressors adolescents experience and how they are perceived to interact to affect their mental well-being is a useful addition to quantitative studies of risk that can demonstrate significant effects on outcomes.

Yet, despite the increasingly recognised benefits of qualitative studies, a relatively small number of qualitative studies have been conducted to examine both

risk and protective factors in relation to mental well-being and the risk of psychopathology. Of extant qualitative work, studies have tended to focus on specialist populations. For instance, Cluver and Gardner (2007) interviewed children orphaned by AIDS in Cape Town, South Africa ( $N = 30$  orphans and  $N = 30$  matched controls), as well as caregivers ( $N = 42$ ) and social care professionals ( $N = 20$ ) about their experience of risk and protective factors for their emotional and behavioural well-being. Reported protective factors included positive family functioning, social support, and access to education (Cluver & Gardner, 2007). Another study investigated risk and protective factors of young Naga from Nagaland, India, finding that risk of substance abuse was informed by peer influence and acceptance, novelty seeking, permissive parenting styles, insecure attachment and a perceived lack of love in childhood, and childhood trauma (Kizhakumpurath, 2012). Applying a novel methodology, Smokowski and colleagues (1999) collected autobiographical essays written by adolescents as a means to understand the protective factors for overcoming risk and adversity in a sample of 86 inner-city, high-risk adolescents in the United States. The study found that internal attributes such as perseverance, determination, as well family and teachers' support, were protective (Smokowski et al., 1999).

In the English context, a study examined risk and protective factors reported by adolescents (aged 13 to 19 years old) with experience of living in local authority care ( $N = 15$ ) (Dearden, 2004). In addition to interviews, participants were asked to use timelines to identify factors that helped them when experiencing difficulties and were asked to score themselves on a Likert scale of 1 to 5. Based on their responses, participants were then classified by the author into 'resilient' and 'non-resilient' categories. Resilient individuals were those that were attending school, attaining average or high levels of attainment, exhibiting positive self-perceptions, reduced alcohol, or drug dependency, and having positive plans for the future (Dearden, 2004). The main themes from the analysis included: disruptions to schooling (due to change in care placements), quality of facilities (with good facilities and positive activities being highly rated), and poor facilities as being a source of frustration. Supportive friends versus peers that bully was another theme, as was the presence (or absence) of significant adults, such as a supportive teacher, information sharing and involvement in decisions. Dearden (2004) suggested that such findings could

inform policy on how to improve outcomes for children in care. Other researchers have also suggested that qualitative data on risk and protective factors can inform intervention design and identification (Rich & Ginsburg, 1999; Ungar, 2015).

Whilst few qualitative studies have been conducted with adolescents describing their own taxonomies of coping, recent qualitative research has explored the range of coping strategies that early adolescents identify (Stapley, Demkowicz, Eisenstadt, Wolpert, & Deighton, 2019). A thematic analysis of a large qualitative interview dataset ( $N = 82$ ) found eight overarching themes relating to types of coping strategies and support used or accessed: activities and strategies, disengaging from problems, standing up for yourself, acceptance of problems, social support, HeadStart and other professional support, and hiding feelings or problems (Stapley et al., 2019).

Overall, examining how adolescents respond to stressors, and the effects on their mental well-being and risk of psychopathology, is ripe for qualitative inquiry. Qualitative studies are widely recognised as having the potential to shed light on the mechanisms underpinning the links between variables and outcomes (Ungar et al., 2008). Essentially, qualitative studies are well-suited to capturing variation in the effects of a particular phenomenon (DeJonckheere & Vaughn, 2019), such as stressors on mental well-being and risk of psychopathology, by seeking to understand the lived experience or perceptions of stressors from adolescents' perspectives. In addition, qualitative studies can provide in-depth insight into both what stressors are and how stressors are understood to affect mental well-being by adolescents (Cheetham-Blake, Family, & Turner-Cobb, 2019; Weber, Skodda, Muth, Angerer, & Loerbroks, 2019), as well as the ways in which they might influence each other or interact to affect well-being as experienced by the individual.

Of the existing corpus of qualitative studies of adolescent experiences of stressors worldwide, many of the studies have focused on stressors for specialist adolescent populations (this is similar to the qualitative literature on experiences of risk and protective factors described above) (Bradshaw, Sudhinaraset, Mmari, & Blum, 2010; Mutumba et al., 2015; Parikh et al., 2019). This line of inquiry is important to the focal point of the thesis because many everyday stressors are

considered universal and have been found in a range of contexts (Gelhaar et al., 2007). However, some stressors are context specific and reflect the local ecology (Parikh et al., 2019; Seiffge-Krenke et al., 2009). Examples include a qualitative study of stressors experienced by adolescents in military families (Bradshaw, Sudhinaraset, Mmari, & Blum, 2010), adolescents living with HIV in Uganda (Mutumba et al., 2015), adolescents' appraisals of stressors within sport (Tamminen & Holt, 2010) and stressors and coping reported by adolescents in Goa and Delhi in India (Parikh et al., 2019). Researchers have also qualitatively investigated the experiences and prevalence of stressors, as reported within samples of North American adolescents from minority groups (Chandra & Batada, 2006; Farrell et al., 2007; Garcia & Lindgren, 2009; LaRue & Herrman, 2008). For instance, Chandra and Batada (2006) focused on perceptions of stressors and coping among 9th grade, African American students in East Baltimore and found that stressors associated with school, friends and family were reported most frequently.

In the English context, a recent qualitative study involved 38 children (22 boys and 16 girls), aged 7 to 11 years old, and 38 parents who undertook dyadic interviews about their experiences of stressful life events, adversity, and coping (Cheetham-Blake et al., 2019). Four themes were derived through a thematic analysis: (1) navigating the social minefield; (2) pressure to thrive in the modern world; (3) fear of the unknown; and (4) learning life's lessons (Cheetham-Blake et al., 2019). The authors found that issues around social relationships were a large component of children's stress experiences and concluded that a range of pressures can be experienced by young children (including school, extracurricular activities, pressure from self and others) (Cheetham-Blake et al., 2019). The final theme proposed that children learn from the experiences of stress as well as learn to cope (Cheetham-Blake et al., 2019). This study provides insight into the experience of children before the transition to secondary school, yet an opportunity remains for qualitative research on the experience of the early adolescent age group.

## **1.7 Conclusion**

The aim of this thesis is to examine how qualitative investigations into adolescent experiences of stressors, risk factors and protective factors can further

our understanding of adolescent mental well-being and the prevention of adolescent-onset psychopathology. This aim sits within a broader context of the need to understand the possible factors contributing to rising rates of psychopathology, given the evidence that suggests a reduction in the mental well-being of British adolescents and a rise in rates of psychopathology (Deighton, Yoon, & Garland, 2020; Fink et al., 2015). This topic is arguably of central concern in research and opportunity to explore qualitatively what adolescents perceive as stressors and their effects on their well-being, how they manage and counteract stressors and other risk experiences, and what factors they find help increase mental well-being and reduce their risk of psychopathology.

Understanding adolescents' subjective perspectives is necessary because of the heterogeneity that is evident in the ways that mental well-being is experienced (Sharpe et al., 2016). Research based on the transactional model of stress also suggests that the manner in which stressors are perceived, appraised, and coped with are subjective (Lazarus & Folkman, 1984). Qualitative studies of adolescent taxonomies of coping have suggested that adolescents might use language and identify factors that diverge from, or add to, extant literature (Stapley et al., 2019). Therefore, illustrating the full range of mechanisms, processes, and links between the experience of stressors and effects on mental well-being and psychopathological outcomes would be an important contribution to the evidence base. Consequently, qualitative studies on what reduces the experience of stressors and the negative effects, amongst other types of protective factors reported by adolescents, are needed.

Furthermore, whilst it is well known that stressors are linked with the onset of psychopathology (Grant et al., 2003), knowledge of stressors is limited in terms of 'how' interactions of stressors lead to outcomes, and further gaps exist in what the lived experience might be like for adolescents in specific contexts. Whilst there have been qualitative studies of the effects of singular stressors, such as bullying, it can be argued that a qualitative study of the interaction of different types of stressors is important and *may* more accurately reflect the lived experienced of adolescents, many of whom manage multiple stressors in their daily lives. Qualitative research can potentially surface unforeseen types of stressors, as well as potentially

illuminating the meaning of stressors to the adolescent and how they may contribute to poor mental well-being and the risk of psychopathology (Ungar, 2003).

Whilst the evidence base on the topic of protective factors is both in-depth and broad, this chapter identified a number of challenges with the literature, namely the inconsistent use of terminology and the lack of referencing across studies to previous studies and frameworks that collate existing research. The study of protective factors could advance by collating existing knowledge from different samples, as well as contributing to knowledge of which protective factors have been found to be effective for specific age groups. Moreover, the potential of qualitative studies to illustrate the mechanisms linking protective factors to outcomes is clear (Ungar, 2003). In the context of applying research from protective factors to policy, a recent Department for Education report entitled, *State of the Nation 2019: Children and Young People's Wellbeing*, stipulated that:

Protective and risk factors overlap in different ways in different groups of children; and they cut across many areas of their lives, experiences, and wider environment. The challenge this poses is understanding what affects whom, and when in their lives, to guide how we best equip children with the skills they need to support their own wellbeing for the range of experiences they face growing up (Department for Education, 2019, p. 5).

In summary, from the review within this chapter of current research on risk, stressors, and protective factors in relation to mental well-being and the risk of psychopathology during adolescence, the main gaps identified and relevant to this thesis were:

- The absence of qualitative data from English adolescents in relation to a broad range of adolescent-defined stressors and reported effects on their subjective experience of mental well-being and risk of psychopathology.

- The lack of studies that examine the interplay of factors contributing to mental well-being and risk of psychopathology using qualitative data.
- An indicated need for further research illustrating mechanisms that link protective factors to mental well-being and psychopathology outcomes.
- Given the wide range of studies on protective factors in relation to the outcome of mental well-being and risk of psychopathology, there have been relatively few collations of recent research on protective factors into frameworks or typologies, which could be used to organise existing research and which future research in this area could then draw on.
- The paucity of qualitative data on what adolescents themselves perceive as protective factors and how they are perceived to be helpful for increasing their mental well-being, including the scarcity of qualitative data on patterns of risk and protective factors and how they might be experienced, interact, and change over time.

The thesis will draw on both cross-sectional and longitudinal qualitative data on adolescents' experiences of stressors and protective factors in relation to mental well-being and the risk of psychopathology. This will be supported by a literature review on the types of protective factors linked to the outcomes under study, structured through use of an existing protective factors framework. The specific research questions that this thesis seeks to answer (through four empirical studies) to address its overall aim are as follows:

1. What types of stressors do adolescents report and what are the perceived effects on their mental well-being?
2. What types of protective factors have been found to increase adolescent mental well-being and reduce the risk of psychopathology in current research?
3. What patterns exist in adolescents' experiences and reports of protective factors in relation to mental well-being and the risk of psychopathology?
4. How do patterns of protective factors in relation to mental well-being and risk of psychopathology as reported by adolescents change over the course of one year?

The next chapter provides an overview of the research methodology of this thesis.



## Chapter 2. Research Design and Context

## **2 Research Design and Context**

### **2.1 Introduction**

This chapter will set the scene for the thesis in terms of the wider research projects of which the thesis is part: the HeadStart pilot evaluation (Phase 2, 2014-2016) and the evaluation of the third and current phase of HeadStart (Phase 3, 2016-2021), including my role within these two research projects. The research questions that this thesis explores are also described, as are methodological details for each of the empirical studies conducted. Finally, the underlying epistemological position that informed the design of and analysis in these studies is outlined. This is followed by an overview of strategies undertaken to achieve trustworthiness in the qualitative studies within the thesis.

#### **2.1.1 An overview of HeadStart Phase 2**

HeadStart is a national programme formed by The Fund which aims to explore and test new ways to improve the mental health and well-being of children and adolescents and prevent serious mental health issues from developing (Stapley et al., 2019). In Phase 2 of the HeadStart programme (2014 to 2016) (the pilot phase), 12 local authority partnerships implemented well-being and mental health focused interventions for young people across 90 schools in England. The Evidence Based Practice Unit (EBPU), a partnership between University College London (UCL) and the Anna Freud National Centre for Children and Families (AFNCCF), evaluated the partnerships' programmes (Stapley et al., 2019). I was a member of the evaluation team, as were my supervisors (JD, ES and MW). The evaluation was reviewed and given approval by the UCL Research Ethics Committee (Project ID Number: 1530/006).

As part of the evaluation, 12 partnerships were requested to choose one intervention for the evaluation team to evaluate qualitatively, in terms of exploring the experiences and perceptions of the young people involved in each intervention. The interventions are provided in the table in Appendix C but included both universal

interventions, such as PATHS<sup>1</sup> (in the Birmingham partnership), and targeted interventions, such as art and equine therapy (in the Blackpool partnership). I was involved in designing the semi-structured interview schedule (see Appendix B) and in conducting the interviews for the qualitative evaluation at the 12 partnerships: Birmingham, Blackpool, Cornwall (Kernow), Cumbria, Newham, Kent, Knowsley, Hull, Lewisham, Middlesbrough, Southampton, and Wolverhampton. I was then involved in writing up case studies for each partnership and documenting TIDierR (Template for Intervention description and replication) frameworks for each intervention (Hoffmann et al., 2014). I analysed the qualitative interview dataset in the first study of the thesis (Chapter 3).

### **2.1.2 An overview of HeadStart Phase 3**

In Phase 3 of the HeadStart programme (2016-2021), six of the original 12 partnerships were awarded an additional five years of funding to deliver school- and community-based interventions within their local authority. The partnerships comprised Blackpool, Cornwall, Hull, Kent, London Borough of Newham, and Wolverhampton. Across all six partnerships' HeadStart programmes, 62 mental health, well-being and resilience interventions are currently being implemented, which includes 51 interventions aiming to increase mental well-being, 20 interventions that aim to improve school engagement, 20 interventions that aim to provide support for individuals with mental health difficulties, and four interventions that aim to reduce risky behaviour (EBPU, 2019). The evaluation of HeadStart Phase 3 (HS3), led again by the EBPU, consists of both quantitative and qualitative research components. Ethics approval for the qualitative evaluation of HeadStart was granted by the UCL Research Ethics Committee (ID Number: 7963/002). Studies 3 and 4 of the thesis are situated within the context of the qualitative research component of the HeadStart Phase 3 evaluation.

The HeadStart Qualitative Longitudinal Study (QLS) is a major component of the qualitative evaluation of HS3. This five-year study commenced in schools participating in HS3 in 2017. It consists of annual semi-structured interviews with the same cohort of children and adolescents in schools at each HeadStart partnership

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<sup>1</sup> <http://www.pathseducation.co.uk/>

(one to three schools per partnership) over the five-year period of the HeadStart programme. Each year, participants are asked about their experiences of problems and difficulties, factors that mitigate problems and difficulties, coping strategies, and engagement with formal and informal support (including HeadStart). In contrast to HeadStart Phase 2, rather than focusing on participants' experiences of the HeadStart interventions in isolation, the QLS in HS3 aims to look additionally at broader factors that can affect adolescent well-being, as well as specific interventions, and this includes examining protective factors, coping, how adolescents handle difficult situations, and seek help. These questions were guided by an intention to explore the whole system around the adolescent that included all of the types of support that they interacted with, of which HeadStart would be one.

Each of the six HeadStart partnerships chose the schools (one to three per partnership) where participants would be recruited. Designated school leads or HeadStart staff at the schools invited 10 to 15 young people at each partnership to take part in the study. Adolescents were offered the opportunity to participate in the research interviews if school staff or HeadStart staff identified the young people as having already begun receiving support from HeadStart or identified the young people as being those who may in future receive support from HeadStart. HeadStart support could be universal, universal plus or targeted as specified by each partnership (Stapley & Deighton, 2018). The definition of these types were as follows:

universal (e.g., a psychoeducational intervention delivered to a whole school class or year group), universal+ (e.g., a group support intervention for young people about whom school staff have emerging concerns around their mental wellbeing), or targeted (e.g., one-to-one counselling for young people with exposure to particular risk factors, such as domestic violence) (Stapley & Deighton, 2018, p. 7).

My role in the Qualitative Research Team (QRT) involved a number of activities. I collaborated with my supervisors in designing the QLS and the interview schedule for the first, second and third year, incorporating questions that aimed to collect data on the topics of risk and protective factors. Before the first data collection timepoint, once the schools had been selected by the HeadStart partnerships as sites for the QLS to take place at, my supervisor and I visited the relevant schools to explain the purpose of the study, build a working relationship with the school contacts and headteachers (or other relevant contacts), and share our requirements to undertake the interviews and discuss safeguarding procedures. This included asking the lead contact at each school to invite young people to take part (according to the criteria outlined above). After this, my role involved communicating with schools to arrange the interviews and make sure that the necessary conditions were in place in advance of the data collection visits, such as parental consent obtained for all participants to take part. I conducted and transcribed a subsample of the interviews across the partnerships and checked other transcribed interviews against the audio files for accuracy.

I have conducted interviews with participants in three areas for three consecutive years: Cornwall, Newham and Kent including two home visits for students that no longer attended their original school and were being home-schooled and two visits to schools to interview participants that left their original school but wanted to remain part of the QLS. I have been involved in colleagues' analysis of the data across all years of the QLS so far. For example, I co-authored a paper about early adolescents' coping strategies that drew on the first year of data collected during the QLS (Stapley et al., 2019), and authored a study for an evidence briefing detailing key lessons from my PhD research on patterns of reported protective factors in relation to risk and mental well-being<sup>2</sup>, and I formed themes for an evidence briefing led by my supervisor (ES) entitled, Young Peoples Experiences of HeadStart Support in Year 2 that uses ideal types analysis to explore reported changes in well-being drawing on the HeadStart QLS Time 1 and 2 data.

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<sup>2</sup> Eisenstadt, M., Stapley, E., & Deighton, J. (2019). *Learning From Young People in HeadStart: A Study of Young People's Reported Protective Factors in Relation to Risk Factors and Wellbeing*. London: EBPU.

### 2.1.3 Ethical considerations (HeadStart Phase 2 and Phase 3)

It is widely agreed that a key requirement of conducting research with children and adolescents, across a range of academic disciplines, involves careful adherence to ethical guidelines (Greig, 1999; Greig, Taylor, & MacKay, 2011; Kirk, 2007; Morrow & Richards, 1996; Skelton, 2008). For instance, Skelton (2008) has stated, “Ethics are extremely important in research practice and there needs to be specifically sensitive ethical approaches when working with children and young people” (p. 23). Guidelines aim to ensure that research does no harm to child or adolescent research participants, that informed consent is obtained and confidentiality is maintained (Kirk, 2007; Shaw, Brady, & Davey, 2011). The National Children’s Bureau have developed guidelines that includes recommendations for qualitative research such as creating a comfortable environment and practicing active listening during an interview (Shaw, Brady, & Davey, 2011). UCL has provided information on conducting ethical research with children (Greig, 1999). To proceed, both the pilot study and longitudinal study as part of the evaluation of HeadStart required ethical approval from the UCL ethics board.

Within psychological research, the principle that research does no harm refers to the notion that steps are in place to ensure that participating in the research study does not negatively affect the adolescent and that participants are treated with respect (BPS, 2018). The British Psychological Association (BPA) has recommended that psychologists follow the principles of respect, competence, responsibility and integrity in both decision making, reasoning and behaviour (BPS, 2018). Further, in considering the rights of participants, research needs to ensure “physical, psychological and emotional support” for child and adolescent participants (Greig, 1999). Informed consent refers to the fact that participants are suitably informed about the aims and methods of the study, how their data will be used and stored, when the research is completed, their right to withdraw and to *not* answer questions in the interview context (Greig, 1999; Kirk, 2007). Additionally, informed consent refers to providing agreement to participate in the research study (Greig, 1999; Kirk, 2007). Informed consent also implies that the participant is legally able to give consent and for this reason, adolescents under the age of 16 years old are

legally minors and thus parental consent is required legally in order for research to be undertaken (Greig, 1999).

Furthermore, the researcher has a responsibility to care for the child or adolescents' welfare and this necessitates following a safeguarding protocol (Furey et al., 2010). This means if a researcher became aware of an issue regarding maltreatment or neglect (or some other type of harm) they would have a responsibility to report said issue to an appropriate member of staff (Furey et al., 2010). Safeguarding refers to "protecting children from maltreatment, preventing the impairment of children's health or development and ensuring that children are growing up in circumstances consistent with the provision of safe and effective care." (Furey et al., 2010, p. 122). Authors in the field of child protection have suggested that given the likelihood that child protection or safeguarding issues may arise in the process of conducting research, it is important that researchers have a level of *ethical literacy* that refers to the capability to make decisions on behalf of research participants (Furey et al., 2010, p. 122).

#### *Ethical procedures followed*

All interviews conducted in both phases of the evaluation were confidential, and participants were informed of this at the outset of the studies. At the beginning of each interview, in line with informed consent, the purpose of the study and the confidentiality of participants' reports were explained to the participant (along with a written information sheet), as well as the possible circumstances where confidentiality may need to be breached. All interview transcripts were anonymised, with any identifying details spoken by the participants in their interviews, such as names and places, removed from the transcripts. In some cases of individual participants in this thesis, identifiable details (e.g., types of physical illness) have been replaced by an equivalent report so that data is not traceable to a specific participant. All interviews were assigned a unique identifier to label their transcripts to ensure anonymity, and in the case of the QLS, pseudonymised data linkage over time for interviews. This identifier was linked to participants' names and contact details solely for follow-up purposes throughout the duration of the study. In this

thesis, I have used pseudonyms to denote individual participants, some of which were suggested by participants.

Following receiving information about the study from school staff or HeadStart staff, participants could elect to be part of the study by submitting an expression of interest form (EOI), or by being invited by school staff or HeadStart staff (a copy of the EOI form is provided in Appendix F). Participants were then sent an information sheet for parents and for the young person detailing the aims of the study, what was involved in the study, and their rights in relation to the study. Signed parental consent forms were obtained by school or HeadStart staff. In some cases, parental consent was taken over the phone by a member of the QRT and the parents' consent was audio-recorded. The documentation made clear that participation in the study was optional and that the parent and child had the right to withdraw from the study at any point. In the QLS, parental consent for all five years of the study was sought in the first year of the study. The QRT also sought assent to take part from participants on the day of their interviews. Examples of the study information sheets and consent forms can be found in the appendices (Appendices I-L). Physical copies of the forms were stored in a locked cabinet at the AFNCCF. Participants in the QLS were given a £10 voucher after each interview as a thank you for taking part.

A safeguarding procedure was adhered to by the QRT. The QRT reported any safeguarding concerns that arose during the interviews to the relevant safeguarding leads at each site, as well as kept a record of the incident for the Safeguarding Oversight Group (SOG) at the AFNCCF. Participants were informed at the outset of the interview that if possible risk of harm to the interviewee or to another person was discussed in the interview, then the researcher would need to report it to their supervisor (JD or ES) and to an allocated member of staff at the school (typically a member of the pastoral team or learning support team). The safeguarding procedure is provided in Appendix Q. Participants were provided with a document at each interview detailing sources of support specific to their local area, should they want to seek help or support after the interview (see Appendix R for an example leaflet). Participants were also provided with findings from the research in outputs that were designed for young people as a target audience from the second year onwards.

#### **2.1.4 Data collection (HeadStart Phase 2 and Phase 3)**

The interviews took place on a one-to-one basis in a private meeting room at the participant's school. The interviews were recorded on encrypted dictaphones and transcribed verbatim. The transcripts were then anonymised and checked for any errors in transcription. Both interview schedules for Phase 2 and Phase 3 (see Appendix B and P) were semi-structured. Semi-structured interviews provide a window into participants' personal experiences, attitudes, perceptions and beliefs around a chosen research focus (DeJonckheere & Vaughn, 2019). Therefore, a semi-structured interview is an appropriate research tool when objective knowledge about a given topic already exists within the literature, but a lack of subjective knowledge (Morse & Field, 1995; Richards & Morse, 2007). Within the context of a semi-structured interview, participants are able to respond to open-ended questions as they choose, and the researcher may probe their responses as necessary to find out more information. The advantage of a semi-structured interview format is that data collection is responsive to participants' unique experiences, within the context of an established area of research interest (Bartholomew, Henderson, & Marcia, 2000).

The interview schedule in Phase 2 was structured towards understanding participants' experiences of HeadStart interventions and drew on a client change interview to understand how the intervention had led to perceived changes by the participant (Elliot, 2000). Whilst the interview schedule developed for the HeadStart Phase 2 qualitative evaluation was directly focused on participants' experiences of particular well-being and mental health focused interventions, the dataset also included data on participants' experiences of stressors, as the interview schedule also covered participants' experiences of difficult situations in life (as defined by them) and included questions about changes in participants' emotional well-being following the intervention, and the issues that they perceived young people to be facing in general.

The QLS interview schedule in Phase 3 was iterated each year but included specific follow-up questions each year on issues that participants had raised in previous years. This was important to elucidate changes in participants' experiences

of particular risk and protective factors, as well as changes in well-being (and the drivers behind this) over time. The interviews usually began with more conversational questions about school or activities that participants enjoyed, such as their hobbies. These questions both built rapport and contributed to our understanding of what the participant liked about school or what activities they enjoyed (and potentially contributed to their well-being). The interviews aimed to understand the young person’s experiences of life, their experience of emotions (positive and negative), difficult situations and how they handle them (coping), and their experiences of sources of support (e.g., from family, friends, school, other professionals) and help-seeking, including their experiences of HeadStart interventions. The core questions from the QLS interview schedule are provided in Table 2.1.

**Table 2.1**

*The Core Questions Asked During the Interviews in Phase 3 at Time 1 (the First Year of the QLS) as Published in Stapley et al. (2019)*

No.	Question
1.	Can you tell me about being at school / life at home and in your local area / your friendships?
2.	What kinds of things can make you feel happy?
3.	What kinds of things can make it harder or more difficult for you to feel happy? How do you handle this?
4.	What sorts of feelings or emotions do you experience when you are not feeling happy? How do you handle this?
5.	When you are having a hard time, what do you do to feel better?
6.	Have you ever received any help or support in relation to this? What?
7.	Can you tell me about your experiences of being involved in any support, activities, or lessons as part of HeadStart?

Note. Questions published in Stapley et al., 2019, the full set of questions are provided in appendix P.

A demographics form, completed by participants after each interview in the Phase 3 QLS, captured their age at the time of interview (in years and months), gender, and ethnicity (see Appendix S).

### **2.1.5 The samples**

The first sample was drawn from the qualitative evaluation of HeadStart Phase 2. Participants were selected from a wider pool of 75 participants on the basis of whether adolescents had directly discussed their experiences of difficulty or stressors in their interview. This sample selection strategy meant that 21 interviews from the original pool were excluded, thus yielding a final sample of 54 participants (23 males and 31 females). The age of participants ranged from 10 to 15 years old. Participants were chosen on account of participating in a site-specific intervention that was distinct to each partnership. A list of interventions has been provided in the table in Appendix C. Interventions included both universal interventions such as PATHS<sup>3</sup> (in the Birmingham partnership), and targeted interventions, such as art and equine therapy (in the Blackpool partnership).

In the second sample, interviews were conducted with 63 adolescents at the first timepoint of the QLS (May to July 2017). The number of participants ranged from 12 to 16 participants per HeadStart partnership (drawn from two to three schools per local authority). The sample included 28 females (44.44%) and 35 males (55.55%). Participants' ages ranged from 9.10 to 12.9 years old ( $M = 11.90$ ,  $SD = 0.59$ ). By the second data collection point (April to July 2018), three participants had left the study due to attrition leading to a total of 60 participants. As per the previous year, participants were asked to self-report their age, gender, and ethnicity in a brief demographics questionnaire at the end of their interviews. Participants who did not take part in the study a year later at Time 2 (e.g., because they chose not to or were uncontactable by the research team), and thus only had interview data from Time 1, were not included in this study ( $N = 3$ ). In the Time 2 sample, participants' ages ranged from 10.07 to 13.90 years ( $M = 12.35$ ,  $SD = 2.95$ ), with one instance of missing age data.

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<sup>3</sup> <http://www.pathseducation.co.uk/>

In terms of recruitment, adolescents were invited to express interest in participating in the study if they had been receiving HeadStart interventions or that they had been selected to participate in a HeadStart intervention at a later date. HeadStart support either included universal interventions, or targeted interventions such as a group intervention for young people with anger or emotional regulation difficulties or one to one counselling for young people that had been identified as having exposure to a risk factor (Stapley et al., 2019).

Demographic data was collected annually for the QLS and was self-reported by participants after the research interview (see Table 2.2 below).

**Table 2.2**

*Total Number and Percentage of Participants from Different Ethnic Groups —  
Demographic Data for Time 1 (2017) and Time 2 of Qualitative Longitudinal Study (2018)*

Ethnicity	Total at Time 1 N (%)	Total at time 2 N (%)
White British	41 (65)	39 (65)
Any other White background	6 (9.52)	7 (11.66)
Black or Black British: African	3 (4.76)	2 (3.33)
Mixed: White and Asian	3 (4.76)	1 (1.66)
Any other Asian background	2 (3.17)	2 (3.33)
White: Irish	1 (1.58)	1 (1.66)
Mixed: White and Black African	1 (1.58)	0
Mixed: White and Black Caribbean	2 (3.17)	1 (1.66)
Asian or Asian British: Indian	1 (1.58)	1 (1.66)
Asian or Asian British: Bangladeshi	1 (1.58)	1 (1.66)
Asian or Asian British: Pakistani	1 (1.58)	2 (3.33)
White British and any other Black Background	0	1 (1.66)
Any other Black Background	0	1 (1.66)
Any other ethnic background	1 (1.58)	1 (1.66)

## **2.2 Thesis design and overview of studies**

The overall aim of this thesis is to explore how qualitative investigations into adolescent experiences of stressors, risk factors and protective factors further our understanding of mental well-being and the prevention of psychopathology. To address this aim, this thesis draws on both cross-sectional and longitudinal data, and consists of a scoping review and three qualitative studies (further details about the design of each study, including the specific methodology applied, will be given in each relevant chapter).

### **Study 1: What Types of Stressors do Adolescents Report to Experience and What are the Perceived Effects on Their Mental Well-being and Risk of Psychopathology?**

Study 1 aimed to explore the types of stressors that adolescents in receipt of preventative interventions identify and the perceived effects on their mental well-being, noting differences in perspective by age and gender. This first study used data from the pilot qualitative evaluation of HeadStart (Phase 2). Whilst the primary focus of the Phase 2 data collection was to evaluate participants' experiences of HeadStart interventions, a wide range of stressors were reported by participants in their interviews enabling analysis.

### **Study 2: What Types of Protective Factors Have Been Associated with Increases in Mental Well-Being and a Reduction in the Risk of Psychopathology in Adolescence in Current Research? A Scoping Review.**

In Study 2, a scoping review was conducted to review the literature on the types of protective factors identified to influence well-being in adolescence from 2000 to 2019. A scoping review was deemed an appropriate method to map key concepts, types of evidence and highlight gaps in the literature in a systematic manner (Colquhoun et al., 2014). A scoping review can reveal norms or patterns in how research on a given topic has been generated, as well as identify any gaps in the field (Munn et al., 2018). Conducting the review provided an overview of all relevant

studies on protective factors in relation to adolescent well-being to date, which enabled me to generate a comprehensive list of protective factors, and highlighted patterns where scholarship was densely populated or scarce.

### **Study 3: What patterns exist in Early Adolescents' experiences in Protective Factors in Relation to Mental Well-being and Risk of Psychopathology? A Typology of Reported protective factors**

Study 3 aimed to qualitatively investigate patterns in the types of protective factors reported by adolescents aged 9 to 12-years- old. This study drew on data from the first timepoint of the QLS of the HS3 evaluation, for which adolescents' experiences of protective factors were a key focus of the interviews. The aim of this study was to address the gap in the literature on adolescents' lived experience of protective factors, as well as explore if it was possible to develop a typology from qualitatively reported protective factors. This research could illuminate both what adolescents deemed to increase their mental well-being, as well as what adolescents identified as reducing or mitigating the risks and stressors that they experienced.

### **Study 4: A Qualitative Study of Changes in Types of Protective Factors in relation to Mental Well-being and the Risk of Psychopathology over the Course of One Year for 10- to 13-year-olds.**

Study 4 aimed to qualitatively explore how adolescents' experiences of protective factors changed over the course of one year. The QLS in HS3 was a unique opportunity to access qualitative data from a large sample where young people's experiences of risk and protective factors and their well-being could be examined from the second wave of data collection. There are few qualitative studies in the current literature base that examine changes in reported protective factors over time (Kim et al., 2015). The typology developed in Study 4 provided a framework to observe if participants had changed type membership over one year (using the typology developed in the previous study) or identify whether there were continuities (or differences) in individual experiences of protective factors at the second data collection point.

## 2.3 Epistemological positions underpinning the thesis

Epistemology refers to a theory of knowledge, including the origins and nature of knowledge, such as what is knowledge, what is knowing and how is knowledge produced and known to be reliable (Denzin & Lincoln, 2008; van der Tuin, 2016; Wenning, 2009). A *positivist* epistemology assumes an external reality that is separate from the researcher, in which variables can be isolated and controlled within careful experimental design, enabling objective research to produce replicable and generalisable findings (Breen & Darlaston-Jones, 2010; Michell, 2003). This notion, i.e. that there is a separate reality independent from the knower, is a *realist* epistemological perspective, which contrasts with a *social constructionist* view that in aiming to know about social reality, the knower constructs knowledge in a relationship between the knower and the subject (Willig, 2012). *Critical realism* (CR) is a branch of a realist epistemology that has informed all of the qualitative analysis and interpretation conducted within this thesis.

CR strikes a balance between the positivistic epistemology that aims to establish truth, that can be described as *hyperrealist*, and a social constructivist position that views truth that can be obtained through social research as socially constructed through language or less accurate accounts of reality (such as a participant's reports), described as *hyporealistic* (Alderson, 2016). A critical realist perspective suggests that whilst it is theoretically possible to obtain objective truths through inquiry, interpretation is needed to understand the underlying structures that shape theories, methods and patterns in the data (Bhaskar, 2008; Fletcher, 2017; Willig, 2012). As Willig (2012) explains, "a critical realist approach does not assume that the data directly reflect reality (like a mirror image); rather, the data need to be interpreted to provide access to the underlying structures that generate the manifestations that constitute the data" (p. 13). Thus, CR encourages examination of the structures that influence behaviour (Bhaskar, 2008). From a critical realist perspective, a participant may not be consciously aware of the drivers behind their behaviours, but a researcher can identify deeper structures and influences in the analysis phase (Fletcher, 2017). Therefore, CR views individuals not as independent agents but as situated within influential social contexts (Bhaskar, 1975). This perspective also implies that participants' accounts of a phenomenon (such as

stressors and protective factors) are not objective representations of reality, and that whilst it is difficult to obtain an accurate portrayal of reality, we can aspire towards it, and specifically aim to understand the causal mechanisms underpinning phenomena (Fletcher, 2017).

The interest in subjective experience and meaning throughout this thesis is also informed by a *phenomenological* epistemological approach (Neubauer et al., 2019), in that I have endeavoured to understand individuals' lived experiences and meaning-making of stressors, risk and protective factors. *Lived experience* refers to the meaning of experience that has been recollected and passed through (Lindseth & Norberg, 2004; Patton, 2002). Phenomenologists focus on 'the what' and 'how' a topic is experienced by a participant (Neubauer et al., 2019). Such a focus can generate new meanings and new understandings for researchers (Willoughby, Good, Adachi, Hamza, & Tavernier, 2013). Thus, the phenomenological strand is brought together with the critical realist approach outlined above to inform my approach to data analysis and interpretation in this thesis. A practical implication conferred by this phenomenological episteme is that taking "a genuine interest coupled with an attitude of openness and wonder that puts pre-understandings at risk, is essential in order to explore lived experience in any depth" (Råheim et al., 2016, p. 17)

The other influence on my practice within the research process was a *feminist* epistemology. Specifically, two components have been drawn on. Firstly, feminist theorists have argued that rather than a detached scientific inquiry, feelings and emotions influence research (Campbell & Wasco, 2000). For example, in the context of emotion-laden responses to questions around emotion-laden topics (such as discussions of experiences of stressors such as being bullied or receiving maltreatment) this accepts that such topics and responses will have an effect on the researcher. Thus, acknowledging the role of emotions involved in interviewing requires interviewers to attend to the emotions of their interviewees, as well as in themselves. Upon completing an interview, I was sometimes emotionally affected by the content shared by a research participant. On those occasions it was helpful to reflect on interview technique and share emotionally difficult interviews, as well as interviews that may have involved safeguarding concerns, with my supervisors. It

was also helpful for me to develop greater understanding of the type of stressors and risk factors described by participants that affected me through journaling and reading related content within existent research.

Secondly, a feminist perspective is cognizant of power divides within research, particularly between the researcher and researched (Campbell & Wasco, 2000). The focus on the power divide between researcher and researched is found in theories of *positionality*, which refers to the socio-political context that influences my social identity, that is influenced by age, race, level of education, social class, sexuality, presence of a learning or physical disability (Adeagbo, 2020; Holmes, 2014; Løvgren et al., 2020). This idea is relevant because when conducting interviews with participants about their lives, I would operate with a different set of assumptions and experiences to the research participant, that could influence the ways that I interacted and engaged in dialogue with participants.

Another theoretical concept of relevance to the underlying epistemology of the thesis is that of *intersectionality* (Carbado, Crenshaw, Mays, & Tomlinson, 2013; Cole, 2009; Grzanka, Santos, & Moradi, 2017). Intersectionality refers to the influence of intersecting influences, including racial, socio-economic, cultural, and social contexts, and the relation to inequalities (Howard & Renfrow, 2014). The implication of this was that in addition to my adult status (relative to that of a child or adolescent), other aspects of my social identity could confer privilege in an interview that it was important to be aware of, such as skin colour, even if it were not possible to reduce these sources of privilege. Moreover, whilst the power divide in research interviews cannot be overcome, there are a number of strategies to reduce the power divide that can be implemented, such as: provision of a clear explanation of the study's aims, purpose and methodology; asking for the adolescent's assent, in addition to the parents' consent for their child to take part; emphasising at the outset of the interview that the participant can skip questions, does not have to answer a question if they do not want to, and that they can withdraw from the study at any time (Greig, 1999; Kirk, 2007). These strategies to ensure both consent and the right to withdraw and to not answer a question were all undertaken as part of the research design.

## 2.4 Ensuring trustworthiness in the qualitative studies of this thesis

Following work from Guba (Guba, 1981), Lincoln and Guba (1985) developed the following widely cited criteria for ensuring trustworthiness in qualitative research: *credibility*, *transferability*, *dependability* and *confirmability* (see Table 2.3 below). Credibility, the qualitative equivalent of the idea of *internal validity*, has been defined as the confidence that can be placed in the truth of the qualitative research findings (Lincoln & Guba, 1985). Credibility establishes whether or not the research findings represent plausible information drawn from the data and are a correct interpretation of the participants' original views (Graneheim & Lundman, 2004; Lincoln & Guba, 1985). Transferability refers to the generalizability of inquiry and, within the evidence base, there are mixed views as to whether the findings of a qualitative study can be (or should be) transferable to other populations (Graneheim & Lundman, 2004; Shenton, 2004). The provision of detailed information about the specific context and population within which the research was conducted can facilitate the reader in assessing the level of transferability of the findings of a study. The researcher is responsible for providing 'thick descriptions', so that those who seek to transfer the findings to their own site can judge transferability (Lincoln & Guba, 1985). The third criterion, dependability, refers to ensuring that both data collection and analysis processes are clearly and exhaustively documented to permit other researchers to be able to follow and even replicate similar procedures (Shenton, 2004; Tobin & Begley, 2004). The fourth criterion, confirmability, is concerned with establishing that the researcher's interpretations and findings are clearly derived from the data (and not their own views and preconceptions), which requires evidence illustrating how interpretations have been reached (Tobin & Begley, 2004). Koch (1994) recommended that researchers include markers for this, such as the reasons for theoretical, methodological, and analytical choices, throughout the entire study, so that others can understand how and why decisions were made (examples are provided in the table below). Finally, Lincoln and Guba (1985) also propose that researchers consider 'fairness' in their research, which refers to allowing equal coverage of a range of views to be featured within a research report.

An *audit trail* provides evidence of the decisions and choices made in the study design and implementation, and requires a clear rationale for such decisions (Koch,

1994). A study and its findings are auditable when another researcher can clearly follow the decision trail. Many qualitative researchers propose that reflexivity is a key aspect of the audit trail, for both documenting logistics, as well as for documenting thought processes and relevant research ideas and hypotheses (Tobin & Begley, 2004). Part of this process involves reflections by the researcher on their values, insights, and experiences in collecting data in the field (further reflection on this is provided in section 2.3.2). The studies in the thesis have also been guided by Qualitative Design Reporting Standards (JARS-Qual) that have been tabulated by APA (Levitt et al., 2018).

**Table 2.3**

*Examples of Strategies for Establishing Credibility in Qualitative Research, Based on Criteria Recommended by Lincoln and Guba (1985), with Evidence for Their Implementation*

Criterion	Strategy	Evidence of implementation
Credibility	Adoption of established methods (Shenton, 2004)	<p>Within all studies of the thesis, qualitative methods were used: thematic analysis and ideal-type analysis, which already have detailed documented procedures for how such methods ought to be applied systematically and rigorously in research (Braun &amp; Clarke, 2006; Gerhardt, 1994).</p>
	Reflection on interview technique and possible biases	<p>In the data collection phase, I received feedback on my interview technique from my second supervisor (ES) and another researcher conducting the interviews (Ola Demkowicz). After each interview I undertook a structured reflection (written or verbal) about what went well and what went less well. Verbal reflections included: self-assessment on interview technique and the emotional load of the interview on the researcher. The interview reflections tool is provided in Appendix S.</p> <p>I also re-listened to some of my interviews to reflect on effective and less effective interview techniques. In addition, I listened to interviews from other members of the research team to inform my practice, as well as to gain greater familiarity with the dataset (an integral starting point for qualitative analysis).</p> <p>I reflected on my biases that were in relation to my identity as a parent, a mature PhD student, a white woman with a</p>

Criterion	Strategy	Evidence of implementation
		<p>minority ethnic parent and a mixed-race child, having an interest in understanding changes in mental well-being and having previous experience with the HeadStart programme and being part of the evaluation team.</p>
	<p>Iterative questioning  (Shenton, 2004)</p>	<p>Within the semi-structured interviews, iterative questioning was followed, and questions were sometimes rephrased or followed-up with a probing question to gather additional understanding on a complex topic, or to ask for more information on a given response (the exception was for interviewees who expressed a wish to pass on a particular question).</p>
	<p>Credibility checks  (Lincoln &amp; Guba, 1986; Shenton, 2004)</p>	<p>In the analysis phase of Study 1, the codes and themes were read and reviewed by JD and ES, as well as checking that the extracted quotes corresponded logically with each theme and subtheme. Any differences in interpretation were discussed and promptly resolved. For instance, in one case, two of the themes was collapsed together to form a broader theme.</p> <p>In Studies 3 and 4, the case reconstructions (descriptions of interview transcript content) were reviewed for accuracy against the original interview transcripts. Moreover, the allocation of cases in the typology was also performed by a research assistant (Rosa Town; RT) and ES, who were blind to my original allocations. Where there were instances of disagreement in terms of to which type cases should be allocated to, these were resolved by JD. The language of the types was also reviewed for bias by RT, a young advisor, and my supervisory team. A detailed explanation of this process is also provided in the relevant chapters.</p>

Criterion	Strategy	Evidence of implementation
	Peer scrutiny of the research project (Lincoln & Guba, 1986)	My supervisory team provided scrutiny of the steps in the research process and what was involved. Scrutiny of the typology was provided in the generation phase by RT and a young advisor, and further scrutiny was obtained when presenting the typology to supervisors, colleagues at EBPU and conference participants at International Association of Youth Mental Health and asking for feedback on the types, as well as scrutiny from second year clinical psychology doctoral students at UCL.
Transferability	Thick description (Lincoln & Guba, 1986)	Detailed narrative description of the methodology and the phenomenon under study has been given throughout the qualitative studies in this thesis - in this case, detailed description of participants' experiences of stressors, and protective factors in relation to mental well-being and the risk of psychopathology, thick description was used in the textual representation of stressors and protective factors in the case reconstructions.
	Data about the context, the number of participants, the methods and length of data collection sessions and the period of collection (Shenton, 2004)	Information about the participants and interview lengths is provided in each respective study.
Dependability	Dependability audit (examination of methods (including how data was collected, stored,	Researchers have provided guidance for ensuring trustworthiness in thematic analysis (Nowell, Norris, White, & Moules, 2017) which I draw on in my thematic analysis

Criterion	Strategy	Evidence of implementation
	<p>analysed and reported) including auditing by a 'competent, external disinterested auditor' (Lincoln &amp; Guba, 1985, p. 77)</p>	<p>(Chapter 3). This included checking the relevance of the transcript content coded to each of the themes. Use of NVivo (qualitative data analysis software) facilitated the audit trail, as my supervisors could easily view the coded extract and its original source (the transcript). It also provided a shared platform where all coding could be viewed between myself and my supervisor.</p> <p>In both ideal-type analysis studies (Chapters 4 and 5), case reconstructions (descriptions of interview transcript content) were produced using the same replicable format for each individual participant. The accuracy of each case reconstruction was also assessed by ES, and RT. I kept an audit trail about key decisions, such as the evolution of the names and descriptions of the types developed, which also included why particular cases were allocated to a type and cases that were difficult to allocate.</p>
Confirmability	<p>Examines the findings to check that the findings are supported by the data (Lincoln &amp; Guba, 1986; Shenton, 2004)</p>	<p>To check that the findings were consistent with the dataset, for my thematic analysis in Study 1, I went through an iterative process of developing the themes and then revisiting the transcripts to ensure that the themes reflected the transcript content. My supervisors also reviewed this.</p> <p>For Studies 3 and 4, ES and RT reviewed the correspondence between the case reconstructions and the individual transcripts. ES reviewed the formation of the types and assisted with type development. ES and JD conducted credibility checks regarding how I had allocated each participant to the type. My supervisors (JD, ES and MW) reviewed the type names and use of language. A Young Advisor from Common Room reviewed the type names and descriptions from a young person's point of view.</p>

Criterion	Strategy	Evidence of implementation
		<p>For the scoping review, a calibration exercise was performed where a research assistant, Lauren Garland (LG), selected the studies using the same inclusion and exclusion criteria. Inconsistencies were discussed and resolved.</p>
	<p>The audit trail  (Lincoln &amp; Guba, 1986; Shenton, 2004)</p>	<p>In all studies, records of the raw data (audio files, transcripts, codes and case reconstructions), field notes, and procedures followed were kept, as well as a reflexive journal (Bradbury-Jones, 2007).</p>

*Note.* ES= Emily Stapley, JD= Jessica Deighton, LG= Lauren Garland, RT= Rosa Town

### 2.4.1 Reflexivity

Reflexivity is important to enhance the quality and trustworthiness of the research, including being transparent about any biases brought by the researcher to the research process and to make clear the influences that a researcher might have in the collection and analysis of qualitative data (Bourdieu, & Wacquant, 1992; Steedman, 1991). Horsburgh (2003) proposed that:

Given that the researcher is intimately involved in both the process and product of the research enterprise, it is necessary for the reader to evaluate the extent to which an author identifies and explicates their involvement and its potential or actual effect upon the findings (p. 309).

Therefore, reflexivity involves reflection on the self in generating knowledge (Berger, 2015). Considering one's own subjectivity and keeping a journal or noting reflections is a key component of forming an audit trail and establishing rigour in qualitative research (Bradbury-Jones, 2007). Reflexivity necessitates acknowledging that aspects of my identity and social position, such as gender, race, class, age, ethnicity, and level of education can influence the data collected, the research process, and how I may be perceived by interviewees in the interview setting (Berger, 2015). Interviewees also occupy social positions that may be different or similar to aspects of my own identity, which means that aspects of their experience (being an adolescent, being a student at a particular school, or being a different gender) may be difficult for me to understand. Unlike a view of knowledge creation which sees the scientist as detached from the object of study, reflexivity takes ownership of the role of the researcher in influencing the research (Berger, 2015). Berger (2015) argues that a difference in understanding is reached when a researcher has personal experience of the phenomenon under study, versus no previous experience of it. For example, a researcher that has lived experience of a mental health disorder for themselves or within their family, will likely listen differently to a participant talk about depression than a researcher that has had no direct experience of depression.

Through reflection I noted that a number of factors in relation to my own subjectivity could yield an influence on the research: being an adult, a woman, a mature student, having worked on HeadStart previously in a communications capacity, being a mother, White, middle-class, of English, American and Jewish heritage, and growing up in a blended family with some lived experience of the risk factors included in the thesis. Whilst it is common to acknowledge a researcher's subjective biases and social position in qualitative research studies, some authors argue that it is not sufficient only to note aspects of identity, but instead to record when aspects of subjectivity can directly influence the research process (Peshkin, 1988). For example, when a researcher may take more interest or have more empathy with one participant relative to another participant (Bradbury-Jones, 2007; Peshkin, 1988). Following the structure of the interview schedule, I aimed to keep my interviews as similar as possible across individuals. However, I did note in my reflexive journal that I may have had particular biases towards particular topics in the interview setting. For instance, as a mother, I would like to explore how to improve adolescents' well-being and 'what works', thus I had a risk of bias towards asking participants more questions about what they enjoy and what makes them happy.

It has been argued that conducting research with children and adolescents involves a researcher considering their own perspectives on what childhood or adolescence is, as these are ideas that involve particular sets of assumptions about what it means to be a child or adolescent that may change over time (Fasoli, 2001). My consideration of the construction of childhood has been informed by studies that have developed a sociology of childhood and examined the ways that notions of childhood and adolescence vary cross culturally (Brady, Lowe, & Olin Lauritzen, 2015; Moran-Ellis, 2010). As part of my reflexive practice during data collection and data analysis, I aimed to suspend my pre-judgements about what it means to be a child or what it means to be an adolescent, to enable participants to share their experiences without looking through the lens of my own experiences or world view. I read about changes in the conceptions of childhood and the notion of adolescence as a construct, as well as noted down some of my assumptions, such as a belief that adolescents would benefit from supportive parents. I explored the literature to find studies that have investigated the effects of supportive parents for adolescent well-

being (Giannakopoulos et al., 2009). I decided to endeavour to bracket my beliefs about what is good and normative for adolescents, and endeavoured to understand, from their perspectives, the difficulties that they experience and how they manage them, and what they understand to increase their mental well-being.

## **2.5 Conclusion**

This chapter began with an overview of HeadStart (Phase 2 and Phase 3), as the settings where the three qualitative studies that comprise this thesis were undertaken. The key epistemological influences throughout this thesis were then described, including CR and phenomenology. Finally, Lincoln and Guba's (1986) criteria for establishing trustworthiness in qualitative research were outlined, with strategies described for how each of the criteria was achieved in this thesis. In relation to establishing trustworthiness, I also reflected on my social position, values, and biases that I may have brought to the research process.



Chapter 3. What types of Stressors do Adolescents Report to Experience and What are the Perceived Effects on their Mental Well-being and Risk of Psychopathology?

### **3 What Types of Stressors do Adolescents Report to Experience and What are the Perceived Effects on Their Mental Well-being and Risk of Psychopathology?**

#### **3.1 Introduction**

Research indicates that there has been a rise in the incidence of psychopathology and a decrease in the mental well-being in British adolescents (Deighton, Yoon, & Garland, 2020; Pitchforth et al., 2019; The Children's Society, 2019). Normal adolescent development necessitates competence at handling stressors, such as setbacks and disappointments that are specific to the adolescent period (Zimmer-Gembeck & Skinner, 2008). Yet, adolescents respond to stressors in many ways and there a range of effects on mental well-being and risk of psychopathology (Zimmer-Gembeck & Skinner, 2008). It is well-established within the literature that exposure to multiple stressors has a negative effect on well-being and in fact, can precipitate the development of types of psychopathology, such as anxiety and depression (Larkin, Felitti, & Anda, 2014; Richards & Smith, 2015). On this basis, there is a potential value to understand the broad range of stressors that adolescents and reported effects that adolescents can experience, in order to better understand the effects on their mental well-being and risk of psychopathology.

The definition of stressors adhered to in this study includes both environmental stressors (negative life events, traumatic experiences, daily hassles) and internal stressors (mental and emotional states, such as worry or difficulties regulating emotions), that may be temporary, intermittent, or chronic, and have a perceivable effect on the adolescent mental well-being (from the adolescent's point of view). The interest within the current work is in the subjective perception of stressors and their reported effects on mental well-being and risk of psychopathology. Existing research on the types of stressors that adolescents experience has investigated a range of factors including school and academic pressure, adverse family events, career and employment concerns, challenges in romantic and sexual encounters, peer conflict and bullying on adolescent mental health and well-being (Moksnes, Espnes, & Haugan, 2014; Parikh et al., 2019). Stressor researchers have remarked that "46%–

82% of all stressful everyday events named by adolescents pertain to interpersonal relationships” (Seiffge-Krenke et al., 2009, p. 260). Interpersonal stressors include conflicts between parents and adolescents, conflicts with friends and romantic partners (Seiffge-Krenke et al., 2009).

Whilst studies of one or two stressors may enable understanding of the mechanisms or precise interactions between these particular stressors and outcomes, they may also omit other important contributing factors to adolescent mental well-being, such as parental well-being or stress occurring in the family context, such as work stress or socio-economic hardship. Some studies have specifically examined the effects of multiple stressors on adolescent mental well-being and risk of psychopathology (Evans & English, 2002; Williams, Aiyer, Durkee, & Tolan, 2014). For example, to measure multiple stressor exposure, Evans and English (2002) measured the incidence of participants’ exposure to three psychosocial stressors (violence, family turmoil, and child–family separation) and three ‘physical’ stressors (crowding, noise, and housing quality) to produce an index (0–6) of multiple-stressor exposure for each child (Evans & English, 2002). The study found that children with socio-economic disadvantage were exposed more often to each stressor domain and the intensity of stressor exposure was significantly higher for these children, in comparison with those with greater socio-economic advantage (Evans & English, 2002). This study brings attention to the wider social ecology of multiple stressors that may occur concurrently for an adolescent. However, the full range of multiple stressors may not be taken fully into account within approaches that study one or two variables in isolation.

To measure stressors systematically, population-level checklists and surveys have been frequently applied, such as the Stressful Life Events Schedule (SLES), which involves asking participants to report back on the occurrence of stressful life events during the prior year (Grant et al., 2004; Williamson et al., 2003). Such measures have been criticised, however, because subscales are based on preconceptions of adolescent experience that limit the type, number, and duration of stressors captured (Duggal et al., 2000). Qualitative investigation would allow for wider exploration of the experience of stressors for young people; however, interviews and other qualitative approaches are used much less commonly in

stressor research. In a review of 500 studies, less than 2% used interviews, with checklists more commonly used (Grant et al., 2004). Furthermore, given the subjectivity involved in perceiving stressors, understanding variations in adolescents' perceptions of stressors, and how they understand them to affect their mental well-being, is particularly important.

How adolescents respond to stress, or how they cope with stress can moderate the effect that it may have on well-being and the risk of psychopathology (Compas, Orosan, & Grant, 1993; Kraaij et al., 2003). Researchers have developed taxonomies of coping behaviour (Compas, Connor-Smith, Saltzman, Thomsen, & Wadsworth, 2001). Some taxonomies distinguish between 'engagement' or 'active coping strategies' (direct efforts to change a stressful circumstance) and 'disengagement' or 'avoidant' coping strategies (behaviours that involve distraction or distancing from the stressor (Carver & Scheier, 1994; Compas et al., 2001; Frydenberg, Lewis, & Frydenberg, 2009). Studies have shown that attempts to cope with stressors that are maladaptive (such as aggression or rumination) then in turn represent risk factors for psychopathology (Compas et al., 2001; Thompson et al., 2010). Conversely, adaptive coping can potentially strengthen the capacity of adolescents to manage future stressors (Zimmer-Gembeck & Skinner, 2016). According to the *social stress model*, the more types of stress that adolescents experience within their social environment, the greater the risk of employing maladaptive coping strategies, such as drug and alcohol use to manage the effect of stressors (Aneshensel, 1992; Aneshensel & Mitchell, 2014). Therefore, understanding and reducing a number of stressors, and facilitating coping behaviour, is important to promote adolescent well-being (Pearlin, 1999; Rhodes & Jason, 1990).

Previous studies have also explored whether gender differences exist in the types and frequency of stressors experienced by adolescents, finding mixed results. A study with a sample of 2,505 (1012 boys and 1493 girls) New Zealand adolescents (aged 10 to 20 years old) found that females reported higher stressor frequency than males after the age of 12 and greater intensity after the age of 13 (Jose & Ratcliffe, 2004). Another study found that teenage girls experienced more friendship loss than boys and that they experienced more internalising and externalising symptoms

associated with friendship loss, concluding that girls have increased sensitivity to changes in relationship dyads (Bakker et al., 2010). Gender differences in coping styles have been identified with females found to be more likely to draw on social support (Bakker et al., 2010; Hong, Hwang, Liu, & Peng, 2011). To manage peer-related stressors, studies found females were found to disengage, as well use more isolation, self-blame and crying, whilst males used strategies such as physical activity and aggression (Jose & Kilburg, 2007; Piko, 2001).

Overall, substantial research has been conducted on the experience of stressors in adolescence; however, there are a number of gaps in the study of stressors in relation to age that need to be explored (Seiffge-Krenke et al., 2009). For example, it is not yet clear how adolescents' perceptions of stressors may change over time in the adolescent period (Seiffge-Krenke et al., 2009). Of the relatively scant research on age-related stressors in adolescence, the transition to and adaptation to secondary school can serve as a major stressor for adolescents at age 12 to 13 years old (Zeedyk et al., 2003). Sitting GCSE school examinations (at age 15 to 16 years old) can also constitute another age-related stressor (Denscombe, 2000). Denscombe's (2000) study found that GCSE examinations were important to adolescents as they were perceived by adolescents to have far-reaching effects on adolescents' lives beyond secondary school to their anticipated future success.

Qualitative research in this area has revealed that when adolescents are asked about the types of stressors that they experience, a broad range of stressors are described, which may vary with geographic and other demographic factors. For instance, a qualitative study of problematic situations experienced by low income, urban African American adolescents in Virginia found that as many as 39 stressors were reported (Farrell et al., 2007). Of these, 'internal child problems' were most frequent, including emotional dysregulation, rumination, and perceptions of unfairness; followed by problems in the external domains of peers, school, family, and neighbourhood (Farrell et al., 2007). Internal stressors tended to be reactions to experiences or external stressors but were nevertheless viewed by the adolescents as, "problems in their own right" (Farrell et al., 2007, p. 424). In another recent study of adolescent stressors with participants aged 11 to 17 years old in India, reported stressors included academic pressure, difficulties in romantic relationships,

negotiating parental and peer influences, and exposure to violence and other threats to personal safety (Parikh et al., 2019). Additionally, girls highlighted experiencing the stressor of having to conform to normative gender roles and in managing the risk of sexual harassment in the city (Parikh et al., 2019).

Qualitative studies of stressors can allow for the articulation of unforeseen types of stressors, outcomes, and processes based on adolescent reports within their social and cultural contexts (Bishop, 2007). Moreover, if adolescents are viewed as social actors, with perspectives equally valid as those of adults then adolescents are experts in their own experience of their lives (James & Prout, 1997; Kirk, 2007; Morrow & Richards, 1996). Research suggests that the effects of stressors on adolescent mental well-being and emotions is complicated (Sigfusdottir et al., 2017). Qualitative studies can potentially illuminate individual experiences, without limiting responses to pre-conceived categories (Bishop, 2007). Yet, as discussed, few qualitative studies of stressors on adolescent mental well-being have been conducted, particularly in the English context. Such research may provide valuable insights into the ways in which stressors can affect mental well-being and the risk of psychopathology in adolescents. This may include how adolescents perceive the drivers of psychopathology or the symptoms of psychopathology to develop.

Therefore, the primary aim of the current study was to build on existing work in this area by qualitatively investigating the types of stressors experienced by adolescents in England. The second aim was to understand, from participants' perspectives, the perceived effects of the stressors that they identify on their mental well-being. Whilst it is noted that the definition of stressor employed throughout this thesis includes an effect on mental well-being, the first research question in the current study seeks to understand what the stressor is, and the second research question aims to understand how it affects mental well-being. The third aim of the current study was to note gender and age differences in qualitative reports of stressors.

The definitions of mental well-being and psychopathology employed throughout this study follow the same terms introduced at the beginning of the thesis. To recap, mental well-being is defined following Ryan and Deci (2001) as a: "A

multidimensional phenomenon that includes aspects of both the hedonic and eudaimonic conceptions of well-being.“ (p.148). Psychopathology is equated within this thesis with the concept of types of mental disorders, in line with existing literature (Butcher & Hooley, 2018; Krueger & Markon, 2006; Moleiro, 2018). Within the thesis, a mental disorder refers to:

A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one of more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. (American Psychiatric Association, 2000, p. xxxi).

## **3.2 Method**

### **3.2.1 Setting for the study**

This study is a secondary analysis of data from a qualitative study, which was conducted to evaluate the HeadStart Phase 2 programme in England. As part of the qualitative evaluation of HeadStart Phase 2 (as described further in Chapter 2), 75 adolescents aged 10 to 14 in 12 regions across England (Blackpool, Cornwall, Southampton, Lewisham, Hull, London borough of Newham, Wolverhampton, Birmingham, Knowsley, Kent, Middlesbrough, and Cumbria) were interviewed about their experiences of receiving particular mental health and well-being focused interventions as part of HeadStart, including their perceptions of experiencing and overcoming difficulties in life. The primary aim of the semi-structured interviews was to enquire into participants' experiences of taking part in resilience and mental well-being focused interventions as part of HeadStart. The secondary aim was to understand participants' own experiences regarding risk/stressors and resilience/well-being. Thus, the dataset included coverage of specific difficulties that adolescents face, as well as the ways that participating in the intervention assisted adolescents in addressing aspects of the difficulties, as well as aspects of difficulties

that were not addressed. On account of covering these topics, the dataset was an appropriate repository of data about stressors as experienced by adolescents.

### 3.2.2 Participants

The sample in Study 1 was selected from a wider pool of 75 participants on the basis of whether they had directly discussed their experiences of difficulty or stressors in their interview. This sample selection strategy meant that 21 interviews from the original pool were excluded, thus yielding a final sample of 54 participants. The age of participants ranged from 10 to 15 years old. The final sample comprised 23 males and 31 females. Exact age data were not collected and thus only the school year group of each participant is known. A breakdown of age and gender information about the sample is provided in Table 3.1

**Table 3.1**

*Study Participants by Age (Given as School Year) and Gender*

	School Year						Total
	Year 6	Year 7	Year 8	Year 9	Year 10	Unspecified	
M	4	2	13	1	1	2	23
F	1	4	13	9	4	0	31
Total	5	6	26	10	5	2	54

*Note.* Year 6 = 10-11, Year 7 =11-12, Year 8 12-13, Year 9 =13-14, Year 10=14-15 as per secondary schooling year groups in England. M= Male, F= Female.

### 3.2.3 Data collection

The data were collected between September 2015 and January 2016 by the HeadStart national evaluation team (including myself and my supervisor). The interviews were audio-recorded and transcribed verbatim. Information about interview audio file length is not available due to ethical constraints on the length of time that audio files could be stored. The interview transcripts ranged in length from 8 pages to 47 pages (Font: Times New Roman, Size: 11) ( $M = 18.59$  pages,  $SD = 7.32$ ).

### 3.2.4 Data analysis

A thematic analysis (TA) was conducted to address the following research questions: what types of stressors do participants report and what are the perceived effects on their well-being and risk of psychopathology? Thematic analysis is “a method for identifying, analysing and reporting patterns within data” (Braun & Clarke, 2006, p. 79). TA pays attention to both prevalence (frequency of occurrence) and meaning in response to a given research question across a qualitative dataset (Braun & Clarke, 2006). Prevalence can be defined as the number of individual participant accounts across the dataset relating to a given theme (Braun & Clarke, 2006). Braun and Clarke’s (2006) guidelines for conducting a TA consist of six steps applied in the present study.

The first step, familiarisation with the dataset, involved listening to the interview audio files, checking the transcript quality, and re-reading the dataset. The transcripts were then imported into the NVivo qualitative data analysis software package (Version 11). The transcripts were coded in NVivo, which involved systematically labelling or describing the content of transcript extracts that had direct relevance to the two research questions under study (step two). A long list of codes pertaining to the content of all relevant extracts from the transcripts was generated. Similar codes were then clustered together to form initial themes pertaining to the research questions (step three). The names and definitions of the themes and codes derived from the dataset were captured in a coding frame (a guiding conceptual framework). Through reading the coded transcript extracts and comparing them with the written description of each theme and what it included, all codes and themes were checked for consistency and errors (such as a coded extract being assigned to the wrong theme) (step four). The first author then shared the themes and theme names with the second and third author and these were reviewed and agreed upon (step five). The themes and subthemes were then described with supporting quotes in the final report (step six) (Braun & Clarke, 2006).

### 3.3 Results

Six main themes were derived from the dataset relating to the types of stressors experienced by participants that comprised: negative mental states and/or emotions, peer difficulties, behavioural difficulties, bullying, school difficulties and family difficulties. The main themes and subthemes are listed in Table 3.2 in order of prevalence in the dataset, and the effects of each theme on mental well-being, as according to participants, are discussed in the text. Themes and subthemes represent different types of stressor (e.g., difficulties with anger, a subtheme, is subsumed within the main theme of negative mental states and/or emotions). Whilst there were six main themes, including subthemes, a total of 32 stressors were found. Gender and age differences have not been reported in relation to the adolescents' perceptions of the effects of stressors on their mental well-being and risk of psychopathology, due to the relatively small amount of data available for addressing this research question.

**Table 3.2**

*Frequency of Themes with Subthemes, Given as Percentage in Total Sample (N =54) and the Total Number of Males (M) and Females (F) Reporting Each Theme — the Percentage of Participants from Each Year Group Reporting Each Theme is then Given for Each Year Group (Y6-10)*

<b>Themes and subthemes</b>	<b>N</b>	<b>% of total</b>	<b>M</b>	<b>F</b>	<b>Y6 %</b>	<b>Y7 %</b>	<b>Y8 %</b>	<b>Y9 %</b>	<b>Y10 %</b>
1) Main theme: <i>Negative mental states and/or emotions.</i> Subthemes: Anger, lack of confidence and low self-esteem, worry and anxiety, emotional suppression and worries about exams, school and future choices, low mood, feeling unsafe, sadness and shyness.	49	90.7	26	23	100	50	96.2	30	100
2) Main theme: <i>Peer difficulties</i> Subthemes: Peer arguments, rivalry and taking sides, falling out and romantic relationships, secrets, social isolation, and swearing amongst peers.	41	75.9	14	26	80	100	65.4	70	40

<b>Themes and subthemes</b>	<b>N</b>	<b>% of total</b>	<b>M</b>	<b>F</b>	<b>Y6</b>	<b>Y7</b>	<b>Y8</b>	<b>Y9</b>	<b>Y10</b>
					<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>
3) Main theme: <i>Behavioural difficulties</i> Subthemes: Peer influence, aggressive behaviour, truancy and walking out, risk of exclusion, bad reputation, and binge drinking.	38	70.4	24	14	60	83.3	76.9	40	80
4) Main theme: <i>Bullying</i> Subthemes: Name-calling and teasing, cyberbullying, duration of bullying, lack of support, and feeling depressed.	32	59.3	15	17	0	16.7	76.9	90	40
5) Main theme: <i>School difficulties</i> Subthemes: Misbehaviour at school, difficulties with teachers, emotional issues at or about school and moving school.	31	57.4	18	13	40	66.7	84.6	10	40
6) Main theme: <i>Family difficulties</i> Subthemes: Disruption of the role of parent, family member or caregiver, relationship issues within the family and maltreatment.	26	48.1	9	17	40	50	57.7	20	80

*Note.* \*N = Number of participants (out of the total sample of 54) who referred to this theme in their interviews, %= percentage of total number of participants.

### 3.3.1 Theme 1: Negative mental states and/or emotions

In total, 90.7% of participants directly reported experiencing some type of difficulty with a negative mental state (e.g., a negative state of mind, such as a negative belief) and/or a negative emotion. Of the negative mental states described, the most frequent were anger (22.4%), lack of confidence and low self-esteem (22.4%), worry and anxiety (18.4%), 'bottling-up' emotions (12.2%), and worries about exams, school, and future choices (12.24%). Less frequent stressors included low mood, feeling unsafe, sadness and shyness. Negative mental states and/or emotions were discussed by participants both as reactions to external stressors, such as difficulties in relationships with parents and peers, and as problems in their own right that required coping behaviours. Thus, negative mental states and/or emotions were reported as both precursors to external stressors and consequences of them. For example, in the following quote, a participant begins discussing an internal stressor (negative mood) which then leads to specific behaviours leading to negative consequences (disciplinary action at school).

I'd come to school in a negative mood all the time and I wouldn't really be interested in learning so then I'd maybe get a behaviour point 'cause I'd be angry and I wouldn't know how to deal with my emotions then I'd anger the teachers and that would cause me problems (Female, Year 10).

Of the participants reporting anger as a stressor, the majority were male (nine males versus two females) aged 12 to 13. Some participants discussed difficulties with controlling their anger, with it manifesting as externalising behaviours, describing the need to 'let it out' at something or someone. Participants described how feelings of anger could be elicited by other stressors, such as problems with peers, teachers, and family members, and could potentially lead to disciplinary consequences or that the feelings were overpowering. For example, one participant described, "when I get annoyed... I can't think of anything: can't think of my dog, family, anything, and em, I just go off, like I'm just like a dog, go for the person who [I] hate." (Male, Year 8).

Under the subtheme of lack of confidence and low self-esteem (22.4%), some participants directly reported struggling with a lack of confidence about themselves and in some cases their bodies and body image. These participants outlined negative beliefs or concerns about body image that they described as leading to difficulties socialising. For example, “I used to think I was ugly, and nobody liked me” (Female, Year 8). One participant expressed that girls were more preoccupied with the way that they looked, but that boys also focused on particular aspects of appearance. He reported, “Mostly girls really. Boys just think about muscles and who’s got better hair and stuff like that.” (Year 8).

Worry and anxiety, a related subtheme, was described more often than males by females (14.81% relative to 5.55%). For example, a participant reported: “I feel quite worried when I’m watching the news and what’s happened because... like if there’s something really bad going on in the world... I’m g- I’m scared it’s gonna happen to me” (Female, Year 6). Worries about exams, school and future choices was another subtheme, though reported less commonly and often reported as one of many stressors. For example, a participant reported, “I’m in Year 10 next year and that’s a year closer to my GCSEs and pressures built on me” (Female, Year 9).

Within the mental states theme, participants also spoke about ‘bottling up’ their emotions, particularly in the context of interpersonal conflicts. In describing a peer argument, for example, one participant reported how “expressing my feelings was hard. I was bottling them up until I couldn’t control them” (Male, Year 6). In another case, a participant described being in a negative mood and not knowing how to deal with her emotions.

### **3.3.2 Theme 2: Peer difficulties**

Peer difficulties was another highly prevalent stressor discussed by 75.3% of participants. Peer difficulties included the subthemes of: ‘peer arguments’ (25.3%), ‘conflicts in relation to romantic relationships’ (20.0%), ‘falling out’ (17.5%), and ‘rivalry and taking sides’ (17.5%). Less frequently reported stressors included secrets (3.70%) (in the sense of peers feeling left out that they would not share personal information, gossip, and stories with them), social isolation and peers engaging in

swearing (1.85%). Peer difficulties were markedly higher for females than for males ( $N = 26$  versus  $N = 14$ ). Peer arguments were reported mostly by females in Years 6, 7 and 8 but also pertinent for males. One participant described peer difficulties as linked to competitive behaviour and leading to arguments and falling out. He said peer conflicts were constant and involved: “Competition about, like, who’s stronger and who’s better looking. People always like arguing, get stressed and everything can like... like falling out and it’s just a big problem all the time.” (Male, Year 8).

Conflict in relation to romantic relationships was a stressor described by both sexes in year groups 7, 8, and 9 only. This stressor included concerns about a friend’s perception of their new girlfriend or boyfriend, “If your mates say, ‘He’s or she’s ugly’, [you] just get into an argument which ruins your friendship” (Male, Year 8). It also included a sense of stress about sexual relations. One participant described that, “everyone’s thinking about sex and they’re getting stressed about it” (Male Year 8).

Participants described experiencing both gradual and more immediate effects on their mental well-being, as a result of peer difficulties, that could have large perceived effects on their self-evaluations. For example, one participant stated, “It [an argument] bothers you and nibbles away at you, eventually” (Female, Year 8), while another described the effect of falling out with a friend on their self-esteem: “When someone’s not friends with you, your self-esteem comes off and when you’re friends, your self-esteem comes back” (Male, age unspecified).

### **3.3.3 Theme 3: Behaviour difficulties**

The theme of behaviour difficulties was also a common reported stressor, featuring in 70.4% of the interviews. Prevalent subthemes included peer influence on deviant behaviour (44.0%), aggressive behaviour (18.4%), and reported difficulties related to not wanting to go to school and walking out of school lessons (7.9%). Less frequent stressors in this theme included the risk of exclusion (1.85%), having a bad reputation (1.85%), and binge drinking (1.85%). Males reported behavioural difficulties more frequently than females ( $N = 24$  versus  $N = 14$ ).

Reports of behavioural difficulties were especially common among Year 7 participants (83.3%), followed by 76.9% of participants in Year 8, and 80.0% of Year 10 participants with the Year 6 (60.0%) and Year 9 (40.0%) age groups reporting behavioural difficulties the least. Participants also referenced past periods of behavioural difficulties and linked it to a particular year in school, for example, “Year 7 was the biggest, naughtiest, moment of my life” (Male, Year 8). Linked to the previous theme, the role of peer influence on behavioural difficulties was reported as a stressor to contend with by both sexes, when trying to avoid participating in deviant behaviour, for example, “Some of my friends will tell me to go and fight” (Female, Year 7). Indeed, acts of aggressive behaviour were mentioned by seven participants, who referred to this in the domains of school and home. One participant discussed feeling triggered when his mother asked him to tidy his bedroom “Say if I didn’t tidy my bedroom, I’d probably wrestle everyone and just punch walls” (Male, Year 6). Finally, truancy or walking out of class was mentioned by three participants, described as a means of coping with bullying or difficulty in school and completing work. For example, one participant described when he found his work difficult, he would leave the classroom, “If there’s a problem and it’s something like my work and I can’t do it, I just quit doing the work and walk off” (Male, Year 8).

The effects of behavioural difficulties on mental well-being were varied. Some participants discussed short-term consequences, such as feeling angry, receiving additional discipline at home, or feeling singled out. For example, “All of them [teachers] just targeted me” (Female, Year 8). Whereas others discussed worries about long-term consequences, such as permanent exclusion.

### **3.3.4 Theme 4: Bullying**

Bullying was another prevalent stressor described as experienced by 59.3% of the sample. Bullying included instances of name-calling and teasing (40.6%), cyberbullying (28.1%), and reference to the duration of the bullying (15.6%). Less frequent stressors included a lack of support (in relation to bullying) and feeling depressed. Bullying was reported by the majority of participants in Year 8 (76.9%) and Year 9 (90.0%). Experiences of being bullied were not reported by Year 6

participants, less frequently reported by Year 7 participants (16.7%) and reported the least by students in Year 10 (40.0%).

Episodes of name-calling and teasing were often described as ‘taking the mick’, which involved mocking perceived differences concerning family, appearance, or identity. For example, one participant described bullying about appearance as a stressor he encountered, “Bullying... like people take the mick out of other people cause like if they’re taller they call you like “talley” or like if you small they call [you] like a “smalley” (Male, Year 8). Cyberbullying, bullying conducted online through negative comments or via inappropriate images, was another key subtheme (28.6%). Several participants discussed the duration and/or time of onset as an indicator of how serious the participant perceived the bullying to be, with several participants describing it as an ongoing problem that could be traced back to primary school.

In terms of effects on mental well-being and the risk of psychopathology, participants described experiencing truancy, social isolation, fighting, feeling depressed, and avoiding school or peers. For instance, one participant stated, “I got bullied and it used to make me feel depressed” (Male, Year 8). Bullying was also often identified as the cause of anger or emotional problems, that led to acts of retaliation: One participant described that after been mocked by a peer, he would respond: “I go “oh, time for me to take the mick out of you now” and then I start taking the mick out of them, [it’s] like payback, innit?” (Male, Year 8). Several participants reported finding strategies ineffective to cope with bullying. For example, one participant explained, “I used to try and get my mum to get me off school a lot, trying to skive. I tried to ignore them, but it never worked” (Female, Year 9). Moreover, two participants described that they avoided social media as a strategy: “I find that not going on social media helps” (Male, Year 8).

### **3.3.5 Theme 5: School difficulties**

Reports of school difficulties were raised in 57.4% of the interviews. This theme included behavioural difficulties at school (29.0%), difficulties with teachers (25.8%), reasons for disliking school (16.1%), emotional issues at school or about school (25.8%) and moving school ( $N=1$ ). Adolescents in Years 7 and 8 spoke about

school difficulties most frequently (66.7% and 84.6% respectively) with participants in Years 6, 9, and 10 describing school difficulties much less (all less than 40.0%). School difficulties were discussed in terms of both minor and severe effects on mental well-being. Minor effects included temporary emotional states and singular disciplinary consequences (e.g., being on report), while more severe effects included symptoms of psychopathology, such as panic attacks, and feeling to emotionally unwell to attend school. “I kept like stressing out in the mornings ‘cause I didn’t want to come to school” (Female, Year 8).

Difficulties with teachers included feeling unfairly labelled following an act of misbehaviour, for example, as one participant stated, “When you have been naughty before and the teachers still blame you for it” (Male, Year 8). More males discussed difficulties with teachers (six males versus one female in Year 8) as a stressor, while more females reported emotional issues at or about school (four Year 8 females).

Participants also discussed experiencing emotional issues at/or about school. Emotional issues at or about school included a range of complex feelings, which coloured the adolescent’s relationship to school or impaired attendance. Some participants pinpointed a previous negative school incident as the cause of contemporary emotional issues that translated into school avoidance and symptoms of anxiety. For example, one participant recalled an incident of being reprimanded by a teacher in the first weeks of secondary school, which he felt was the cause of his panic attacks and anxiety during his GCSEs, “It all stemmed from an incident in Maths, from Year 6 to Year 7 from [the] second week in” (Male, Year 10).

### **3.3.6 Theme 6: Family difficulties**

In total, 48.1% of the sample discussed family difficulties as a stressor. Family difficulties branched into two broad subthemes (and one rarer subtheme) that were: disruption in the role of a family member, parent, or caregiver, as articulated by 57.7% of the sample, and relationship issues within the family, as discussed by 38.5% of participants, with one participant describing experiences of child maltreatment within this theme. Reports of family difficulties varied by age; they were most reported by participants in Year 10 (80.0%) and least reported by those in Year

9 (20.0%). Girls discussed experiencing family-related difficulties more than boys (17 females versus 8 males).

The disruption of the caregiving role of a parent included parental absence or parental mental and physical illness. Some types of disruptions to the role of their caregiver were sometimes cited as a main cause of a negative mental state and behaviours, which was part of a reported chain leading to negative mental well-being negative outcomes. For example, in one case, a participant identified her mother's illness as a trigger for her "spiralling out of control" (Female, Year 10), referring to her experience of emotional issues, delinquency, association with a 'tough crowd' and, not completing her exams and leaving school prematurely. Moreover, another young person described her mother's illness as a stressor that compromised what she could do, such as extracurricular activities, "My mum... 'cause she's got [chronic health condition] [...] so I would do things like after-school clubs, but I can't, 'cause I need to help my mum" (Female, Year 8).

The second subtheme, relationship issues within the family, comprised a cluster of stressors, including conflict with parents, between parents, and between participants and their siblings. For example, regarding conflict with his mother and stepparent, one participant stated, "Every day at my mum's I get shouted at" (Male, Year 8) in the context of discussing how he found it difficult when he spent time at his mother's house, relative to staying with his father. This subtheme included stressors such as relationship issues with specific family members and receiving discipline at home, "Me and mum weren't getting on really well and I was grounded" (Female, Year 8), and associated negative mental states and/or emotions.

### **3.4 Discussion**

This study identified six main themes of reported stressors: Negative mental states and/or emotions, peer difficulties, behavioural difficulties, bullying, school difficulties and family difficulties, which described the range of types of stressors from a large community sample of adolescents in receipt of preventative interventions in England ( $N = 54$ ). The reported stressors were, in many ways, congruent with extant quantitative and qualitative research on the types of stressors

that affect adolescents, but the current study shows a more diverse range of stressors ( $N = 32$ ) and indicates the individualised ways in which participants report both their experiences of a stressor and effects on mental well-being. This study provides some explanation of the pathways between stressor and effects on mental well-being in a wider context where explanations for the trend of rising rates of psychopathology (as observed in the UK) can be either absent or overly simplistic (Costello, Copeland, & Angold, 2011). The study shows how overlapping stressors are in their effects, with mental states affecting relationships and behaviour at school. It is increasingly understood that focus on one stressor may not take into account other stressors that affect psychopathological outcomes (McLaughlin & Lambert, 2017; McLaughlin & Sheridan, 2016). Focus on a narrow range of stressors may fail to account for the range of individual experiences that involve multiple factors within an adolescent's social ecology (U. Bronfenbrenner, 1994; Tudge, Mokrova, Hatfield, & Karnik, 2009).

The prevalence of negative mental states and/or emotions as a key type of stressor found in this study is consistent with qualitative research from Farrell et al.'s (2006) study of the stressors experienced by African American adolescents. Farrell et al. (2006) found that internal problems, such as emotional dysregulation, generalised worry, and low self-esteem, were the most frequent stressors reported. Similarly, in the present study, I also found that these same types of internal stressors were reported as stressors by participants. This finding mirrors Farrell et al.'s (2006) study despite a different timeframe and cultural context. Indeed, in the present study, within all themes, participants reflected on their mental states and behaviour, and some reported chains of effects of stressors on their mental well-being, such as emotional dysregulation affecting relationships with peers (e.g., by an adolescent becoming aggressive), which then led to disciplinary consequences at school. Or, in another reported chain, low self-esteem and negative beliefs about body image affected attending school and socialising with peers.

Indeed, this study has added to other findings from qualitative research in this area with its suggestion that some participants can experience *chains of stressors*, whereby stressors in different domains interacted to lead to a negative outcome. This study thus finds that whilst clear themes of stressors can be identified, different

domains of stressors are highly interconnected and influence one another. Thus, the experience of stressors is crosscutting across various domains of mental well-being, home, school, and friendships. The chains of stressors identified in this study are consistent with the notion that stress can be a link in a causal chain (Aneshensel, 1992). The notion of '*social stress*', is relevant here, as adolescent conceptualisations of chains of stressors imply that they were connected, influencing, and moderating each other, rather than isolated variables (Aneshensel, 1992). Further research is needed to explore the ways in which adolescents may identify a trigger for a chain of events that leads to reduced mental well-being or psychopathological symptoms, and how these triggers may vary across adolescents. The other notable point here is that generally knowledge about the variables mediating or moderating the relationship between stressors and outcomes is derived through statistical models; however, in the examples given in this study, adolescents themselves are identifying mechanisms or processes that mediate the relationships between variables. Future research could explore what disrupts the negative effects of stressors or chains of stressors or reduces the impact of stressors on mental well-being or the risk of psychopathology for adolescents, including but not exclusively focused on, the preventative interventions that they may have experienced.

Across all six themes identified in this study, some gender differences were found that suggest some agreement with extant research. For example, within the negative mental states and/or emotions theme, more males reported experiencing anger and aggression (intent to hurt or harm others), while more females reported worry. This finding is consistent with what is known about gender differences in internalising and externalising states (e.g., Fink et al., 2015; Trudeau et al., 2012). Anger was most commonly reported by Year 8 males in this study, mainly in reaction to others, which is in line with theories of *reactive aggression* and research that indicates a surge in direct aggression occurs in males after the transition to secondary school potentially due to the need to establish new social hierarchies (Crick & Dodge, 1996; Pellegrini, 2002; Pellegrini & Bartini, 2000). Boys in the current study were also found to experience more school difficulties, particularly at age 11 to 13, again mirroring previous research indicating that boys experience increased difficulties at school after the transition to secondary school (Pellegrini, 2002).

Peer stressors were common threads throughout this study, in agreement with other research that suggests that peers are a key stressor for adolescents (Parikh et al., 2019). Peers difficulties were discussed most commonly by girls, who described arguments and falling out with others. Existing studies have suggested that due to different social cognitive styles, females are more involved in, and can be distressed by, peer difficulties (Ge, Lorenz, Conger, Elder, & Simons, 1994; Hankin & Abramson, 2001). Peer difficulties were reported most by participants in Year 7 and 8 which reflects previous research which has found that peer aggression typically increases at this time over the transition to secondary school (typically Years 6 to 7 in England), and can be somewhat explained by behaviours aiming to increase social dominance (Espelage, Bosworth, & Simon, 2001; Pellegrini & Long, 2002) but may also be due to other factors linked to attending a new phase of schooling.

Some participants in the current study also reported lacking strategies to cope with bullying and described its negative effects on their mental well-being, with some symptoms of depression described as an outcome. Within participants' accounts, there was a perceived lack of useful coping strategies available, leading them to use avoidant coping such as avoiding social media altogether, withdrawal from social activities, and truancy and absenteeism from school. This fits with previous research which finds effects of bullying to include withdrawal, internalising problems, delinquency, and reduced educational attainment (Bender & Lösel, 2011; Esbensen & Carson, 2009; Przybylski & Bowes, 2017; Rethon et al., 2011). The negative effects on mental well-being from bullying and other stressors also fits with research that finds during early and middle adolescence young people may not have sufficient coping strategies to manage the increase stressors that they experience (Hampel & Petermann, 2005).

Within the final theme of family difficulties, both daily stressors, such as arguing with a parent or discipline at home, and traumatic events featured. While increased parent-child conflict is part of normal adolescent development, harsh parental discipline has been found to be a risk factor for externalising behaviour in adolescents (Bailey, Hill, Oesterle, & Hawkins, 2009; Laursen, & Collins, 2009). Parental illness is well established to be a risk factor for adolescent maladjustment

and poor mental well-being (Barkmann, Romer, Watson, & Schulte-Markwort, 2007; Gupta & Ford-Jones, 2014; Sieh, Dijkers, Visser-Meily, & Meijer, 2012). Some participants outlined a chain of links between family-related stressors and distressing outcomes, with one particular family-related stressor attributed as the cause of a chain. For instance, a participant described a family-related stressor (e.g., mother's illness) and its effects on both their mental well-being and development of psychopathology (e.g., it led to 'losing control', behavioural difficulties at school, association with deviant peers, giving up on exams, leaving school, and internalising symptoms, such as sadness and worry). It may be important to consider how the adolescent views the interaction between the stressors that they experience, in the context of providing support to the adolescent to manage stressors, including the 'initial or trigger stressor' and subsequent linked stressors.

### **3.4.1 Strengths and limitations**

This study identified a wide range of stressors and effects on mental well-being, drawing directly on the verbal reports of participants from a large community sample. This study adhered to established guidance for trustworthiness in qualitative research (Shenton, 2004). My supervisors were involved in checking and reviewing the development, finalisation and naming of the themes developed through thematic analysis and reduced the risk of my personal perspective exerting undue influence on theme formation. To minimise bias in interpretation, the study aimed to use the young people's language as much as possible, such as through the inclusion of quotes where the adolescent directly reports the effects of the stressor on their mental well-being. My supervisor then checked that the quotes were sufficiently reflected in the language used to describe the themes. During data collection, I reflected on my interview technique, through discussions with my supervisors and to listening to the audio files. Feedback helped me to minimise bias by becoming aware of pre-held assumptions that I bring towards the research process and learn about aspects that I may focus on too much, due to my own biases and interests. A limitation of the study is that I did not check the themes with the participants themselves, and this type of member checking would have improved the study and would be helpful to include in future research on stressors (Birt, Scott, Cavers, Campbell, & Walter, 2016).

It is important to note that the adolescents interviewed in this study were a specific group who had been identified as eligible for preventative interventions around their mental health and well-being as part of the HeadStart Phase 2 programme, thus the extent to which these themes would be found in other samples of adolescents in the British, and wider, context is unclear. Data on ethnicity were not captured as part of the study design and would be an important addition to future research seeking to explore possible cultural variation in stressors experienced. Moreover, the numbers of participants for each age group varied, with Year 10 (age 14 to 15 years) and Year 6 (age 10 to 11 years) being underrepresented. Thus, conclusions about differences between age groups in this study should be drawn tentatively.

Participants' recall of past events may be influenced by factors such as mood at the time of reporting and social desirability bias, or the tendency of participants to provide socially desirable responses to questions, rather than those that more accurately represent their actual experiences (Hardt & Rutter, 2004; Krumpal, 2013). It is possible that participants might be more willing to talk about some stressors, such as peer conflict, than others, such as difficulties within the family. An example of this is that some participants were taking part in a HeadStart intervention to help them to cope with difficult family relationships (including domestic violence), and this subset of the sample did not talk about family difficulties or domestic violence in their interviews (although domestic violence was described by other participants who had received other interventions).

### **3.4.2 Future studies**

Further study would benefit from seeking to understand the factors that reduce the negative effects of stressors, from adolescents' perspectives. Given the potentially damaging effects of a series of, or parallel stressors on adolescent mental well-being, more qualitative studies are needed to understand the factors that adolescents report to help alleviate the negative effects of stressors and promote their mental well-being. Future qualitative studies could also conduct direct comparisons in the stressors subjectively perceived by different age groups with

larger samples, as well as further examine factors considered to be 'causal' by adolescents, as within wider research it is very difficult to identify causal risk factors or those that are simply likely to affect the outcome (Kazdin et al., 1997). Future studies could explore if specific chains of stressors described by adolescents in this study were reported by other adolescents in other samples, to understand the extent that they were individually specific or whether common pathways exist.

### **3.5 Conclusion**

There is a gap in the literature regarding the lived experience of the types of stressors that adolescents report to experience, particularly within a UK context. Thus, the present study has provided a thematic analysis of adolescent reports of the types of stressors experienced and their varied effects on their mental well-being. From this analysis, four key findings were apparent. First, six main themes of types of reported stressors were identified (which, including subthemes, totalled 32 different stressors): 1) Negative mental states and/or emotions; 2) Peer difficulties; 3) Behavioural difficulties; 4) Bullying; 5) School difficulties; and 6) Family difficulties. Second, internal mental states were the most prevalent type of stressor reported by participants, suggesting that processes involved in managing mental states, such as worry, low self-esteem, and anger, were a significant threat to mental well-being and include some early symptoms of psychopathology, in addition to (and prompted by) external stressors. This finding is noteworthy, given that the majority of the stressor literature has focused on environmental stressors. The implication of this is that it is important to understand from adolescents' perspectives how internal and external stressors interact, and not consider stressors in isolation. Thirdly, when considering the effects of stressors on mental well-being, a range of effects were reported for each stressor. For example, bullying was reportedly linked with low mood, worry, distress, behavioural difficulties, truancy, and exam failure, that exemplified the concept of multifinality derived from general systems theory, that the same stressor or conditions can lead to different outcomes and differential susceptibility to the negative effects of stressors (Belsky & Pluess, 2009; Cicchetti & Rogosch, 1996). Fourth, a subset of adolescents made causal attributions as to the role of a specific stressor in a chain influencing other stressors, which led to negative outcomes and the increased risk of psychopathology.

This type of qualitative data is a useful complement to other types of data on risk and stressors that can keep the weighting of separate risk factors unweighted, so views the relative strength of stressors as the same (Evans et al., 2013). The qualitative data is interesting because adolescents identify particular stressors as more deleterious or problematic to their mental well-being as compared to other stressors, the data can show how stressors cluster and is also relevant to debates in the study of cumulative risk as to the extent that stressors (or risk factors) cluster (Evans et al., 2013; Hebron et al., 2016).



Chapter 4. What Types of Protective Factors Have Been Associated with Increases in Adolescent Mental Well-being and a Reduction in the Risk of Psychopathology in Current Research? A Scoping Review.

## **4 What Types of Protective Factors Have Been Associated with Increases in Adolescent Mental Well-being and a Reduction in the Risk of Psychopathology in Current Research? A Scoping Review**

### **4.1 Introduction**

In the first chapter of the thesis, a literature review established that a range of scholarship on stressors and protective factors. This research is of critical importance in understanding factors that can reduce the negative effects of risk factors and can be applied in interventions to both increase mental well-being and decrease psychopathology (Cicchetti & Rogosch, 2002; Coie et al., 1993; Hawkins, Catalano, & Miller, 1992; Kim et al., 2015; Toth, Sturge-Apple, Rogosch, & Cicchetti, 2015). However, though the literature on protective factors was extensive, differences in definitions across studies were found and the lack of consistent language used has meant synthesis of relevant literature has been constrained, as pointed out by Luthar and colleagues (2000). The literature review also established a need for further qualitative research on the topic of stressors faced by English adolescents as well as on the topic of protective factors that reduce the effects of stressors and risk factors more broadly. Before embarking on empirical investigation into adolescents' experiences of protective factors, a comprehensive search of the available literature on protective factors is required. Searching available studies will serve to further clarify what is known and what gaps on the topic of protective factors remain within the evidence base at this stage.

As stated at the outset of this thesis, a protective factor is defined as a variable that may change, interact with, improve, or influence an outcome, either in the context of a known risk factor or not. This draws on the definition by Kazdin (1997), which states that protective factors refer to: "antecedent conditions associated with a decrease in the likelihood of undesirable outcomes or with an increase in the likelihood of positive outcomes" (Kraemer et al., 1997, p. 377). Following this conceptual basis, in this current scoping review I am considering protective factors to

be variables that decrease the likelihood of the outcomes of poor mental well-being and/or psychopathology and increase the likelihood of positive mental well-being.

A scoping review refers to a “review that seeks to explore and define conceptual and logistic boundaries around a particular topic with a view to informing a future predetermined systematic review or primary research” (Sutton, Clowes, Preston, & Booth, 2019, p. 211). This type of review of the literature at this stage in the thesis is critical. A scoping review enables a broad oversight of the range of the current literature on protective factors in relation to outcomes of interest. Moreover, given the range of factors that influence adolescent mental well-being and the risk of psychopathology, an additional aim of this review is to consider how the types of protective factors identified can be systematically grouped and codified in a manner that could provide fresh research insights. Despite the wealth of studies and protective factors that have been found to associate with mental well-being, only a few frameworks have sought to tabulate these factors, and few in relation to the specific outcome of mental well-being (Hamby et al., 2017). Considering the entire knowledge base of what is already known about protective factors in relation to mental well-being in psychopathology is an important reference point and theoretical background, prior to exploring adolescent understandings of the construct. Through conducting the review, it ought to be possible to make comparisons between the factors that adolescents construe to be protective, with what existing studies have found to be protective for adolescents through empirical research.

The study of protective factors is important for promoting adolescent mental well-being and reducing the risk of psychopathology because protective factors can be targeted as specific sites for intervention (Olsson, Bond, Burns, Vella-Brodrick, & Sawyer, 2003). Within resilience research, a number of protective factors have been found to increase positive outcomes in adolescents when exposed to high levels of risk: high child intelligence quotient (IQ), emotion regulation capacity, positive parenting, low parental discord, advantaged socio-economic status (SES), effective schools, and safe neighbourhoods (Masten & Reed, 2002). The identification of such variables is important, as evidence-based interventions aim to modify a risk factor or provide a new protective factor within the context of an intervention with the aim of improving adolescent outcomes or preventing a type of disorder (Beardslee et al.,

2013; Kazdin et al., 1997; Rice & Rawal, 2011; Saxena, Jané-Llopis, & Hosman, 2006). For example, studies of parenting practices (e.g. Strength Based Parenting) have been found to increase child competence and mental well-being outcomes over time (Loton & Waters, 2017; Masten, 1999; Tunariu, Tribe, Frings, & Albery, 2017).

#### **4.1.1 Current frameworks of protective factors**

A small amount of existing reviews of the literature on protective factors have produced some frameworks of types of protective factors, but few have been specifically focused on the outcome of mental well-being (Eriksson, Cater, Andershed, & Andershed, 2010; Fritz et al., 2018). Fritz et al. (2018) conducted a systematic review which examined the 'resilience factors' associated with mental health and the risk of psychopathology for young people (aged 13 to 24 years) exposed to childhood adversity. Fritz et al. (2018) defined resilience factors as variables found to empirically reduce the risk of mental health problems following adversity and included a range of variables such as friendship support and positive self-esteem. The definition of psychopathology focused on in the review was mental distress and suicidal or self-harm behaviours; the review search found 22 studies that met the inclusion criteria (Fritz et al., 2018). A resilience factor was included if a) it was a moderator or a mediator of the relationship between childhood adversity and psychopathology, b) it fit within individual-, family- or community-level categories, and c) it related to cognitive, behavioural, social, or emotional functioning (Fritz et al., 2018). The review found empirical support for 13 of 25 individual-level resilience factors (e.g., high self-esteem, low rumination), six of 12 family-level resilience factors (e.g., high family cohesion, high parental involvement), and one of five community-level resilience factors (i.e., high social support), to benefit mental health in adolescents exposed to childhood adversity (Fritz et al., 2018). Fritz et al. (2018) also found that some factors were associated with the outcome of well-being when tested in isolation, but not when tested with other factors. Fritz and colleagues (2018) concluded that resilience factors should not be studied separately but in combination, because of the interrelations between protective factors.

A review of previous reviews of protective factors conducted by Eriksson and colleagues identified 30 reviews of protective factors in relation to outcomes of

internalising (anxiety and depression) and externalising problems (aggression and delinquency) behaviour in youth. Identified protective factors were grouped using three categories; “individual (e.g., temperament and intelligence), family (e.g., close relationships with caregiver and high socio-economic status), and environment outside the family (e.g., neighbourhood quality and pro-social peers)” (Eriksson et al., 2010). The review did not include groupings of online communities or digital protective factors (such as use of social networks). The review found that whilst many studies establish “what” factors are protective, there is still a lack of studies showing “how” protective factors protect adolescents (Eriksson et al., 2010). Eriksson and colleagues (2010) commented that reviews often do not note the specific outcomes studied, nor provide more information about the age specificity of a protective factor. The current scoping review within the thesis will seek to retrieve studies of protective factors in relation to the outcome of mental well-being and risk of psychopathology, so takes a more explicit focus on mental well-being than previous reviews, as well as consideration of the outcome studied, reviewing how this may vary across studies.

Another common framework applied to the study of protective factors is Bronfenbrenner’s Social Ecological Model (Bronfenbrenner, 1994). Studies that adopt a Social Ecological model assume that an adolescent is in the centre of a complex, interrelated set of systems and that these various systems, described as *micro*, *meso*-, *exo*-, *macro*-, and *chronosystems*, shape the individual (Cramer & Kapusta, 2017). As applied to the study of protective factors, a range of studies have considered risk and protective factors at each of these levels (Cross et al., 2015; El Kazdough, El-Ammari, Bouftini, El Fakir, & El Achhab, 2018; Hong & Garbarino, 2012). The Social Ecological model is frequently applied within the field of protective factors to consider the range of diverse influences on adolescent outcomes (El Kazdough et al., 2018; Hong & Garbarino, 2012). The benefit of the model is that it includes both close influences (to the adolescent), such as gender and sexual orientation and distant influences, such as cultural and economic influences on the individual (Blum et al., 2014; Cross et al., 2015; El Kazdough, El-Ammari, Bouftini, El Fakir, & El Achhab, 2018; Hong & Garbarino, 2012). However, the Social Ecological model is a broad framework, and the current study will aim to codify in more detail the range of protective factors generated by the review.

In the preface to an edited volume, Masten and Powell (2003) expanded upon Garmezy's much cited framework of (1) attributes of adolescents; (2) aspects of families; and (3) characteristics of wider social environments (Masten & Garmezy, 1985). Within this framework, Masten & Powell provide examples of individual and contextual protective factors (2003). For the purpose of this scoping review, this further population of the broad framework with examples provides a starting point, as it is a clear, organising structure for grouping protective factors retrieved in the review. The framework was chosen for the current review to organise the studies derived from this scoping review in tabular form, as it is widely cited, and builds on the work of Garmezy, a prominent theorist and researcher of protective factor research. Garmezy's (1985) initial framework was based on his own reviews of the literature (Masten & Powell, 2003). The benefit of this framework is that it covers a wide range of individual protective factors within the three domains and it already includes examples of an extensive, yet not exhaustive, list of protective factors; it has scope to demonstrate where literature has found further support for these factors and where new protective factors have been found. A second aim of the review was to add a second layer to this example framework, by further populating the examples provided by Masten & Powell (2003) to produce more detailed subdomains of protective factors drawing from the literature.

**Table 4.1**

*Example Attributes of Individuals and Their Contexts Often Associated with Resilience*

Individual differences	Social relationships	Community resources and Opportunities
Cognitive abilities, Self-perceptions of competence, worth, confidence (self-efficacy, self-esteem)	Parenting quality (including warmth, structure and monitoring, expectations)	Good schools
Temperament and personality (adaptability, sociability), Self-regulation skills (impulse control, affect and arousal regulation),	Close relationships with competent adults (parents, relatives, mentors).	Connections to prosocial organizations (such as clubs or religious groups)
Positive outlook on life (hopefulness, belief that life has meaning, faith)	Connections to prosocial and rule-abiding peers (among older children)	Neighbourhood quality (public safety, collective supervision, libraries, recreation centres), Quality of social services and health care

*Note.* Examples of attributes associated with resilience from Masten & Powell (2003, p.13).

The current scoping review diverges from previous reviews by focusing on the outcome of protective factors that promote mental well-being as well as reduce risk of psychopathology. This entailed the exclusion of studies that were found to be protective only for a specific group, such as refugee children in the first three years of settlement or LGBTQI adolescents in relation to the outcome of smoking behaviour (Newcomb, Heinz, Birkett, & Mustanski, 2014; Zwi et al., 2018). The focus in this review was on universal populations, rather than specialist populations, due to interest in this thesis in the applicability of knowledge on protective factors generally in the English and UK context. The emphasis of the review of is on mental well-being, rather than protective factors that prevent against specific types of

psychopathology such as depression, or anti-social behaviour; however, protective factors that are protective against symptoms of psychopathology, were included.

## **4.2 Method**

Scoping reviews are an appropriate methodology to explore broad areas of evidence, map extant research on a topic, and ascertain the need for a systematic review (Arksey & O'Malley, 2005). A scoping review is “a form of knowledge synthesis that addresses an exploratory research question aimed at mapping key concepts, types of evidence, and gaps in research related to a defined area or field by systematically searching, selecting, and synthesizing existing knowledge” (Colquhoun et al., 2014, p. 1292). In the current study, Arksey and O'Malley's (2005) methodology for conducting a scoping review was applied (see Table 4.2 below). This involved identifying the research question, searching for relevant studies, selecting studies, charting the data, collating, summarising, and reporting the results. This is an additional stage that involves consulting with stakeholders to inform or validate study findings that was not conducted for this review (Arksey & O'Malley, 2005).

**Table 4.2**

*Five Stages of the Scoping Review with a Summary of the Activities (Arksey & O'Malley, 2005)*

Stage	Activities
1. Defining the research question	<p>For this review, the research question was, “What types of protective factors have been found to increase mental well-being in adolescents?” Using PICO (Population, Intervention, Comparator and Outcome, the critical components of this question were broken down, the comparison aspects of PICO was not relevant (Bronson &amp; Davis, 2012). For this review, the population referred to adolescents, intervention referred to protective factors and outcome referred to mental well-being. Synonyms for each of the key terms were generated.</p>
2. Identifying all relevant studies	<p>The majority of literature was identified through database searching. A search strategy was developed for the databases PsycINFO, ProQuest Central, PubMed and Ovid MEDLINE. Variations for each keyword were combined with the “OR” operator to maximise results. The search function ‘AND’ was used to identify articles with a focus on both protective factors and well-being, although articles with either well-being or protective factors were also retrieved. In addition, the wildcard: * was used to search for words beginning with a set of letters such as child* to retrieve all studies containing children, children’s, childhood in the title (Bronson &amp; Davis, 2012, p. 31).</p>
3. Study selection	<p>An iterative process was used to establish inclusion and exclusion criteria as an understanding of the literature developed. Inclusion criteria involved limiting the search to include English articles published since January 1, 2000 involving male and female adolescents aged 10 to 19. Peer reviewed studies and quantitative and qualitative research designs were included. The most important criteria were that studies had investigated at least one or more protective.</p>

factor, which had been found to have an association with well-being. To ensure included articles focused on the target population of adolescents or 'low risk' adolescents (adolescents identified as low risk for a type of psychopathology) or studies that included both high-risk and low-risk populations. Studies were excluded if they were centred on high-risk adolescents or specialist populations. Studies were also excluded if they focused only on risk factors, or if the protective effect of a variable was not described but could be deduced by the inverse of a risk factor. Adhering to the method of Arksey and O'Malley (2005), quality assessment is beyond the scope of this study.

4. Interpreting and synthesising

Data were interpreted and synthesised through charting the data and recorded in tables, which included a list of all studies with protective factors and associated outcomes, and a second table where studies of protective factors were arranged according to a typology and a table of outcomes studied in retrieved studies.

5. Summarising and reporting

Results were summarised in order to present an overview of the evidence. Qualitative analyses were used to describe studies. These analyses allowed major themes and gaps in the literature to be identified, through noting commonality across the chart described above, the results of which are described further below. A framework from Masten and Powell (2003) served as a guide to sort the protective factors found, using their three overarching categories. Additional subdomains were created based on the actual studies found in the review.

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*Note. Five methodological stages taken from Arksey & O'Malley (2005, p. 22).*

#### **4.2.1 Inclusion and exclusion criteria**

Inclusion and exclusion criteria refer to the rules by which studies are selected, these criteria are tabulated at the beginning of the study, to decrease the risk of bias if the criteria for inclusion were to change over the course of the review (Bronson & Davis, 2012).

##### **Inclusion criteria**

- a. Quantitative and qualitative studies: this includes systematic reviews, reviews, longitudinal cohort studies, cross-sectional studies, and ethnographic studies.
- b. Studies subject to peer review.
- c. Studies including a definition of protective factors that would sit within the specific definition of protective factors provided above.
- d. Studies that found either a statistical association with a protective factor and mental well-being and mental health as broad constructs as the outcomes, or an association reported by a participant in a qualitative study.
- e. Intervention studies are included provided that such interventions were given to a general or non-targeted population and focused on the outcome of well-being.

##### **Exclusion criteria**

- a. Any studies that were not peer-reviewed journal articles (e.g., no comments, letters, grey literature, commentaries, or position pieces).
- b. Studies that were published in a language other than English.
- c. Papers published before 2000. Luthar's (2003) book, *Resilience and Vulnerability*, included a chapter by Masten and Powell (2003) that provided a comprehensive overview of the literature pre-2000 of types of protective factors involved in resilience).
- d. Studies that only focus on risk factors and do not mention protective factors (or the protective factors would have to be deduced by the reader as the inverse of a risk factor).

- e. Studies that focus on protective factors for the prevention of specific mental health disorders as an outcome (e.g., eating disorders or conduct problems, rather than mental health or well-being as a general outcome), or studies that focus on one mental health disorder symptom without any other outcomes, e.g., symptoms of depression without other well-being related outcomes.
- f. Studies that focus on adolescents that have a specific existing condition, learning disorder or mental health disorder, or a physical health ailment.
- g. Animal studies.
- h. Studies focusing on the outcome of improved physical health.
- i. Studies focusing on adult populations, university students, or beyond the stated age range or examine outcomes in adulthood beyond adolescence.
- j. Studied protective factors that begin prior to adolescence (e.g., positive attachment in early years)
- k. Studies that have focused as their research question on the protective factors for well-being for only adolescents that belong to a specialist group, for example adolescents that live in a war zone, refugees, immigrant populations, LGBTQI+ adolescents, or adolescents exposed to a natural disaster, juvenile delinquents, adolescents that have been maltreated, adolescents in care or a residential setting, or adolescents from particular ethnic minority or racial group.
- l. Articles where the full text is not available online.

#### **4.2.2 Definitions of outcomes to inform the selection of studies**

The definitions of mental well-being and psychopathology were defined in the introduction to this chapter. It is important the selected studies focus on these outcomes or outcomes that either fit within, or overlap with, these broader constructs. Other outcomes that overlap with mental well-being included 'wellbeing', 'life satisfaction', 'happiness', 'quality of life', and 'resilience'. Intervention studies were also included if they found an association between an intervention and the outcome of well-being. Not all selected studies provided a definition of well-being, but if studies used a well-being related construct then this was deemed sufficient and the outcome measures clarified that the study was indeed focused on the outcome of

mental well-being. Owing to outcome measures utilising different measurement tools, there were no principle summary measures set.

### **4.2.3 Screening and selection of publications**

Once the protocol had been finalised, keywords were selected for usage in retrieving all studies related to protective factors, adolescents, and mental well-being (please refer to Appendix D for a full list). MeSh (medical subject headings) terms were checked using the thesaurus in each of the databases. Searches were conducted with database search engines PsycINFO, ProQuest Central, PubMed and Ovid MEDLINE. The search returned approximately 11,352 articles. Article titles and abstracts were first scanned to ascertain article relevance. An independent reviewer, Lauren Garland (LG), screened 20% of article titles and abstracts according to inclusion and exclusion criteria. Once completed, LG and I reviewed any differences between her screening and my screening together to achieve consensus. The rate of agreement between LG's sorting and my own was 85.48%. Initially, there were some differences in opinion on whether to include studies on the risk of mental health disorders or studies that only examined the outcome of depressive symptoms. Ultimately, studies that only examined depressive symptoms were removed because the interest was in the broader construct of well-being. Thus, if a study examined protective factors in relation to mental well-being and the symptoms of depression, as one type of psychopathology, they were included, if not they were excluded. During full text screening, articles were read to assess their eligibility, notations were made on the outcomes studied, and checked that the outcome fit within the definitions of mental well-being applied within this review. Following this, a total of 118 articles were deemed eligible for inclusion and full articles were obtained and included in the review (Figure 4.3).

### **4.2.4 Charting the data**

Articles were organised in a table according to protective factors found to have a statistically significant association with a mental well-being outcome, or, if they were qualitative articles, according to protective factors that were reported to link to well-being. Articles were read in full, annotated, and entered into the table format developed to organize analysis, charting the article reference (author and year),

sample size, objective, outcome, and type of protective factor for each study. At this stage, another 14 articles were removed yielding a total of 104 studies. These were articles that examined protective factors hypothesised to affect well-being but not found to have a relationship with a mental well-being related outcome, and they were removed from the final list of studies. The full list of definitions of each protective factor found in the review is presented in a table in Appendix F.

#### **4.2.5 Collating and summarising the results**

Results were presented in two tables (and a further table in the appendix). The first table grouped protective factors into themes applying Masten and Powell's (2003) framework of three domains: Individual, Social Relationships, and Community Resources and Opportunities', and a number of subdomains. Protective factors were selected for inclusion from each study that were found to be a protective in relation to mental well-being. A second table tabulated the frequency of type of outcome studied within each study. An additional table of the full list of studies found in the review was generated. Owing to the size of this table, it is located in the appendix of the thesis (Appendix E).

Information about which factors were found to be protective were extracted verbatim with page numbers from each paper that met the inclusion criteria. In some instances, a given variable was found to increase the outcome of mental well-being (or a related construct) but not described as a protective factor as such; instead, some papers used terminology such as "a resilience factor" or "a variable" as described in studies surmised earlier. In these cases, these studies were still included. Definitions of the type of protective factor studied were extracted from each paper, for example, if the protective factor was peer attachment, the definition applied within the paper was selected. When a definition of a protective factor was not included in the paper, a description of some of the items used to measure the construct was selected instead (Please refer to appendix F for a complete list of definitions of all the protective factors found in the review). For qualitative studies, protective factors were identified that were also factors positively associated with well-being. However, not all protective factors were a single variable and were sometimes described in different terms to those in quantitative studies, which were

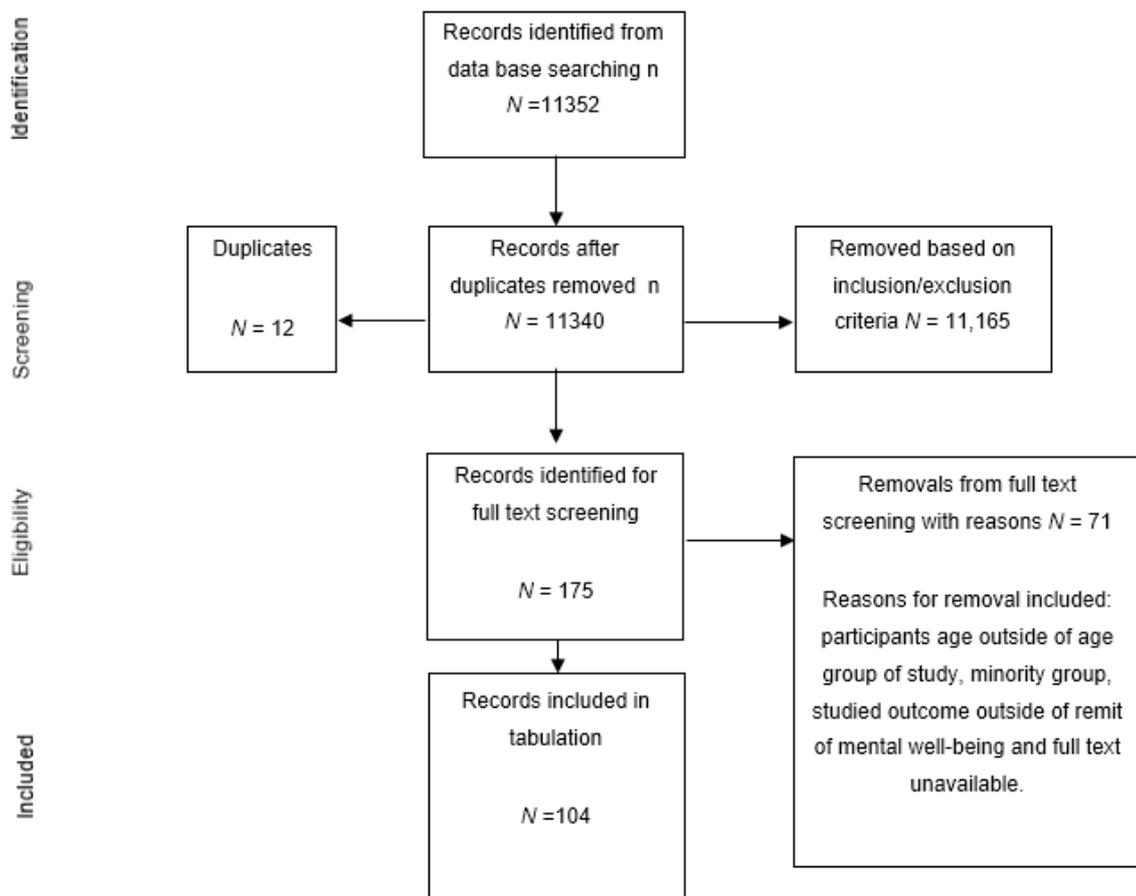
found via a statistical association. For example, Ungar and Teram found that one factor was “the need for personal power and social acceptance” (2000, p. 236). The authors provided an extract from a participant who reported that he spent most time with friends where he felt he could be “himself” around them and thus the protective factor was described in adolescent’s own words (2000, p. 236).

## 4.3 Results

### 4.3.1 Searches

**Figure 4.1**

*PRISMA Flow Diagram for the Scoping Review Process*



The literature search yielded 11,352 citations (Fig. 4.1). Duplicates were removed leaving a total of 11,340 articles. Subject to screening of titles and abstracts, 11,165 were removed because they did not meet the inclusion criteria for the review. In total, 175 papers were identified for full text review. Of these, 71 papers were removed based on original exclusion criteria and full text review led to a further six papers being removed leading to a total of 104 relevant studies.

Data are presented in two tables and a written narrative summary. The first table (Table 4-3) provides all the protective factors found according to domain and

subdomain, categorised based on the three overarching categories from Masten and Powell's (2003) framework: Individual Differences, Social Relationships, and Community Resources and Opportunities. A fourth, 'Other' category was added in which to group any protective factors found that could not be placed definitively in the three overarching categories, these included perceived academic achievement, the laws of life essay, the need for relatedness and fun (Banyard, Hamby, & Grych, 2016; Coholic, 2011; Leversen et al., 2012; Moreno et al., 2016).

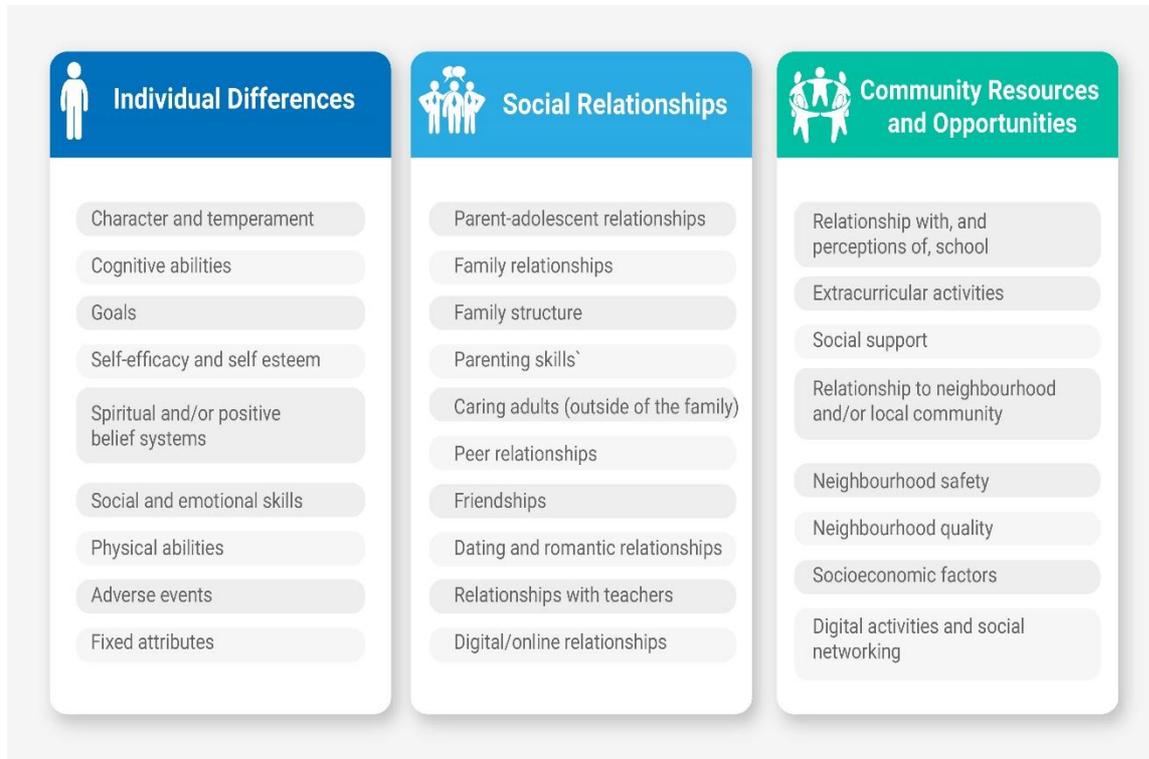
Retrieved studies were sorted in accordance as to whether they included a protective factor that could be grouped under these four domains. Individual protective factors were further sorted into Masten and Powell's (2003) example attributes such as into the subdomains of cognitive abilities or temperament. When a study or several studies formed a protective factor that had not already appeared in Masten and Powell's (2003) table, such as physical abilities and activities, a new subdomain was created. A brief description of the protective factors found for each domain and subdomain is provided in the narrative summary in Section 4.3.4.

#### **4.3.2 Grouping protective factors into a framework**

Protective factors identified in the review were grouped according to Masten and Powell's (2003) example framework. The framework, as detailed in the infographic below, adds additional protective factors based on the findings of the literature review. For example, digital activities and social networking is a new subdomain of protective factors that includes a number of variables relating to digital activities and social networking. The full framework with the complete list of protective factors identified in the review has been provided in Table 4.3.

**Figure 4.2**

*Protective Factors Found in the Review, Expanding on Masten and Powell (2003)*



**Table 4.3**

*Types of Protective Factor Grouped According to Masten & Powell's (2003) Framework, Including Domain, Subdomain, Protective Factor, Author, and Year of Publication and Outcome Studied*

Domain	Subdomain	Protective factor	Authors and year of publication	Outcome
Individual Differences	1. Character & temperament (e.g. easy temperament)	Extraverted, agreeable, and open to new experiences	Davey et al., 2003	Self-worth
		Curiosity	Moreno et al., 2016	Resilience
		Temperance	Toner et al., 2012	Wellbeing and happiness
		Vitality	Toner et al., 2012	Wellbeing and happiness
		Caution	Toner et al., 2012	Life satisfaction and happiness
		Zest	Toner et al., 2012	Life satisfaction and happiness
		Trust	Correia & Dalbert, 2009	Life satisfaction
		Cooperative	Crescentini et al., 2018	Wellbeing and strengths
		Low level of anti-social behaviour/prosocial behaviour	Tiêt & Huizinga, 2002	Resilience

Domain	Subdomain	Protective factor	Authors and year of publication	Outcome
Individual Differences	1. Character & temperament (e.g. easy temperament)	Personal belief in a just world	Correia & Dalbert, 2009	Mental health and life satisfaction
		Character maturity specifically self-directedness	Crescentini et al., 2018	Adjustment
		Leadership factors	Weber, et al., 2013	Positive affect
		Autonomy (described as a psychological need)	Leveresen et al., 2012	Life satisfaction and self esteem
		Personal and social responsibility* (intervention study)	Johnson, et al., 2007	Positive Youth Development
		Responding with resilience*	Tunariu & Tribe, 2017	Wellbeing and related constructs
		Resilience	Rodríguez-Fernández et al., 2016	Adjustment
		Personal resources	Wille, et al., 2008	Mental health
	2. Cognitive abilities (IQ, academic achievement)	High academic aspirations	Almroth et al., 2018	Mental Health

Domain	Subdomain	Protective factor	Authors and year of publication	Outcome
Individual differences		Academic achievement	Calmeiro et al., 2018a	Life satisfaction
		School related self-efficacy	Correia & Dalbert, 2009	Life satisfaction
		Cognitive competence	Johnson, et al., 2007	Positive Youth Development
		Cognitive resources: divergent thinking and imaginativeness	Thomsen & Greve, 2013	Adaptive resources
		Choice & option (intervention study)	Tunariu & Tribe, 2017	Wellbeing and related constructs
		Functional beliefs	Cheie & Miu, 2016	Quality of life
	3. Goals (planning goals, achieving goals and disengaging from goals)	Planning and obtaining goals* (intervention study)	Leventhal et al., 2015	Improvements in emotional resilience, self-efficacy, social-emotional assets, psychological wellbeing, and social wellbeing.
		Goal disengagement	Thomsen & Greve, 2013	Adaptive resources
		Personal and shared goals* (intervention study)	Eames, Shippen, & Sharp, 2016	Reduction in internalising and externalising symptoms

Domain	Subdomain	Protective factor	Authors and year of publication	Outcome
Individual Differences		Psychological capital	Afzal, et al., 2016	Positive emotion
		Psychological capital	Kaur & Amin, 2017	Reduced stress
	4. Self-efficacy and self esteem	Self-efficacy	Loton & Waters, 2017	Lower distress and higher happiness (p9)
		Self-efficacy	Çelik, et al., 2015	Hope components: Agency and pathways.
		Self-efficacy	Wille, et al., 2008	Mental health
		Self-esteem	Correia & Dalbert, 2009	Life satisfaction
		Self esteem	DuBois et al., 2002	Adjustment
		Self-worth	Shean, et al., 2015	Resilience and wellbeing
		(Positive) self-concept	Wille, et al., 2008	Mental health
		Self-concept & Self-relatedness * (intervention study)	Tunariu & Tribe, 2017	Subjective wellbeing
	Positive schemas	Keyfitz et al., 2013	Resilience (and depression and anxiety)	
	Positive body image	Moreno et al., 2016	Resilience	

Domain	Subdomain	Protective factor	Authors and year of publication	Outcome
Individual Differences		Self-attribution of positive affective states	Gomez-Baya et al., 2018	Life satisfaction
		Acceptable identity	Ungar & Teram, 2000	Mental health
		Identification of character strengths	Leventhal et al., 2015	Improvements in emotional resilience, self-efficacy, social-emotional assets, psychological wellbeing, and social wellbeing; psychological wellbeing
	4. Self-efficacy and self esteem	Need for competence	Leveresen et al., 2012	Wellbeing
		Confidence	Eames, et al., 2016	Positive mental health
		Competence	Furness, et al., 2017	Resilience and connectedness
		Sense of coherence	Moreno et al., 2016	Resilience
		Higher mental toughness	Gerber et al., 2013	Lower depressive symptoms and increased life satisfaction
	5. Spiritual and/or or positive belief systems	Transcendence	Weber et al., 2013	Positive affect
		Transcendence	Toner et al., 2012	Wellbeing and happiness
		Self-transcendence	Crescentini et al., 2018	Wellbeing and strengths
		Hope	Guse & Vermaak, 2011	Wellbeing

Domain	Subdomain	Protective factor	Authors and year of publication	Outcome
Individual Differences	5. Spiritual and/or or positive belief systems	Hope	Toner et al., 2012	Life satisfaction and happiness
		Hope	Afzal, et al., 2016	Wellbeing
		Optimism	Tusaie, Puskar, & Sereika, 2007	Wellbeing; Psychosocial resilience (PR)
		Optimism	Wille, et al., 2008	Mental health
		Optimism	Afzal, et al., 2016	Wellbeing
		Optimism	Oberle et al., 2011	Life satisfaction
	Religious values in females	Heaven & Ciarrochi, 2007	Social and emotional variable	
	Religious values in males	Heaven & Ciarrochi, 2007	Hope, mindfulness, joy, and psychological acceptance	
	Religiosity	Van Dyke & Elias, 2007	Lower levels of depressive symptoms	
	Religiosity	Meltzer et al., 2011	Lower levels of depressive symptoms	
	Religious activity	Briggs, Akos, Czyszczon, & Eldridge, 2011	Confidence and relationships with others	
	Gratitude	Froh, et al., 2009	Positive affect, global and domain life satisfaction, optimism, social support, and prosocial behaviour.	

Domain	Subdomain	Protective factor	Authors and year of publication	Outcome
Individual Differences		Satisfaction	Wille, et al., 2008	Protective for MH in the low risk not high - risk groups
		Life satisfaction	Suldo & Huebner, 2004	externalising behaviours
	6.Social and emotional skills	Emotional intelligence* (intervention study)	Leventhal et al., (2015)	Improvements in emotional resilience, self-efficacy, social-emotional assets, psychological wellbeing, and social wellbeing.
		Perceived emotional intelligence	Salguero et al., 2012	Psychological wellbeing
		Emotional regulation & relating to emotional intelligence; relational competence* (intervention study)	Tunariu & Tribe, 2017	Wellbeing and related constructs
		Emotional understanding of functional and dysfunctional emotions* (intervention study)	David et al, 2018	Mental health and emotional regulation
		Self-regulation	Calmeiro, et al., 2018	Life satisfaction
		Positive rumination	Gomez-Baya et al., 2018	Life satisfaction and self esteem

Domain	Subdomain	Protective factor	Authors and year of publication	Outcome
Individual Differences	6.Social and emotional skills	Primary and secondary control coping	Bryden, Ashlee, & Francis, 2015	Eudaimonic wellbeing
		Self-compassion	Bluth, et al., 2016	Emotional wellbeing, life satisfaction, ability to tolerate stress, reduced anxiety levels for males, reduced depressive symptoms
		Self-compassion.	Temel & Atalay, 2018	Reduction of psychological distress. Reduced depression, anxiety, and stress
		Control	Ungar & Teram, 2000	Mental health
		Social skills (intervention study)	Furness, et al., 2017	Resilience and connectedness
		Peer competence	Wille, et al., 2008	Mental health
		Social competence	Calmeiro et al., 2018a	Life satisfaction
		Social competence* (intervention study)	Johnson et al., 2007	Positive youth development
Effective communication in (intervention study)	Furness et al., 2017	Resilience and connectedness		

Domain	Subdomain	Protective factor	Authors and year of publication	Outcome
Individual Differences	6.Social and emotional skills	Mindfulness	Bluth & Eisenlohr-Moul, 2017	Perceived stress and depression
		Self-awareness	Çelik, et al., 2015	Hope components: Agency and pathways. In addition, holding these resilience factors resulted in increased self-liking"
		Repeating mantras** in the context of a Transcendental Meditation session	Nidich et al., 2011	Calmer, happier, less hyperactive, friendlier and had an increased ability to focus on schoolwork
	7. Physical abilities and physical exercise	Physical activity (in small towns and villages)	Mazur et al., 2016	Mental health
		High levels of physical activity	Ussher, et al., 2007	Wellbeing
		Physical activity	Iannotti, et al., 2009	Positive health indicators
		Physical activity in boys aged 15-16	Sagatun et al., 2007	Emotional symptoms, peer problems and prosocial behaviour
		Regular exercise	Lambert et al., 2014	Happiness
		Increased physical activity	Sánchez-López et al., 2009	Quality of life

Domain	Subdomain	Protective factor	Authors and year of publication	Outcome
Individual Differences		Moderate to vigorous physical activity	Moreno et al., 2016	Resilience
		Good motor skills	Viholainen, et al., 2014	High psychosocial wellbeing and school related self-concept of PE (PSWB)
	8. Fixed Attributes	Being an older male adolescent	Tusaie, Puskar, & Sereika, 2007	Psychosocial resilience (PR)
		Gender	Tunariu & Tribe, 2017	Wellbeing
Social Relationships	1. Parent- adolescent relationships	Parent-child communication	Levin, et al., 2012	Life satisfaction
		Easy communication (girls only)	Levin et al., 2012	Life satisfaction
		Mother-child and father-child communication	Levin & Currie, 2010	Life satisfaction
		Mother child relationship (especially girls).	Levin & Currie, 2010	Wellbeing
		Mother-child relationship	Thomsen & Greve, 2013	Adaptive resources
		Paternal involvement	Zhang, Zhao, Ju, et al., 2015	Resilience

Domain	Subdomain	Protective factor	Authors and year of publication	Outcome
Social Relationships	1. Parent- adolescent relationships	Secure attachment with both parents	Al-Yagon, 2011	Socio emotional difficulties
		Secure attachment style	Keskin & Cam, 2010	"Increased levels of prosocial behaviour, decreased levels of emotional symptoms, hyperactivity/inattention, peer relationship problems, conduct problems
		Parent attachment	Abubakar et al., 2013	Wellbeing
		Parental monitoring for youth in two parent families	Tiet, et al., 2010	Adjustment
		Parental monitoring	Everri, et al., 2015	Sense of familiar responsibility
		Parental support	Oberle et al., 2011	Life satisfaction
		Parental support	Wille, et al., 2008	Mental health
		Parental support	McCoy & Bowen, 2015	Positivity for future success
		Parental support	Stewart & Suldo, 2011	Mental health

Domain	Subdomain	Protective factor	Authors and year of publication	Outcome
Social Relationships		Parental support	Morgan & Haglund, 2009	Health and wellbeing
		Confirmation (validation, acceptance) by parents	Dailey, 2009	Adjustment
		Perceived family support	Rodríguez-Fernández et al., 2016	Adjustment
	2. Family relationships	Perceived family support	Tusaie, Puskar, & Sereika, 2007	Adjustment, Psychosocial resilience (PR)
		Family support	Calmeiro, et al., 2018b	Life satisfaction
		Confirmation from family members.	Dailey, 2009	self-concepts
		Frequency of meals with family	Lambert et al., 2014	Happiness
		More sibling warmth	Buist et al., 2011	Less internalising and externalising problems,
		Sibling warmth	Waite et al., 2011	Depressive symptoms for family wide events
	Family climate	Wille, et al., 2008	Mental health	

Domain	Subdomain	Protective factor	Authors and year of publication	Outcome
Social Relationships		Family connection	Lambert et al., 2014	Happiness
		Bonding to family	Tiet, et al., 2010	Adjustment
		Family sense of belonging	Morgan & Haglund, 2009	Hope
		Family resilience	Çelik, et al., 2015	Hope
		Lower levels of parental discord (in two parent families)	Tiet, et al., 2010	Resilience
		Differential parenting	Feinberg & Hetherington, 2001	Adjustment
		Parental accommodative coping	Thomsen & Greve, 2013	Adaptive resources
	3. Parenting skills	Mindful parenting	Moreira, et al., 2018	Wellbeing
		Strength-based parenting	Loton & Waters, 2017	Lower distress and higher happiness
	4. Family structure	Family structure (for boys and girls aged 13 and 15 years)	Levin, et al., (2012)	Life satisfaction

Domain	Subdomain	Protective factor	Authors and year of publication	Outcome
Social Relationships		Traditional two parent family (protective factor for boys).	Levin & Currie, 2010	Life satisfaction
	5. Supportive adults outside the family	Caring relationships	Laursen & Birmingham, 2003	Resilience
		Closeness to grandparents	Flouri et al., 2010	Moderated life stress on hyperactivity and broad psychopathology
	6. Peer Support	Peer support* in the context of an intervention	Eames et al., 2016	Happiness
		Peer support	Rodríguez-Fernández et al., 2016	Adjustment
		Peer support for pupils aged 11-12 years	Lester & Cross, 2015	Wellbeing
		Classmate support (only for adolescents aged 12-13)	Stewart & Suldo, 2011	Students' internalizing and externalizing symptoms
		Positive peer relationships	Oberle et al., 2011	Life satisfaction
		Peer attachment	Balluerka et al., 2016	Wellbeing
	Peer attachment	Abubakar et al., 2013	Wellbeing	

Domain	Subdomain	Protective factor	Authors and year of publication	Outcome
Social Relationships		Less association with deviant peers	Tiet, et al., 2010	Resilience
	7. Friendships	Males with more face-to-face friendships	Donchi & Moore, 2004	Higher self-esteem and lower loneliness
		Friendship quality for adolescents with low levels of autonomy and relatedness.	Collibee et al., 2014	Adjustment
		Friend/peer connection	Lambert et al., 2014	Happiness
		8. Dating and romantic relationships	Good quality dating relationship	Viejo et al., 2015
	High crush status for adolescents with high levels of anxious withdrawal		Bowker & Etkin, 2016	Depressive symptoms
	9. Teacher support and relationships	Bonding to teachers	Tiet, et al., 2010	Resilience
		Support from teachers	Rodríguez-Fernández et al., 2017	Adjustment (psychological)
		Teacher support	Moreno et al., 2016	Resilience
	10. Digital/online relationships	Females with more online friends	Donchi & Moore, 2004	Self-esteem and lower loneliness

Domain	Subdomain	Protective factor	Authors and year of publication	Outcome	
Community Resources and Opportunities	1. Relationship with, and perceptions of, school	High quality School	Çelik, et al., 2015	Self-competence	
		School commitment	Tiet, et al., 2010	Adjustment	
		School sense of belonging	Morgan & Haglund, 2009	Wellbeing	
		School connectedness	Pate et al., 2017	Mental health	
		School connection	Lambert et al., 2014	Happiness	
		School connectedness	Oberle et al., 2011	Life satisfaction	
		School connectedness	Riekie, et al., 2017	Resilience	
		Feeling connected to school	Lester & Cross, 2015	Emotional wellbeing	
		School connectedness	Calmeiro et al., 2018a	Life satisfaction	
		Class emotional intelligence	Balluerka et al., 2016;	Wellbeing and adjustment	
		Social environment	Wong et al., 2009	Happiness	
		Feeling safe at school	Lester & Cross, 2015	Wellbeing	
		2. Extracurricular activities.	Extracurricular activities	Tiet, et al., 2010	Resilience
			Belonging to an artistic group	Ruvalcaba et al., 2017	Higher level of emotional intelligence and resilience.

Domain	Subdomain	Protective factor	Authors and year of publication	Outcome
Community Resources and Opportunities		Belonging to scout group	Ruvalcaba et al., 2017	Higher levels of emotional intelligence and resilience
		Participation in sport activities (PSA)	Griciute, 2016	Resilience
		Belonging to a sport group	Ruvalcaba, et al 2017	Higher levels of emotional intelligence and resilience
	3. Sports activity participation	Positive impact of sport	Eames et al., 2016	Internalising and externalising symptoms reduced and enjoyment reported.
		Sport participation	Vella et al., 2017	Mental health including social and emotional problems
		Sport participation	Briere et al., 2018	Lower social anxiety and loneliness
	4. Relationship to neighbourhood and/or local community	Social networking (in the neighbourhood)	Morgan & Haglund, 2009	Health
		Connected identity* (intervention study)	Eames, et al., , 2016	Positive mental health/reducing in internalising and externalising symptoms
		Social support	Prabhu & Shekhar, 2017	Resilience
		Social support	Wille, et al., 2008	Mental health
	Social support	Stewart & Suldo, 2011	Life satisfaction	

Domain	Subdomain	Protective factor	Authors and year of publication	Outcome
Community Resources and Opportunities	4. Relationship to neighbourhood and/or local community	Social support **	Duggan et al., 2011; Ko & Kuo, 2009; Quinn & Oldmeadow, 2012; Siriaraya et al., 2011; Tichon & Shapiro, 2003; Valaitis, 2005; Williams & Merten, 2013	Benefits such as increased emotional support, self-disclosure, reduced social anxiety and belongingness
		Offline social support **	Parris et al., 2012	Reduce the risk of cyberbullying
		Social support	DuBois et al, 2002	Adjustment
		Social connections* (intervention study)	Johnson, et al., 2007	Positive Youth Development
		Community relationship	Wong et al., 2009	Happiness
		Neighbourhood support	Oberle et al., 2011	Life satisfaction
		Neighbourhood involvement/neighbourhood sense of belonging	Morgan & Haglund, 2009	Health
		Lead others* (intervention study)	Johnson et al., 2007	Positive Youth Development
		Care and compassion* (intervention study)	Johnson et al., 2007	Positive Youth Development

Domain	Subdomain	Protective factor	Authors and year of publication	Outcome
Community Resources and Opportunities		Autonomy and control in the neighbourhood	Tusaie, Puskar, & Sereika, 2007	Psychosocial resilience (PR)
	5. Neighbourhood safety	Safe neighbourhood	McCoy & Bowen, 2015	Hope and aspirations for the future; wellbeing
		Perceived neighbourhood safety	Huynh et al., 2013	Wellbeing
	6. Neighbourhood quality	Protective structural characteristics	Mykota & Muhajarine, 2005	child and youth health outcomes
		Neighbourhood green space quality	Feng & Astell-Burt, 2017	Wellbeing
		Lower levels of perceived rundown houses in neighbourhoods	Huynh et al., 2013	Wellbeing
	7. Family wealth	Family wealth	von Rueden et al., 2006	Quality of life
		Family affluence	Huynh et al., 2013	Wellbeing
	8. Digital activities and social networking	More time playing video games and watching television (boys)	Ohannessian, 2009	Lowest level of anxiety

Domain	Subdomain	Protective factor	Authors and year of publication	Outcome
Community Resources and Opportunities	9. Online communication	Facebook use	Ziv & Kiasi, 2016	Wellbeing
		Social Networks Use (SNS) in boys.	Quinn & Oldmeadow, 2012	Feelings of belonging
		SNS use (with friends)	Valkenburg & Peter, 2006	Self-esteem; wellbeing
		Online communication **	Donchi & Moore, 2004	Self-esteem
		Online communication ** such as chatting with peers or strangers	Gross, 2009	Greater reduction of negative affect in younger adolescents
		Positive feedback on the profiles	Valkenburg & Peter, 2006	Self-esteem and wellbeing
		Online communication	Davis, 2012	Sense of belonging
		Online communication for adolescents with depressed mood	Hwang et al., 2009	and self-disclosure Improved mood
		Weblog Use	Anderson-Butcher, et al., 2010	New relationships
4.Other		Perceived academic achievement	Moreno et al., 2016	Resilience
		The Laws of Life Essay	Banyard et al., 2016	Wellbeing

Domain	Subdomain	Protective factor	Authors and year of publication	Outcome
		The need for relatedness	Leveresen et al., 2012	Wellbeing
		Fun	Coholic, 2011	More effective coping
		Lower number of bad life events	Tusaie, Puskar, & Sereika, 2007	Psychosocial resilience (PR)
		Fewer adverse life events	Tiet, et al., 2010	Resilience

*Note. Protective factors found in review grouped according to Masten & Powell's (2003) example framework (2003, p. 13) by domain and subdomain.*

**Table 4.4***Number of Studies Found for Each Domain and Subdomain of Types of Protective Factor*

Domain and subdomain	Number of relevant studies to subdomain of protective factor
<b>1. Individual Differences</b>	93
Character & temperament	18
Cognitive abilities	6
Goals	6
Self-efficacy and self esteem	18
Spiritual and/or positive beliefs	17
Social and emotional skills	18
Physical abilities	8
Fixed Attributes	2
<b>2. Social Relationships</b>	55
Parent-adolescent relationships	17
Family relationships	14
Family structure	2
Parenting skills	3
Caring adults (outside of the	2
Peer relationships	8
Friendships	3
Dating and romantic relationships	2
Relationships with teachers	3
Digital/online relationships	1
<b>3. Community resources and opportunities</b>	58
Relationship with school	12
Extracurricular activities	8
Social support	6
Relationship to neighbourhood	9
Neighbourhood safety	3
Neighbourhood quality	2
Socio-economic factors	2
Digital activities & social networking	10
<b>4. Other</b>	6
<b>Total</b>	<b>206</b>

*Note.* Number of studies for each domain and subdomain grouped according to Masten & Powell's example framework (2003, p.13)

### **4.3.3 Narrative summary of protective factors in the framework**

This section includes an overview of the factors found to associate with increased well-being or related constructs, or reduced symptoms of psychopathology, such as reduced depressive symptoms found within the review. The majority of studies defined each protective factor, and many studies used an alternative definition to study the same construct. A table of definitions used (where provided in the study) can be found in the appendix. The factors are grouped according to the example framework from Masten and Powell (2003).

#### **1. Individual Differences**

Individual differences refer to protective factors at the level of the individual adolescent, that may be psychological, personality-related or relate to the physical body. The individual differences domain comprised protective factors from 95 relevant studies. Individual differences include factors that were innate as well as variables that can be learned, such as socio-emotional skills. It included factors that are understood to be fixed, such as gender, as well as those that are potentially modifiable through intervention, such as level of self-confidence. Within this domain, types of protective factors were then grouped into nine subdomains: 1) character and temperament, 2) cognitive abilities, 3) goals, 4) self-efficacy, self-esteem, and self-confidence, 5) spiritual and/or positive belief systems, 6) social emotional skills, 7) physical activities and physical abilities and 8) fixed attributes.

##### **1.1 Character and temperament**

The first subdomain under individual differences referred to character and temperament and included of a broad range of characteristics that are found early in life. Character and temperament factors are thought to be biologically determined, such as aspects of personality. 18 studies provided support for a range of protective factors relating to character and temperament linked to adolescent mental well-being. For example, a 'combination of being extraverted, agreeable and open to new experiences' were protective for the outcome of self-worth in one study and two studies found the qualities of 'resilience' to be a protective factor for the outcomes of well-being and adjustment. 'Resilience' was defined in one study as "personal competence, trust in

one's intuition, tolerance of adversity, positive acceptance of change, control and spirituality" (Rodríguez-Fernández, et al., 2016, p.23), the other study defined resilience as overcoming adversity.

### **1.2 Cognitive abilities**

Cognitive abilities referred to factors that relate to the level of functioning in cognition (understanding information) and completing intellectual tasks, such as tasks relating to IQ or academic achievement. In this subdomain, protective factors included 'high academic aspirations', 'academic achievement', 'understanding thought traps', 'flexible thinking and openness to diversity ('choice and option')'.

### **1.3 Goals**

The goals subdomain referred to a range of factors that included planning, achieving, prioritising, and disengaging with goals or targets, comprising of six studies. 'Planning and obtaining life goals', was found to be associated with a range of wellbeing outcomes. 'Psychological capital' was another protective factor found, defined as belief in the capacity to obtain goals, a positive outlook at the goal is possible and a willingness to overcome hurdles in pursuit of ambitions (Afzal, et al., 2016). 'Psychological capital' was found to correlate with increased positive emotions or reductions in stress in two studies.

### **1.4 Self-efficacy, self-esteem, and self-confidence**

This subdomain included protective factors that fit under the three headings of self-efficacy, self-esteem, and self-confidence, and, under these headings, related variables such as competence and positive body image. Eighteen studies were found. Protective factors found in this domain included 'self-efficacy', 'self-esteem', 'self-worth', 'positive self-concept', possessing 'positive schemas' (mental structures that organise the categorisation and understanding of experience), 'positive body image', 'self-attribution of positive states', 'identifying character strengths', and the psychological need for 'competence,' 'a sense of coherence' and 'mental toughness'.

### **1.5 Spiritual and/or or positive belief systems**

This subdomain included both protective factors relating to religion and spirituality as well as and factors related to positive thoughts and behaviours, such as gratitude and optimism. Seventeen studies were found with relevant protective factors. Factors included 'transcendence', 'hope', and 'optimism'. 'Optimism' was defined as a "positive perspective towards the world and the future in general" (Oberle, et al., 2011, p. 894). 'Religious values', was protective for males only (Heaven & Ciarrochi, 2007). 'Religiosity', was another protective factor, with different definitions applied across studies, including aspects such as the strength of religious belief, valuation of religious observance, frequency of prayer and recognition of the divine (Baroun, 2006; Meltzer et al., 2011). Other protective factors found included 'religious activity' and 'gratitude' as well as 'life satisfaction'.

### **1.6 Social and emotional skills**

This subdomain incorporated capacities such as 'emotional competence', 'emotional regulation', and relational skills such as 'problem solving' and 'relationship skills', for example, taking turns and seeking help. In this broad category, eighteen different studies found associations between specific social and emotional skills and adolescent well-being. This category included 'emotional intelligence' (the capacity to perceive, appraise and express emotion), 'self-regulation' (management of thoughts and emotions), 'positive rumination' (recurrence of positive thoughts), self-compassion (non-judgemental self-observance), and 'primary and secondary control coping'. Primary control coping was defined as "efforts directed at changing a stressor (problem solving), or one's emotional reactions to that stressor (emotional regulation, emotional expression)". Secondary control coping was defined as "adapting oneself to a stressor (cognitive restructuring, distraction, acceptance, positive thinking)" (Bryden, et al., 2015, p. 3724).

Other protective factors included 'social and peer competence' (peer competence referred to the capacity to make friends with peers), 'effective communication' and 'mindfulness'. Mindfulness was described as the practice of "bringing attention and awareness to one's momentary experience with a sense of acceptance and non-judgment" (Bluth, Eisenlohr-Moul, 2017, p. 109). 'Self-awareness' and 'repeating

mantras' were also found to be protective. Repeating mantras involved verbalising set phrases or positive affirmations to override attention to unwanted thoughts (Nidich et al., 2011).

### **1.7 Physical activities and abilities**

Physical activities and abilities referred to activities that involved the physical body, as well as some capacities in relation to the physical body itself. Eight relevant studies were found. Three protective factors were identified included those relating to 'physical activity and exercise', 'moderate to vigorous physical activity' and 'motor skills'. Six studies found empirical support for studies involving physical activity as a protective factor associated with well-being. Physical activity was defined in one study as, "any activity that increases your heart rate and makes you get out of breath some of the time" (Mazur, et al., 2016, p. 317). Notably, a study found that physical activity was only protective against emotional symptoms and peer problems and was associated with increased prosocial behaviour *only* for adolescent boys aged 15-16 (Sagatun, Søgaard, Bjertness, Selmer, & Heyerdahl, 2007). An association with 'motor skills' and mental well-being was identified in another study, motor skills were assessed through an adolescent's levels of coordination (Viholainen et al., 2014).

### **1.8 Fixed Attributes**

Fixed attributes referred to non-modifiable protective factors such as gender, race, and age. Two studies specifically identified two separate fixed attributes, being an 'older male', and 'gender' as fixed protective factors linked with well-being.

## **2. Social relationships**

Social relationships included protective factors relating to an adolescent's social network including family, peer, extended family, and other relationships, such as caring adults within the community. This domain also included the quality or characteristics of relationships as well as the presence of them. This domain included nine subdomains: 1) family relationships, 2) family structure, 3) parenting skills, 4) caring adults, 5) peer relationships, 6) friendships, 7) dating and romantic relationships, 8) relationships with teachers, and 9) digital/online relationships. 55 studies were found providing evidence

of types of relationship-related factors that were positively associated with enhanced adolescent well-being.

## **2.1 Parent-adolescent relationships**

Parent-adolescent relationships described relationships and associated characteristics between the adolescent and both their parents, seventeen studies found relevant protective factors. Protective factors included better 'parent child communication' and 'easy communication' (with parents), defined as how comfortable an adolescent felt talking to their parents specifically about an issue or problem. Easy communication was protective for girls only (Levin, et al., 2012). The 'quality of [the] mother-child relationship' was a protective factor, particularly in girls. Further variables found to associate with well-being included the degree of 'paternal involvement', 'secure parental attachment', 'bonding with parents', 'parental monitoring' and 'parental support' and 'confirmation from parents'. Confirmation was defined as "how messages from others impacts individuals' sense of self" (Daily, 2009, p. 292).

## **2.2 Family relationships**

Family relationships referred to protective factors found between the adolescent and their family more broadly, including siblings. Fourteen studies found support for protective factors grouped under family relationships. Protective factors included: 'Family climate' (a caring and supportive environment), 'family connection', 'family bonding', 'frequency of meals with the family', 'family resilience', 'family support', 'perceived family support', 'sibling warmth', 'lower levels of parental discord', and 'differential parenting'.

## **2.3 Family structure**

Family structure, referring to the marital and living arrangements of adolescents and their family. A study found that 'family structure' (living in a two-parent family when compared to living in a single parent family) was linked with life satisfaction for boys and girls aged 13 and 15 (Levin, et al., 2012). Another study a 'traditional two parent family' was a protective variable for boys only (Levin & Currie, 2010).

## **2.4 Parenting skills**

Three studies identified types of parenting skills, techniques applied by parents to raise their children, were protective factors linked with mental well-being. An example of a parenting skill was 'adaptive coping'. This referred to where parents adapted their goals accordingly in parenting situations (Thomsen & Greve, 2013). Other protective parenting skills included 'mindful parenting' and 'strength-based parenting'. 'Mindful parenting' was described as parenting that involved increased attention and compassion during interactions with a child (Moreira, et al., 2018).

## **2.5 Caring adults (outside of the immediate family)**

Two studies found that the 'presence of caring adults' outside of parents and their children were protective factors for mental well-being. Another protective factor found was the role of 'closeness to grandparents'.

## **2.6 Peer relationships**

'Peer support' and 'peer relationships' referred to care and support received from other adolescents and friends, found within eight studies. Of these studies, four studies found 'peer support' to be a protective variable. Of these, one study found 'peer support' to be associated with well-being only for adolescents aged 11 to 12 years old (Lester & Cross, 2015). Another study found 'classmate support' to be protective against internalising and externalising symptoms for adolescents aged 12 to 13 years old (Stewart & Suldo, 2011). Other protective peer variables included 'positive peer relationships' and higher 'peer attachment'.

## **2.7 Friendships**

Protective factors relating to friendships comprised: the presence of 'face to face friendships', 'friendship quality' 'peer connection', and 'positive relationships with peers', found in three studies.

## **2.8 Dating and romantic relationships**

Under this topic of romantic relationships between adolescents, two studies were found with protective factors of relevance. The first, identified a 'good quality dating relationship' and the presence of 'high crush status'.

## **2.9 Relationships with teachers**

'Caring relationships with teachers' (including bonding to teachers) was another protective factor found in three studies.

## **2.10 Digital/online relationships**

A study found that 'having more online friends' was linked to increased self-esteem and decreased loneliness related constructs for females only (Donchi & Moore, 2004)

## **3 Community Resources and Opportunities**

This third domain included all protective factors that related to the wider community/neighbourhood/local area around the adolescent. This included the adolescent's relationship with school, their neighbourhood, perceptions of social support, and interactions with wider social networks and online communities. In total, 56 studies investigated and found evidence for factors that sit under the wider category of community resources and opportunities.

### **3.1 Relationship with school**

Relationships with school referred to the adolescents' connection with school and school environment. Twelve studies identified school related protective factors. Protective factors included: 'a high-quality school' (support, high expectations and meaningful engagement), 'self-competence', 'school sense of belonging', 'school connectedness', 'school climate', 'class emotional intelligence', 'the social environment (SE) of a school' and 'feeling safe at school.'

### **3.2 Extracurricular activities (ECA)**

Extracurricular activities (ECA) referred to types of activity or skills-building undertaken by adolescents in their free time, often held at school or at a community

venue outside of school hours. Protective ECA factors included participation in Scouts, arts groups, sports, and physical exercise. Eight studies found evidence of the link between participating in ECA and elevated levels of well-being.

### **3.3 Social support**

*Social support* referred to caring or supportive relationships around an adolescent. Social support was established to be protective for well-being in six studies. ‘Social support’ was defined in one experimental study as types of comfort provided by friends and family within the adolescent’s life (Stewart & Suldo, 2011).

### **3.4 Relationship to neighbourhood and/or local community**

Nine studies found that protective factors in relation to having a positive relationship to an adolescent’s local community was protective. Protective variables found included a ‘positive community relationship’, ‘increased neighbourhood support’, ‘neighbourhood sense of belonging’, ‘care and compassion’ (for others) and ‘leading others’ in community activities and ‘autonomy and control in the neighbourhood.’

### **3.5 Neighbourhood safety**

‘Neighbourhood safety’ referred to the absence of harm or risk of harm within an adolescent’s community — this protective factor was found in three studies. McCoy et al. (2015) defined neighbourhood safety as comprising three components: “(1) home — can be safe within a few blocks from home, (2) friends — can do things safely with friends in neighborhood, and (3) alone — feel safe alone in neighborhood” (p. 134).

### **3.6 Neighbourhood quality**

‘Neighbourhood quality’ referred to the presence of parks and green spaces in an adolescent’s local community. Two studies investigated and found links with neighbourhood quality and adolescent well-being.

### **3.7 Family wealth**

‘Family wealth’ referred to the level of affluence of the adolescent’s immediate family. Two studies found evidence to suggest that ‘family wealth’ was protective. In

both pieces of research, family wealth was measured using the family affluence scale: "These indicators include family car ownership, whether children and adolescents have their own bedroom, the number of holidays with the parents per year, as well as family computer ownership" (von Rueden, Gosch, Rajmil, Bisegger, & Ravens-Sieberer, 2006, p. 131).

### **3.8 Digital activities and social networking**

This subdomain referred to online digital activities such as communicating on social networking sites such as Facebook or a young person playing video games at home. This area of protective factors did not feature in Masten & Powell's (2003) framework. Ten relevant studies were found. In this subdomain, a study found that 'playing video games and watching television' for boys was protective against anxiety, but not for girls (Ohannessian, 2009, p. 587). At least two studies identified that 'social networking' had a protective effect on well-being for adolescents overall and specifically for boys in terms of feelings of belonging (Quinn & Oldmeadow, 2013). A study by Ziv and Kiasi (2016) found that 'Facebook use' was protective for well-being. Five studies that featured in a review paper by Best et al., (2014) found that 'online communication' overall, either with peers or with strangers were positively associated with mental well-being. However, one of these studies found that it *only* had a positive affect for adolescents who already had a depressed mood (Hwang et al., 2009).

### **4 Factors that were difficult to disaggregate or marked as 'other'**

A small number of studies ( $N = 6$ ) included protective factors that were difficult to classify in the current framework. Either the manner that the construct was measured rendered it difficult to classify or sufficient information was not provided in the article on the protective factor studied to understand which variable led to a change in mental well-being. The first study featured 'perceived academic achievement' that referred to an adolescent's impression of a teacher's thoughts on their academic achievement as compared to their classmates (Moreno et al., 2016) and found an association with resilience. The second, derived from an intervention study, was 'engagement with writing exercises in "the laws of life essay"' (Banyard, Hamby, & Grych, 2016, p. 4) that linked with well-being. However, further study is perhaps required to understand which factors involved in the exercise led to reported changes in mental wellbeing.

Another protective factor that was difficult to disaggregate was the 'psychological need for relatedness'. This referred to "the feeling of being connected to others, which includes relating to and caring for others, feeling cared for by those others, and feeling involved with the social world more generally (Baumeister and Leary 1995)" (Leversen et al. 2012, p. 1589). This factor could be part of temperament or it could sit under relationships, potentially under social and emotional skills or extracurricular activities.

One qualitative study found evidence that 'fun' was a protective factor associated with awareness and emotional regulation that linked to coping for adolescents (Coholic, 2011). Whilst an important factor to include it is difficult to tell what aspects of 'fun' or 'having fun' were protective and thus protective factors such as these require further research to understand the significance for adolescent mental well-being.

Also included in this domain, classed as 'other' protective factors, were 'adverse events'. These were defined in both studies as 'a lower level of negative events' undergone by an adolescent, such as a bad grade on a test or an argument with close friend during the past year (Tiet, et al., 2010). Two studies found that experiencing a reduced number of adverse events had a protective effect.

#### **4.3.4 Outcomes in retrieved studies**

In order to categorise the frequency of outcomes found to associate with protective factors, a table is provided below (Table 4-5). To reiterate, the importance of studying outcomes in reviews of protective factor research has been emphasised by Eriksson et al., (2010). Grouping outcomes enables oversight of what types of mental well-being outcome had been most studied, as well as reducing a fragmented range of outcomes into clear, general categories. A recently developed framework of outcome types from universal interventions, conducted by the Evidence Based Practice Unit was applied to group the outcomes using the following categories: promoting mental well-being (W), promoting resilience (R), preventing behavioural difficulties (PB), preventing emotional difficulties (PE), and preventing emotional and behavioural difficulties (PEB) (Public Health England, 2019). Some protective factors were found to lead to multiple

outcomes, such as resilience and well-being (R & W), and other combinations of the above types (Public Health England, 2019).

**Table 4.5**

*Types of Wellbeing Outcome Cluster and Numbers of Studies that Measured Each Type of Outcome*

Type of wellbeing outcome cluster	Number of studies found measuring outcome
Promoting well-being (W)	74
Promoting resilience (R)	67
Resilience and preventing emotional difficulties and well-being (R, PEB & W)	10
Preventing emotional difficulties (PE)	7
Promoting resilience, well-being and preventing emotional difficulties (R, W)	1
Promoting behavioural difficulties	1
Preventing emotional difficulties and well-being (PE & W)	1
Resilience and preventing emotional difficulties (R & PE)	1
Resilience, preventing behavioural difficulties (R & PB)	1

*Note.* Outcome clusters are based on the Public Health England (2019) groupings.

## 4.4 Discussion

The findings presented in this chapter have provided a comprehensive overview of the range of protective factors (N =145) in relation to mental well-being and the risk of psychopathology, expanding an existing framework (Masten & Powell, 2003). Factors that have only been investigated more recently are apparent, as well as gaps in the study of protective factors. Opportunities in the study of protective factors, identified through this review, include contributing to research on the topic of mechanisms

underpinning some of the associations found, as well as a surprising lack of qualitative research on the lived experience of protective factors in relation to risk.

The goal of this review was to provide an overview of empirical studies of the types of protective factors found to increase adolescent mental well-being, based on extant literature conducted in the period 2000 to 2018. The review found 145 different protective factors identified from empirical studies that were associated with positive well-being (or related constructs) in adolescents. These types of protective factors were grouped into Masten and Powell's (2003) domains: individual differences, social relationships, and community resources and opportunities. For studies that found associations with multiple protective factors in several domains, these studies were then categorised under multiple domains. From tabulating the final studies, the current literature can, for the most part, fit into Masten and Powell's (2003) framework of types of protective factors, with the addition of a wider range of individual protective factors. The current literature synthesis contributes more granularity and potentially more precision to the study of protective factors through creating further subdomains of protective factors within each Masten and Powell's broad categories.

Firstly, the review found some individual protective factors that have received substantial scholarship, such as school connectedness (Lambert et al., 2014; Lester & Cross et al., 2015; Oberle et al., 2011; Riekie et al., 2017) and social support (Eames et al., 2016; Steward & Suldo, 2011; Wille et al., 2008). Other protective factors found have been studied much less within the literature, such as perceived emotional intelligence and class emotional intelligence (Leventhal et al., 2015; Salguero et al., 2012), mindfulness (Nidich, et al., 2011), fun (Coholic, 2011) and 'personal belief in a just world' (Correia & Dalbert, 2009). Such variables require further empirical study for different age groups and genders and further investigation regarding *why* and *how* they are protective.

The review found that some protective factors are only protective to specific age groups and genders or particular contexts, for example a two-parent family structure in one study was found to be protective for boys only (Levin & Currie, 2010), and easy communication was found to be protective for girls only (Levin et al., 2012). To draw on another study, playing video games and watching TV reduced anxiety for boys, but not

for girls (Ohannessian, 2009). A recent study found that gender differences in levels of collective efficacy (social cohesion and social control) moderated the association between cumulative risk and externalising problems for both sexes, but moderated the association between stress and internalising problems for males only (Sharma, Mustanski, Dick, Bolland, & Kertes, 2019). Further, another study found that physical activity was only protective against emotional symptoms, peer problems and associated with increased prosocial behaviour *only* for adolescent boys aged 15-16, bringing attention to the role of both age and gender (Sagatun et al., 2007). The gender and age specificity of protective factors suggests that a) more research is needed to explore and explain gender and age differences in the effectiveness of protective factors, and b) research-informed intervention design is necessary to check that protective factors targeted by interventions have been found to reduce outcomes relevant age and gender group.

Overall, the protective factors identified in this review updated and expanded upon Masten and Powell's (2003) framework. The updated framework presented here includes evidence from almost two decades of research on the topic of protective factors found to associate with adolescent mental well-being. This review found a relative paucity of evidence on the role of relationships within the wider environment beyond home and school, such as the role of youth workers, grandparents, religious institutions workers, extracurricular activity coaches and teachers. This is linked to but separate from social support, which, as the review has indicated, is a highly researched protective factor at this level (Fritz, et al., 2018; Froh, Yurkewicz, & Kashdan, 2009; Ikiz & Cakar, 2010; Ridings, Beasley, & Silovsky, 2017). The review found a lack of research relating to protective factors in relation to mental health and social services and statutory mental health provision for adolescent mental well-being. This might not indicate an absence of evidence, but rather show that these types of studies may not use the language of protective factors within the study title. Another finding was that protective factors that were part of a wider construct or part of an intervention were often difficult to unpack in terms of which precise factor, or combination of factors, led to the improved outcome, and what the mechanism underpinning this change in outcome was.

Another finding of this scoping review was that a wide range of mental well-being outcomes have been studied, including psychological well-being, subjective well-being, and the general concept of well-being. From examining the frequency of studied outcomes, well-being, resilience, the combination of resilience and well-being, and the prevention of emotional difficulties were the most commonly researched. However, sometimes the literature can be difficult to compare when different constructs are used to measure adolescent well-being. It is not always clear whether the findings from a study that examined a protective factor linking with life satisfaction, for example, and the findings from another study that examined an association with quality of life, can be synthesised as examining the same outcome or whether they ought to be considered separately.

The study of protective factors would benefit from referencing detailed frameworks for organising protective factors such as Masten and Powell's (2003), or the extended version presented in this chapter, as well as clarifying definitions and referencing other studies that have adhered to similar definitions. Using such a framework would be helpful because within existing studies there are few tools and frameworks to codify and synthesise the evidence base, as well as sometimes a lack of acknowledgement to the wider range of factors around an adolescent. The framework offered in this review expands on an existing framework (Masten & Powell, 2003) to provide a logical order to studied protective factors and thereby improve coherency across the evidence base.

The current research is in agreement with the call to examine protective factors situated within multiple domains. This is because research has often found that protective factors tend to operate together or interact with each other, rather than in isolation (Fritz et al., 2018; Sharma et al., 2019). At a minimum, studies of protective factors would benefit from using clear definitions of both protective factors and outcomes to consolidate knowledge and compare studies across this important field of research. Ultimately, the challenge across studies, as evidenced in this review, was variation in the definition of both protective factors and definition of wellbeing as the outcome of interest. Heterogenous definitions of a given protective factor of interest were also found (e.g., hope or religiosity).

#### **4.4.1 Implications for intervention design**

This review has provided an overview of the empirical evidence for factors that are associated with well-being that can be incorporated into intervention design. This is particularly critical given that often interventions are designed without being informed by available empirical evidence. For example, the majority of schools in England report using approaches to intervention that have no evidence base (Vostanis, Humphrey, Fitzgerald, Deighton, & Wolpert, 2013). Before forming interventions or policies aiming to increase adolescent mental well-being and/or resilience, policy makers and intervention designers could perhaps usefully focus on incorporating protective factors found to increase well-being in the scientific literature (ideally those factors that have support from several high-quality studies). In addition, it would be important for intervention designers to consider if an association has been found for adolescents the same age and gender as those targeted within an intervention. Interventions or policies aiming to increase multiple protective factors around the child could adopt an ecological approach, which involves reducing risk and enhancing protection to reduce adaptation and promote competence at multiple levels around the adolescent (Luthar et al., 2000; Lynch & Cicchetti, 1998).

#### **4.4.2 Limitations and suggestions for future research**

The scope of the review was limited to general/non-specialist populations in relation to the outcome of mental well-being. Studies that examined protective factors for a particular outcome (beyond well-being), such as teenage pregnancy or drug use, have not been included in the review. Similarly, a sole focus on particular populations, such as adolescents exposed to a natural disaster, for example, or LGBTQI adolescents, were excluded. Therefore, caution should be exercised when planning to apply protective factors found within this study towards specialist groups as the same protective effect may not be found. Further, specialist groups, such as LGBTQI, are known to have additional protective factors that may not be protective for participants that are not part of the specialist group (de Vries Robbé & Willis, 2017). Given the vast amount of literature on protective factors for specialist groups, further scoping reviews would be required to provide a broad overview of the literature on protective factors in relation to mental well-being for specialist groups, such as LGBTQI adolescents. It would be valuable to compare the protective factors found for general populations with

those for more specialist populations, this may facilitate the development of further understanding of which factors could be considered universal.

Most studies in this review are quantitative, cross-sectional studies and provide evidence regarding the strength of a relationship given as a statistically significant association, rather than a causal effect. It was beyond scope of this review to examine the quality of the included studies beyond the fact that all the studies were published and peer reviewed.

It is important to note that some protective factors identified, due to their associations with mental well-being, could also be construed as low levels of a risk factor (as well as a protective factor), such as absence of adverse events (Tiet, Huizinga, & Byrnes, 2010). Furthermore, whilst this review demonstrates which variables have been found to be protective, often it is unclear in the literature with multi-dimensional constructs or multi-component interventions exactly which variable or variables most significantly contribute to a change in outcome. Further investigation of the specific protective mechanisms activated by interventions is, therefore, needed. For example, when considering a protective factor such as repeating a mantra, which aspects of mantras serve to increase well-being (repeating a phrase, repeating a phrase containing positive words, a particular phrase, a phrase meaningful to the individual and so on)? Similarly, given that family meals are protective (Lambert et al., 2014), which aspect counts? Is it homemade food, sitting and eating together, a scheduled mealtime, or dinnertime conversation that contributes to increased well-being, or a combination of all these factors? The study of individual protective factors in relation to mental well-being would benefit from further granularity of investigation, to be able to apply some of the insights gained to both interventions and inform policy.

Future studies are also needed to explore the lesser researched domains of protective factors identified through this review, such as romantic relationships, having fun, subtypes of physical activity, emotional intelligence, and class emotional intelligence. It would be valuable to understand qualitatively what factors adolescents themselves perceive to increase their well-being, and how they prioritise them and compare with the protective factors found within the literature. There is also scope to ascertain a developmental overview of protective factors, and the need for this work has

been previously identified (Eriksson et al., 2010). Some factors have been found to be protective for specific age groups, as well as specific genders. For instance, Windle (1999) suggested that “there has been a general recognition within the literature that risk and protective factors may function in alternative ways for different age groups, and in alternative ways for the same individuals at different periods in the lifespan” (p. 166). However, scope remains for new research that collates protective factors by age for each age group within the adolescent period and could guide intervention design. It could also establish the difference between enduring protective factors, and those that might be protective for a specific time or linked to a specific transition within the adolescent period.

## **4.5 Conclusion**

The framework of protective factors presented in this chapter provides a thorough overview of the range of protective factors associated with increased adolescent mental well-being from research conducted during the period 2000-2019. The review has highlighted where research is in its infancy, with more research needed on some specific factors identified by a small number of existing studies, such as having fun and the level of class emotional intelligence. The review has illuminated some gaps in the study of protective factors, such as missing information about the mechanisms underpinning some of the associations found, and a lack of qualitative research on the lived experience of protective factors in relation to risk. Whilst some qualitative studies were found, the review did not yield qualitative studies of protective factors as experienced by adolescents in England, suggesting research is needed here. A next logical step, in Chapter 5, is to explore adolescents’ own subjective experiences of protective factors in relation to risk and the outcomes of mental well-being and risk of psychopathology. Comparisons of the factors found in this review with those subjectively reported by adolescents will also be drawn in the final chapter of the thesis.



Chapter 5. What Patterns Exist in Adolescents' Experiences and Reports of Protective Factors in Relation to Mental Well-being and the Risk of Psychopathology? An Ideal Types Typology of Protective Factors.

## **5 What Patterns Exist in Adolescents' Experiences and Reports of Protective Factors in Relation to Mental Well-being and the Risk of Psychopathology? An Ideal Types Typology of Protective Factors.**

### **5.1 Introduction**

This thesis explores the overarching question of how qualitative investigations into adolescent experiences of stressors, risk and protective factors can further our understanding of adolescent mental well-being and the prevention of psychopathology in adolescence. In the first study, adolescent perceptions of types of stressors and the effects on their mental well-being were examined. This study found that clusters of stressors were often reported to be highly interconnected and frequently led to a range of outcomes, some of which included the symptoms of psychopathology.

In the second study, a scoping review was conducted to retrieve all studies that had found a positive association between a protective factor and an increase in mental well-being and a decreased risk of symptoms of psychopathology. Identified studies were then grouped using Masten and Powell's (2003) example framework of protective factors to synthesise the existing literature and expand the framework. The review found that, in general, there was an absence of qualitative studies in this area. Further, only a subsection of the studies included in the review revealed the mechanisms through which protective factors increased well-being. Moreover, findings from cross-sectional, quantitative studies were often limited to the strength of an association and were not able to address the "how" question.

A logical next step, therefore, was to explore adolescents' subjective experiences of protective factors in relation to mental well-being and the risk of psychopathology and examine how they might be grouped to form a qualitative typology of protective factors, to add to existing knowledge in this area.

Qualitative studies can elucidate the range of ways in which protective factors can reduce risk or ameliorate the negative effects of a stressor from the perspectives of adolescents themselves (Copeland-Linder, Lambert, & Jalongo, 2010). Qualitative studies can illustrate direct experiences of underlying mechanisms that link variables to outcomes (Ungar, 2003). Such studies tend to take a data-driven or bottom-up approach to the study of protective factors. It is possible, for example, that adolescents themselves may report protective factors that are less studied within the literature. Further qualitative research can also provide a picture of the variation in subjective experiences. Given the vital role of protective factors in reducing the likelihood of psychopathology and promoting adolescent mental well-being, observing patterns in adolescents' experiences of protective factors can assist with identifying when adolescents may or may not require additional mental well-being and mental health support (Bluth et al., 2016; Fergus & Zimmerman, 2004; Hamby et al., 2017; Sharma et al., 2019).

Findings from retrieved studies in the scoping review suggested that the relationships between particular protective factors and mental well-being and the risk of psychopathology can be complex. For example, while social support has been found to increase mental well-being in adolescents, in the context of specific risks however, such as racial discrimination, social support does not always reduce the risk of psychopathology and can in fact increase symptoms (Gaylord-Harden & Cunningham, 2009). For example, research found that when levels of racial discrimination were high for African American adolescents, communalistic coping (defined as drawing on support from family and others as a form of interdependence) could actually raise levels of anxiety — though not when levels of discrimination were more moderate (Gaylord-Harden & Cunningham, 2009). Thus, it is important to understand what factors adolescents report to find protective in relation to mental well-being and the decreased risk of psychopathology in particular settings. Resilience theorists have noted a striking absence of research featuring children and adolescents' views on their own well-being (Luthar et al., 2006). By qualitatively studying patterns in the ways in which adolescents describe their overall profile of risk and protective factors, it may be possible to identify groupings or 'types' of adolescents with similar views and experiences. Such groupings could then have the potential to engender understanding of patterns relating to how

protective factors are drawn upon, when and in what circumstances by adolescents, in this case in a UK context.

### **5.1.1 Typologies of risk and protective factors in relation to mental well-being**

A typology is a system for classifying phenomena, formed by either viewing a concept along a continuum or by using two (or more) dimensions to make a display of key variables, or separate features within a system (Patton, 2002). Typologies can assist in the clinical application of resilience interventions with adolescents to identify those who are most in need of support and who should be targeted, particularly when resources are limited and thus decisions requiring who is in most need of support are pertinent (Bowen et al., 2007). Current methods of identification for support include the assessment of the types of adversity and stressors experienced by the adolescent and the protective and promotive factors in place (Ungar, 2015). Parent and teacher report methods are commonly applied in risk identification (Humphrey & Wigelsworth, 2016). Ungar (2015) has proposed a multi-dimensional assessment of resilience that uses a decision-tree for the diagnosis of resilience in adolescents by resilience practitioners. The assessment involves capturing the severity, chronicity, ecological level, children's attributions of causality, and context of adversity. Promotive and protective factors are gathered, as well as factors of time and culture (Ungar, 2015).

Various typologies of classes of protective factors in relation to risk and resilience have been constructed, as formulated through quantitative methods (Copeland-Linder et al., 2010; Solberg, Carlstrom, Howard, & Jones, 2007; Ungar, Hadfield, & Ikeda, 2018). Both person-centred and variable-centred approaches have been applied in constructing typologies of protective factors (Copeland-Linder et al., 2010). Person-centred approaches focus on individuals, grouping individuals with similar attributes and similar outcomes. Studies using person-centred approaches have used quantitative approaches such as hierarchical cluster analysis and latent class analysis (Solberg et al., 2007). Variable-focused models examine associations among variables using a multivariate statistical model to establish an association with a particular variable and positive outcome (Copeland-Linder et al., 2010). Some researchers have suggested that person-centred approaches are more appropriate for establishing domains or types of protective factors (Bergman & Magunusson, 1997; Masten, 2001, 2011).

A relevant person-centred study was conducted by Solberg et al. (2007) with a sample of 758 mainly Latino and African American adolescents, with the aim of evaluating whether self-efficacy and internal motivation, perceived family support, connections with teachers and peers, and levels of exposure to violence, led to experiences of different types of academic risk. Academic risk was not explicitly defined in the study but was equated with negative outcomes at school. Applying hierarchical cluster analysis, adolescents were grouped into six categories: not at risk; moderately resilient; resilient; disengaged; vulnerable; and most vulnerable. Group membership was associated with levels of academic stress, health status, end-of-semester grades, and retention in school (Solberg et al., 2007). This typology followed a linear scale, with one end classified as the least at-risk/least vulnerable and the other end being designated the most at-risk/most vulnerable. In this typology, the vulnerable and most vulnerable groups reported the lowest connections with peers and teachers, the lowest levels of family support, the lowest motivation, and the highest exposure to violence. The not at-risk group in Solberg's (2007) study had the inverse levels of the same characteristics. The resilient group was found also to be exposed to violence but reported high levels of connections with peers and teachers, family support and internal motivations to provide an overall resilient profile (Solberg et al., 2007).

Another typology was formed through conducting a latent profile analysis (LPA) linking community violence, protective factors (self-worth, parental monitoring, and parental involvement) and adolescent mental health as an outcome (Copeland-Linder et al., 2010). LPA is a type of *structural equation modelling* (SEM) in which individuals can be classified into types, or latent classes, based on their pattern of answers on a set of categorical variables (Copeland-Linder et al., 2010). The study found three categories: 'vulnerable', referring to a class of adolescents with the highest levels of exposure to violence and lowest levels of self-worth and lower parental involvement; the second type, 'moderate risk/medium protection', included young people who reported lower levels of violence but had increased self-worth; thirdly, the 'moderate risk/high protection' group also reported lower levels of violence but had the highest positive self-perceptions in the sample (Copeland-Linder et al., 2010). Copeland-Linder and colleagues concluded that the precise mechanism of how increased self-worth protects against community violence would require the input of qualitative research.

Ungar, Hadfield, and Ikeda (2018) conducted a mixed methods study of 85 adolescents receiving support from therapeutic relationships in Canada. The study involved interviews with young people and the calculation of a risk and resilience score for each participant through their completion of a range of measures. Subsequently, four types were identified from the quantitative aspect of the research, that comprised: 'High-risk, high resilience'; 'high-risk, low resilience'; 'low risk, low resilience', and 'low risk, high resilience' adolescents (Ungar et al., 2018). Adolescents who were found to be exposed to the greatest amount of risk but scored lowest on resilience preferred informal support that could be out of hours. In contrast, adolescents with higher resilience scores described helpful therapeutic relationships that "included more structure, greater expectations and firmer boundaries" (Ungar et al., 2018, p. 277). This typology, formed through a mixed methods approach, provides an example of how patterns in risk and resilience can provide insight into discernible differences in adolescents' preferences regarding support.

### **5.1.2 Ideal-type analysis**

The current study employs a person-centred method to construct a typology from qualitative data, using ideal-type analysis. Ideal-type analysis is derived from the late German philosopher and sociologist Max Weber, and later developed as a qualitative methodology by Uta Gerhardt (1994). The concept of ideal types refers to a hypothesised category of the topic under study (Weber, 1949).

An ideal type is formed by the one-sided accentuation of one or more points of view and by the synthesis of a great many diffuse, discrete, more, or less present and occasionally absent concrete individual phenomena, which are arranged according to a one-sidedly emphasised viewpoint and arranged into a unified construct (Weber, quoted in Gerhardt, 1994, p. 79).

Ideal types are not 'ideal' in the sense that they are utopian or normative, but ideal in the sense that they are an 'idea' and they provide a reference point of comparison for other cases in the dataset (Grønning, 2017). Constructing ideal types involves forming abstract categories based on detailed understandings of individual cases that become

the basis of comparison with other cases (Livesley, 1991). Each type contains a cluster of individual cases (Werbart, et al., 2011), epitomised by an *optimal case*, or a singular case, that best represents that ideal type, in that it most clearly displays the key characteristics of the category (Lewis-Beck, Bryman, & Futing Liao, 2004). Ideal types have been described by Marcelino (2014) as “theoretical tools” from which it is possible to explore similarities and differences across large datasets of qualitative data (Lindner & Briggs, 2010). Ideal-type analysis has been used in qualitative research within psychology, such as to develop typologies of patients’ experiences of therapy or illness perceptions (e.g. O’Keeffe, Martin, Target, & Midgley, 2019a; Stapley, Target, & Midgley, 2017; Wachholz & Stuhr, 1999; Werbart, et al., 2011).

For example, O’Keeffe et al. (2019) applied ideal-type analysis to develop a typology of adolescents’ reasons for dropping out of therapy. Three types of drop out were identified: the ‘dissatisfied’ dropout, the ‘got-what-they-needed’ dropout, and the ‘troubled’ dropout. The ‘dissatisfied’ dropout described those who had found therapy unsatisfactory, which influenced them to drop out. The second type (‘got-what-they-needed’) found the help to be useful and did not need to use the service for an extended period. The third group (‘troubled’) experienced a lack of stability within their lives to the extent that it was too difficult to keep attending therapy sessions and fully commit to the therapeutic relationship (O’Keeffe, Martin, Target, Midgley, et al., 2019). The study examined narratives from both participants and their therapists and found that adolescents in the ‘dissatisfied’ ideal type did not communicate their impressions to the therapist, and thus the therapist was not aware that the participants were, in fact, not happy with the therapeutic experience (O’Keeffe, Martin, Target, Midgley, et al., 2019).

Ideal-type analysis provides a methodology for developing broad, overarching categories, or types of experience or perspective, from diverse individual cases of qualitative data (Wachholz & Stuhr, 1999). It enables the systematic comparison of similarities and differences in participants’ individual experiences and opinions across a large dataset (Werbart et al., 2011). It strikes a middle ground between an *idiographic* approach that focuses on reading and analysis of individual cases, and a *nomothetic* approach that seeks to generate general laws, or examine cross-cutting patterns, through forming a wider ideal type that covers a range of individual cases (Kühnlein,

1999). Ideal-type analysis has been suggested to be particularly suited to psychological and psychotherapeutic research in that it facilitates inquiry towards topics that are difficult to directly measure (Lindner & Briggs, 2010; Malterud, 2001). For example, a researcher may be interested in how adolescents perceive their relationships with their parents or how a participant from a minority background experiences discrimination at school that cannot be easily observed and thus, adolescent reports about such topics can be gathered via the semi-structured interview. Ideal types can also act as conceptual tools for further theorising about a given social phenomenon (Marcelino, 2014; Werbart, et al., 2011).

### **5.1.3 Aims and scope of the study**

To address the lack of typologies based on adolescents' experiences of protective factors in relation to mental well-being and the risk of psychopathology, the aim of the present study was to produce a meaningful set of categories (a typology) based on adolescents' descriptions of protective factors and stressors. The construct of mental well-being that has been adopted throughout the thesis was applied. Protective factors as per usage in the thesis referred to any variable that adolescents reported to help with their well-being or alleviate the negative effects of stressors, which may include positive activities, any form of support, help or intervention, coping strategies, help-seeking and positive self-perceptions. The breadth of this definition enabled adolescents' own formulations of what increased mental well-being and reduced the effects of stressors to emerge from the dataset and generate ideal types based on this data. In theory, categories formed inductively could facilitate exploration of the similarities and differences in reported protective factors across a large sample of qualitative interviews. Comparisons were made both between cases in each cluster, as well as between types (Werbart, et al., 2011).

## **5.2 Method**

### **5.2.1 Setting for the study**

This study drew on data from the first timepoint in the Phase 3 Qualitative Longitudinal Study (QLS) of HeadStart (see Chapter 2 for further details).

## 5.2.2 Participants

Interviews were conducted with 63 adolescents at the first timepoint of the QLS (May to July 2017), ranging from 12 to 16 participants per HeadStart partnership (drawn from two to three schools per partnership). The sample included 28 females (44.44%) and 35 males (55.55%). Participants' ages ranged from 9.10 to 12.9 years ( $M = 11.90$ ,  $SD = 0.59$ ). Ethnicity data for the sample have been presented in the Research Design section of the thesis (Chapter 2). Participants were recruited by the qualitative research team, in liaison with the HeadStart partnerships and school representatives. Participants included adolescents who had already begun receiving support from HeadStart or who may be receiving support from HeadStart in future. The qualitative research team were not informed by the HeadStart partnerships or school representatives about which type of HeadStart support/interventions the participants were eligible for or had received (or any other information about each participant's risk and protective factors). The interventions were specific to each HeadStart area and varied by school and participant (for further details, see Chapter 2). All interviews at Time 1 were conducted by a member of the qualitative research team and were held in private rooms at participants' schools. The semi-structured interviews conducted with participants ranged from approximately 15 to 60 minutes in length ( $M = 39.73$  minutes,  $SD = 10.33$ ).

## 5.2.3 Data analysis

The study applied ideal-type analysis to explore adolescents' descriptions of protective factors and stressors to understand patterns of reported protective factors in relation to outcomes of interest, mental well-being, and the risk of psychopathology. The method for ideal-type analysis drew on the four steps outlined by Werbart et al. (2011), which in turn follows on from Gerhardt's (1994) method, further outlined in the work of Wachholz and Stuhr (1999). The steps consisted of: Step 1) Individual case reconstructions were written for the entire dataset to compare case reconstructions with each other, resulting in emerging clusters of similar cases; Step 2) 'Optimal cases' were selected that particularly illustrate each emerging cluster; Step 3) All remaining cases were then clustered around the relevant optimal case, that is most similar to them. This was achieved through a constant and systematic process of comparing and contrasting single case reconstructions with all other cases, according to the principle of theoretical sampling (allowing a theory to emerge from comparing cases; Strauss, 1987). Each

type was given a heading and a description drawing on participants' own use of language where possible; Step 4) Independent colleague(s) re-sorted the cases into the types according to the descriptions, as a form of a credibility check on the analysis (Werbart et al., 2011). The exact procedures taken in this study for each step are described below.

### **5.2.3.1 Step 1 - Development of individual case reconstructions**

Case reconstructions are summaries of the relevant features of each transcript. Case reconstructions are typically shorter in length than the transcripts — they facilitate examination of the similarities and differences between the cases and grouping them into clusters. In this study, for each transcript from the dataset, the relevant passages pertaining to discussion of stressors and protective factors according to the pre-formulated definitions. A case reconstruction was then drafted with a narrative of the reported stressors and protective factors from each transcript, including a bullet-point summary of the stressors and protective factors. As some statements in transcripts could be both risk and protective factors, these were entered into an additional bullet-point list. These were factors that might be reported as positive but that had a discernible negative effect, such as instances of aggression to peers to reduce stress, or factors described by the adolescent as having either a negative and positive effect or a neutral effect. Statements that could be either risk or protective factors were more common for some adolescents, and less visible within other transcripts.

#### ***Example single case construction from a transcript: 'Elliot'***

*Elliot reported that he regarded his current school as somewhere that he wanted to stay permanently and explained that the possibility of moving to other schools made him feel "nervous" because he perceived that he would struggle to make new friends. Elliot described that he experienced anxiety during exams: "During, like, tests and things, I get really bad anxiety". He reported that he also feels worried about new experiences more generally in case it leads him to "freak out".*

*Elliot described that at school people often perceive him as angry due to the way "he speaks". Because he has been perceived as misbehaving, he was placed in "inclusion" (school behavioural support) as a punishment. Elliot described that he feels that, in fact, he was not shouting, and that others misinterpret his behaviour at school. However, he also reported that*

*“time” in the inclusion unit at school helps him to calm down, at times. Elliot further described that when he was stressed, he has tried to vomit to alleviate the nauseous feeling. Elliot explained that during moments of anger, he felt that: “I don’t really know what I’m doing”.*

*Elliot reported that he enjoyed PE (Physical Education) lessons at school because it is an opportunity to be play around and entertain his friends, “Like, I get to muck with my friend, like me and my mates are, like, all there together just mucking around, I s-, I somehow turn it, turn everything in P.E. as well or to a funny moment.” He then explained that he felt that he often is held responsible for poor behaviour unfairly due to past transgressions: “I’m always usually getting blamed for a lot of things, even when I don’t, doing, nothing wrong.” He described that there is a school disciplinary procedure in which his parents are called by the school about his behaviour. When asked how he finds the behaviour support, he described it as “boring”.*

*Elliot’s mother finds it difficult to physically visit the school to discuss her son’s behaviour when requested to do so. Elliot explained that his mother has received a number of telephone calls from the school about his behaviour. Upon learning about his behaviour difficulties at school, he is then disciplined at home, such as being “grounded”. Elliot described feeling angry in response to occasions when he received disciplinary consequences at home for behaviour at school that, in his opinion, he was not responsible for “but, like, if it’s something I don’t do, I, like, get quite angry and wound up about it.”*

*Elliot described that at the time of his interview his family were experiencing financial struggles and were waiting for a new, better paid job for his father. He described that his mother was not able to work. Elliot explained that his mother gets frustrated by his difficult behaviour at school. He explained to the interviewer that he would like to help his parents with their problems but feels he is unable to and that it may risk “making things worse”. Elliot explained that he copes with the situation at home by being out of his house as much as he can and that he likes to ride on his bike with his friends and have fun with them. “I just, go on my bike with my mates, ride around, go places and just muck around.”*

*Elliot then described that he enjoyed bike riding locally with a large group of 15 or more boys. On occasion, his parents, his friends’ parents, and others criticise them for meeting as a large group: “Like, everyone has a go at us for riding our bikes, but they have a go at us for staying indoors, so, like, it’s make your mind up: do you want us to stay indoors or go outside?” When asked what he would do if he had a problem, Elliot reported that he would not approach an adult as he feels that a young person would not be heard, “cause they wouldn’t listen”.*

To summarise, the following stressors, protective factors, and factors that were both risk and protective were found:

### **Reported stressors**

- Worried about moving to a new school/risk of permanent exclusion
- Anxiety/worry about exams and undertaking exams
- Worried about new experiences and making new friends
- Anger, or feels unfairly perceived as angry by others
- Perceived himself to be unfairly targeted by schoolteachers
- Perceived that others misinterpret his behaviour
- Behaviour difficulties and punishment at school
- Punished at home for difficult behaviour at school
- Mother is unable to work
- Family under some level of financial hardship
- Difficult for his mother to visit Elliot's school to discuss behaviour
- Lacks knowledge of how to help his family with their problems
- Feels criticised for spending time in large groups
- Reported barriers to seeking help/would not go to an adult for help as thinks that adults would not listen

### **Reported protective factors**

- Time in inclusion unit has helped him calm down
- Enjoys making people laugh and telling jokes
- Some positive self-perceptions (positive statements about the self)
- Hanging out with friends to cope with the situation at home
- Spends time on bikes in groups outside with other boys

### **Uncertain protective factors: reported factors that could be construed as either risk and protective factors or both**

- Reported that he likes to make his friends laugh in PE and has a positive self-perception – Whilst this brings him positive feelings, joking around increases the risk of further behaviour-related issues at school.

- Is part of a large group of boys that are criticised by adults
- Whilst the behaviour support received at school helps him to calm down, he also feels unfairly targeted and finds it boring.

### **5.2.3.2 Step 2 - Sorting the types and forming the types**

As the dataset was large for a qualitative study ( $N = 63$ ), the types were initially constructed based on just under half of the data ( $N = 31$ ), reflecting O’Keeffe et al.’s (2019) application of ideal-type analysis. The remainder of the cases were later sorted into the types to examine whether the ideal types could sufficiently capture the whole dataset. The case reconstructions were read and similar cases were then clustered or sorted into groups until distinct types emerged, following a process of “case comparison” (Wachholz & Stuhr, 1999). The types needed to be homogenous within themselves but sufficiently different from each other (Wachholz & Stuhr, 1999). The first sorting of cases led to the development of five provisional types, refined in the upcoming sections:

- 1) The ‘Well-Supported’ adolescent – the adolescent with many forms of support reported from home and school and a low level of stressors.
- 2) The ‘Self-Protective’ adolescent – the adolescent who found ways to increase their own well-being independently or manage their emotions and solve problems themselves.
- 3) ‘The Kids are Alright’ -The adolescent who reported that they socialised with friends with limited adult support. This could include reporting positive feelings and positive self-perceptions, such as those associated with significant involvement in watching YouTube and gaming.
- 4) The adolescent with a ‘Cornerstone Protective Factor’ – adolescents who reported one key protective factor that helped in relation to multiple stressors (such as an extremely supportive mother) but few other forms of support.
- 5) The adolescent ‘On Shaky Ground’ – the adolescent who described many stressors and ambivalent protective factors in relation to reported stressors (in that they fluctuate between being protective and being a source of risk or it is unclear whether a structure that may be supportive, such as the family, has not been clearly reported as increasing mental well-being). ‘Ambivalent’ referred to

factors for which it is unclear whether they are protective or not, such as a supportive parent that also is reported to have maltreated the participant, e.g., through instances of corporal punishment. Or, to take another example, friends that provide emotional support but engage in misconduct at school and increase the risk of disciplinary consequences at school.

### **5.2.3.3 Step 3 - Selecting optimal cases**

As outlined, optimal cases were selected through reading the case constructions within each ideal type. *Optimal cases* refer to cases that represent the rest of the cluster of cases with the best fit (Wachholz & Stuhr, 1999). The optimal case provided an example for comparison with other cases (Wachholz & Stuhr, 1999). Unlike the optimal cases, not all cases assigned to each type were an exact fit with that type, and thus stronger (most commonalities with the optimal case) and weaker cases (least commonalities) were found in each type. However, to be allocated to an ideal type, cases must represent the optimal case to varying degrees (Kühnlein, 1999). Tentative descriptions of each type were written based on the optimal case for each type.

### **5.2.3.4 Credibility and consistency checks**

As discussed in Chapter 2, it was important to recognise the role of myself as a researcher, and the influence of subjectivity and sources of bias, in the research design, data collection and analysis. This necessitated an awareness that I (my person, identity, and my prior knowledge) could have an effect on the collection and analysis of data. For instance, during the analysis for this study, I was also in the process of interviewing the same cohort in the second timepoint of the QLS. Subsequently, in some cases I had some knowledge of participants' outcomes in the following year, which I had to ensure did not influence my analysis. I was also aware of the fact that individual interviews where the adolescent had shown a lot of emotion or made a safeguarding disclosure (such as severe bullying) made a greater impression on me than interviews with adolescents who reported to experience fewer stressors or expressed less emotion. Thus, I had to ensure that this also did not influence my analysis, such as encouraging me to prioritise a particular case over another, due to how well I remembered the specific stressors that they had encountered in the second timepoint. To manage this, my analysis was checked by colleagues (as detailed further below). I also kept field

notes of my biases and assumptions throughout my analysis and reflected on my interview technique after each interview. This helped by writing about how I felt in response to some of the stories that I heard and how I handled specific disclosures as well as reflecting on other factors that influenced the interview and my performance as an interviewer.

Following Werbart et al., (2011), the emerging typology was also audited by Dr Emily Stapley (ES), my supervisor, experienced in ideal-type analysis and highly familiar with the HeadStart dataset. I provided ES with paper copies of all 63 case reconstructions and the type descriptions for each type. Applying the descriptions, ES then sorted the cases into the five types that I had initially constructed. Through this process, ES suggested collapsing the ideal types 'the Kids are Alright' and 'the Cornerstone Adolescent' into the other types, due to the similarities between the cases assigned to them. The final types were, then: the 'Well Supported Adolescent', 'the Self-Protective Adolescent' and 'the Adolescent on Shaky ground'.

Additional input was then also sought from an individual who had not at this point been involved with the QLS or the methodology of ideal-type analysis. A research assistant at EBPU, Rosa Town (RT), gave feedback on the descriptions of the types and the case reconstructions. For example, RT expressed that the designation of 'the Well-Supported Adolescent' was confusing or misleading because some of the cases in this category also reported some stressors (and, therefore, it was clear that they were unsupported). RT added that 'Well-Supported' implied a value judgement that the adolescent would not come to harm. This commentary and input influenced me to rename the type to 'Multiple Sources of Support'. This category allowed for many layers of support that overall were helpful. Adolescents in this type could have experienced some difficulties, or based on their reports, some areas of support that were perceived as less helpful than others. However, overall, the support was adequate or even well-received in relation to particular stressors and increasing mental well-being.

In addition, RT queried the issue of how to treat cases that emphasised friends as a source of support and whether these were a distinct category. Initially, the 'Kids are Alright' type was devised for adolescents who drew substantial support from friendship groups and spoke in-depth about their friends and peers. However, in light of both ES

and RT's suggestions, I decided that support from friends should remain a variable within all three categories, as all three types involved discussion of friendships, but the role of the friendships as a source of support was different for the three types. For the 'Adolescent on Shaky Ground', friends could be an uncertain source of support or lead them into deviant behaviour. In contrast, for the 'Self-Protective Adolescent', friends could be a possible source of positive support (such as in terms of someone to have fun with or to provide support for), and for the 'Well-Supported Adolescent', friends were another strand of support amongst many strands of helpful support.

The three developing ideal types descriptions and names were then reviewed by my supervisory team. At this stage, there were some queries about the use of language employed for the 'on Shaky Ground' ideal type as it was felt to provide a general metaphor (an unstable base of support), rather than a precise description of the type. Miranda Wolpert (MW), suggested an alternative name of 'mixed experiences of support', implying both positive and negative experiences of support and proposed that I clarify the meaning of 'ambivalence' in my description of this type. 'Ambivalent' support referred to participants reporting protective factors, such as parents, that were not experienced as helpful, or where they could not go to them for support. Or, friends that could be helpful at other times, and perceived as a threat, such as source of bullying in another instance. Sometimes, the ambivalence was acknowledged by the participant. In other examples, ambivalence was construed from participants providing conflicting reports in relation to a specific source of support, in the same interview. For example, this label applied to descriptions of a relationship with a parent that was highly valued, but the young person also had concerns about the parent's substance addiction problems. Henceforth my use of the term ambivalence was refined. I considered whether 'uncertainty' was a better construct to use than 'ambivalence'. Uncertainty was preferable because in some cases, the degree to which the protective factor was helpful was not clear from the adolescent's response in the interview.

I then sought the input from a young person as another credibility check, particularly on the language used to describe the types. A Young Advisor (YA) from the former consultancy Common Room provided feedback on the type names. Upon meeting with the YA, I provided the type names with descriptions and some alternative type names, building on prior feedback. After reading the types and the type descriptions, the YA

considered the use of language of the types from a young person's perspective. This YA suggested that use of the term 'on Shaky Ground' sounded pre-disposed towards a negative outcome and that it implied that the young people in this category "were not going to get better". The YA also experienced the language of this type to be too informal for a mental health setting. In contrast, she felt that 'Uncertain Sources of Support' captured the type without evoking a negative trajectory. She explained that she found that the adolescent with 'Multiple Sources of Support' to be useful framing. However, she found the 'Self-Protective Adolescent' type confusing as to whether the young people within this type had some type of psychopathology or not. I agreed and realised that self-protective could be interpreted in different ways and RT had raised a related concern. As all of the types were independent of the presence or absence of psychopathology, I suggested the term 'Self-Initiated Forms of Support' as an alternative and she found the language to be clearer.

Following other studies employing ideal-type analysis (e.g. Philips, Werbart, Wennberg, & Schubert, 2007; Werbart et al., 2011), an independent co-judge then re-sorted the case reconstructions again, using my descriptions of the three types. The independent co-judge, JD, had in-depth knowledge of the definition of mental well-being applied in this study and the study of protective factors, but no previous experience in conducting ideal-type analysis. I provided JD with the type descriptions and a table in Excel within which to allocate types, blinded to their original allocation. I then reviewed where her sorting differed from mine in a spreadsheet of differences in allocation. JD's coding of the cases had 70.96% agreement with my own. I then systematically explored any of the differences in allocation and reached agreement with JD, noting reasons for initial allocations and changes. For example, for two cases (that were originally sorted as SIFS and MSS) we reached agreement that there was sufficient ambiguity in the protective factors to make the participants eligible for the 'Uncertain Sources of Support' category.

#### **5.2.3.5 Types finalisation**

The three ideal types of reported protective factors in relation to mental well-being and risk of psychopathology derived from the first half of the dataset were: The adolescent with '*Uncertain Sources of Support*', the adolescent with '*Self-Initiated*

*Forms of Support*' and the adolescent with '*Multiple Sources of Support*'. The second half of the dataset ( $N = 32$ ) were then assigned to the same three types. Each case clearly reflected one of the three types, except for two cases. A clear audit trail of the reasons for inclusion for each case was kept, along with a record of discussions with ES and JD concerning two cases for whom it was not immediately clear to which type they belonged to. These two cases were discussed until consensus on the types to which they should be assigned was reached.

Specifically, the first case was difficult to classify for the following reasons. The participant described experiencing a protective factor of HeadStart support. He described that this factor was the main type of support that he had received in relation to most of the stressors that he had experienced. Due to reporting only one protective factor, he was not obviously categorised as '*Multiple Sources of Support*'. However, due to the support being externally provided to him, and him reporting that it had helped him in relation to risk, it was agreed that he was in fact most eligible for the '*Multiple Sources of Support*' category, albeit as a 'weak' case. This was a case where the attributes were much less strong than was typical in the optimal case. In the second case, allocation was unclear because the adolescent described experiencing multiple forms of support but did not report these to be effective in the context of a high number of stressors. Through careful review of the case reconstruction, it was agreed that this case was eligible for the '*Uncertain Sources of Support*' ideal type because of the stressors reported where there was no concomitant support in place.

### **5.3 Results**

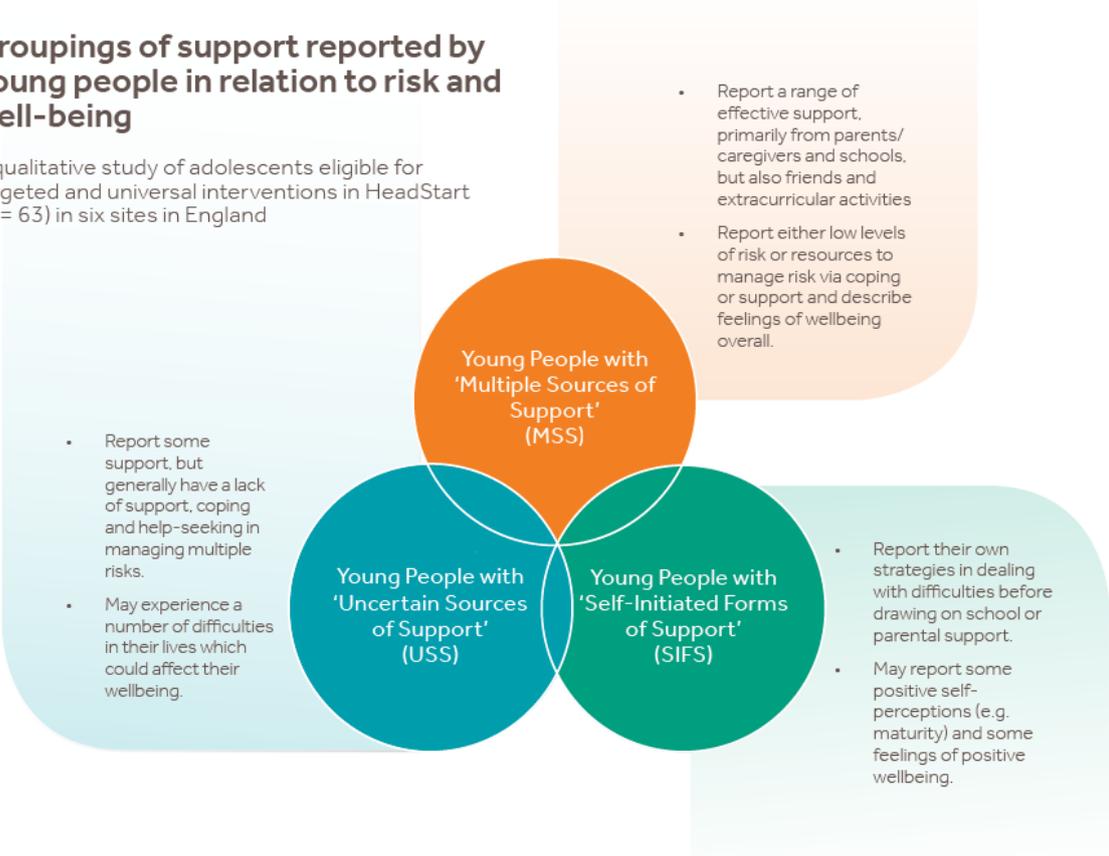
Three ideal types of reported protective factors in relation to mental well-being and risk of psychopathology were found through application of ideal type-analysis. The types were: The adolescent with '*Uncertain Sources of Support*', the adolescent with '*Self-Initiated Forms of Support*' and the adolescent with '*Multiple Sources of Support*'. The number of participants assigned to each type is provided in Table 5.1. The most common type was the adolescent with '*Uncertain Sources of Support*' ( $N = 35$ ) and the least common was the adolescent with '*Self-Initiated Forms of Support*' ( $N = 7$ ). A description of each ideal type is given in this section, together with a description of the optimal case for each type.

**Figure 5.1**

*Three Ideal Types of Adolescents in Relation to Mental Well-Being and the Risk of Psychopathology*

**Groupings of support reported by young people in relation to risk and well-being**

A qualitative study of adolescents eligible for targeted and universal interventions in HeadStart (N = 63) in six sites in England



**Table 5.1**

*Number and Percentage of Participants in the three Ideal Types, by Number of Males and Females*

Gender	The adolescent with 'Uncertain Sources of Support' <i>N</i> (%)	The adolescent with 'Self-Initiated Forms	The adolescent with 'Multiple Sources of Support' <i>N</i> (%)
Males	18 (51.42%)	5 (71.42%)	12 (57.14%)
Females	17 (48.57%)	2 (28.57%)	9 (42.85%)
Total	35 (55.55%)	7 (11.11%)	21 (33.33%)

*Note.* The first two data rows show the number *N* (and %) of M and F within each type; the bottom row shows the number (and %) of adolescents belonging to each ideal type out of the total sample *N* = 63.

### **5.3.1 Ideal Type 1: The adolescent with 'Uncertain Sources of Support' (USS) in relation to mental well-being and the risk of psychopathology**

The adolescent with 'Uncertain Sources of Support' (USS) referred to adolescents who reported a few protective factors, but some of these protective factors were not perceived to alleviate the effects of a stressor, could be inconsistent, and some reported factors could be sources of risk. Adolescents in this ideal type also reported a lack of sources of support and a lack of effective coping and help seeking in relation to a range of stressors. A total of 35 cases (55.55% of the total sample) represented this type - the adolescent with 'Uncertain Sources of Support'. The number of males found in this type was slightly higher than the number of females: *N* = 18 (51.42%) as compared to *N* = 17 females (48.57%). In this ideal type, just over half of the cluster did not report receipt of any type of HeadStart support, *N* = 18 (51.42 %), and the remainder reported that they had received HeadStart support *N* = 17 (48.57%). Interventions received included peer mentoring, supported volunteering, restorative communication psychoeducation programmes, and one-to-one support programmes.

## **Ideal type description for ‘Uncertain Sources of Support’ (USS)**

The USS adolescent tended to describe having few protective factors in a context of multiple reported stressors, some of which could be described as severe and were risk factors for poor mental well-being or risk of disorder. Some factors were reported as protective, as well as sources of risk in other vignettes in the adolescents transcript. For example, a parent that was sometimes supportive and other times highly critical or there has been episodes of maltreatment. The following example is an instance of an uncertain protective factor: In relation to his family, Freddy reported a “happy relationship” with his father. However, he also mentioned that on one occasion his father hit him.

Some coping strategies were described that would potentially constitute types of maladaptive coping, such as aggressive behaviour as self-defence or staying home from school to avoid bullying. Within the USS type, some severe and/or chronic types of risk were described, with the precise collection of stressors unique to each participant. Some of the adolescents in the USS type experienced a high number of stressors (more than three or four, as can be seen in the optimal case). This included risk at the level of the self, including behaviour issues and difficulties managing thoughts and emotions; at the level of the family, including parental unemployment, family poverty, parental disability, conflict in relation to separation and family transitions, and separation from biological parents; with friends and peers, including negative peer influence, bullying, and fights; associated with school, including behaviour issues at school, difficulties with a specific teacher, school exclusion or risk of exclusion, difficulties with schoolwork, worries about school, and behaviour deemed not acceptable by the school, such as dyeing hair.

### **Optimal case for the USS type: ‘Freddy’**

*Freddy described himself in the interview as the most “intelligent” and the “smartest” of his immediate peer group but reported that he struggles with difficulties at school, particularly around managing his behaviour. In relation to his family, Freddy reported a “happy relationship” with his father. However, he also described that his father had hit him on one occasion. In terms of his relationship with his mother, Freddy reported that he feels there is a lack of “respect” in the relationship and reported that his mother had been hitting him frequently and criticising him*

for “talking smart”. He described that he subsequently speaks to his two grandmothers about the abuse as a means of receiving support. Freddy also reported feeling threatened by his mother’s current partner and discussed having a difficult relationship with him, whom he feels allies with his mother against him in arguments. Freddy described that he finds the relationship with his sisters to be strained. He went on to describe that he does not get much support with “being a boy” at his mother’s house. He described that he feels that he experiences a double standard relative to his other family members and that this is instigated by his mother.

On the topic of support for issues he experiences at home, Freddy reported to have a range of people that he could call via his mobile phone, but in circumstances when he needs support he is reticent to ask for help, specifically about family issues. Freddy referred to scrolling through his contacts on his phone during such occasions but not actually calling anyone for help. He explained that the reason that he did not seek help was for fear of burdening others. Freddy described, “To be honest, I don’t wanna be putting my own problems on other people. Like, it’s, it’s something that I have to deal with myself, and if... I really do need help... I’ll know who to get it from.” Later in the interview, he reported that, overall, he felt able to draw on his grandmother, his father, and his friends at school for support when needed. Freddy then discussed coping with difficult feelings in relation to life at home. In these circumstances, he found that holding a favourite stuffed animal helped him to feel better when he is sad.

Freddy talked about his parents’ separation, which occurred in his early life, and explained that he viewed this event as a present-day source of unhappiness. He did not mention any support in relation to the separation or support for his difficult thoughts and feelings in relation to it. When asked about what he enjoyed in life, Freddy reported that he particularly enjoys colours and described that his love of colours was something that contributed to his well-being. Day-to-day, he recounted that he will “act happy” and “sugar coat” his feelings with others when he is sad or angry. Freddy discussed difficulty with managing feelings of fear, anger, and sadness. On the other hand, he mentioned that when he does have the opportunity to “be himself”, he feels happy.

Freddy discussed dealing with his anger through sadness and “crying out” his feelings, which occurs both at home and at school. When he cries at school, he reported that he is sometimes mocked by peers and that leads to fights and conflict. Freddy discussed that watching TV and relaxing and “chilling” with his cat are all things that he knows make him feel happy.

*Freddy described that he had a good relationship with his HeadStart mentor as part of the support provided by HeadStart. Freddy explained that he feels that he can trust his mentor after having been teased at school for other aspects of his life. In particular, Freddy appreciated being able to share his thoughts and feelings privately with the mentor. Freddy also mentioned a memorable mentor in primary school whom he also found helpful at an earlier age.*

*In terms of his friendships, Freddy reported being part of a group of “troublemakers” at school. He described this group as “smart”, but also frequently getting into trouble. He liked the group and gave the example that they help each other to make new friends, and he feels that he is quite popular. Whilst he values this friendship group, he worries about the risk of being excluded for his bad behaviour and losing the friendships he has made at his current school.*

### **Other cases in the ‘Uncertain Sources of Support’ (USS) type**

Within the USS type, a range of cases reflected the definition of the ideal type, including both stronger cases (sharing many similarities with the optimal case) and weaker cases (containing fewer similarities). Strong cases in this type were those participants who stressed ambiguity in the support that they received or could access or an absence of support in relation to risk. For example, Adam reported a period of time in which he was being bullied and stated that he was reluctant to seek help from his parents due to the bully’s parents’ friendship with his parents. He was worried that the bullying would reoccur: “[I feel] kind of insecure, because now, whenever, like, one of my friends does something, like, just for banter, I get really worried that something might start up again, and it really worries me.” This case differed from the optimal case because there was an ambivalence in terms of the support available to him, but some of the support, such as support from his new friendship group, was reported to be effective.

In other cases, an adolescent may not have reported support to be helpful for all stressors, but that it can be effective for some aspects of a stressor. For example, in one case, Thomas reported that he felt that support from a learning difficulties professional was not helpful: “Yes, and, like, she made all the things difficult.” He also expressed that her strict discipline helped him with sitting still: “Yes, because I was always getting told off by the teachers saying, ‘Sit still. Other people can do it, why can’t you?’ So, she sort of, kind of did help me sit still.”

Weaker cases in this type were those where it was difficult for the researcher to interpret how severe the level of risk was and how much support was provided to the adolescent overall. In one example, Bethany described that she “mostly” gets on with her dad, but sometimes she finds his rows with her mother and the whole family difficult: “Mum and Dad just have a few arguments here and there, and then, like, Dad just shouts at everyone.” Bethany explained that she adjusted to it: “[Sniffs] Yes, because it’s, kind of, you can kind of get used to it, so if something does happen, just, like, walk into the other room and just leave it. [Sniff].”

Other weaker cases in the USS category were those participants for whom the full extent that the reported protective factor was actually protective (in the sense of reducing the effects of a risk or stressor) was unclear. For example, Mark spoke positively about his computer programming, gaming, and the popularity of his social media channel, saying, “Coding is something I’m really good at.” He then went on to describe that failing in specific games often provoked him to “break things” and “rage”. He reported that his mother stopped him gaming for periods of time: “I’ve had breaks, because, you can imagine, my mum has banned me.” In this example, the participant derived positive feelings from his accomplishments as a “gamer” outside of school, but his gaming also led to externalising behaviour and difficulties managing emotions. His mother provided some level of monitoring of his gaming. Overall, it is difficult to ascertain whether online gaming served as a protective factor, as it is unclear if it has an overall negative or positive effect on the adolescent’s mental well-being from the adolescent’s perspective.

### **5.3.2 Ideal Type 2: The adolescent with ‘Self-Initiated Forms of Support’ (SIFS) in relation to mental well-being and risk of psychopathology**

This type referred to adolescents who described a range of self-initiated protective factors in relation to their mental well-being and risk of psychopathology. A total of seven cases represented this type (11.11% of the overall sample) — the adolescent with ‘Self-Initiated Forms of Support’ — including five males (71.42%) and two females (28.57%). In this ideal type, five participants reported that they had not received any HeadStart support (71.42%) and two participants reported that they had received

HeadStart support (28.57%) (one had received peer mentoring and the other had participated in psychoeducation programmes).

### **Ideal type description for the ‘Self-Initiated Forms of Support’ type**

The adolescent with ‘Self-Initiated Forms of Support’ (SIFS) tended to emphasise their own role in addressing stressors and increasing their mental well-being, above drawing on support from parents or school. Self-initiated strategies included engagement in particular activities (e.g., participation in sport, listening to music or playing games), providing support to family members, supporting, or defending friends, or supporting themselves emotionally, such as managing their emotions or, in some cases, financially.

Adolescents in the SIFS ideal type may have reported receiving some limited support from such sources as parents, friends, family, school, or well-being interventions at school (such as HeadStart). Cases in this category reflected on some of their own capacities at the individual level, (e.g., traits such as being mature or independent) or drawing on inner resources (e.g., self-control and maturity or the capacity to concentrate). Some adolescents classified as SIFS referenced ambitions and/or goals that they are achieving in addition to school, such as advancing in extracurricular activities such as sports or music, or a career goal.

In the SIFS ideal type, reported stressors included family poverty, arguments with siblings, peer conflicts, parental illness, parental isolation, difficulties with schoolwork and relationship issues with parents. Discussions of risk were often less severe than in the USS type. This was due to the fact that in the SIFS type adolescents designated as SIFS described sufficient support in place to manage risks — for the most part they manage themselves and/or they do not mention as many risks and stressors as the previous type. Belonging to this category did not entail being protected against all risks, but it did entail that a participant reported perceiving themselves to be able to cope with risks and having a range of resources that are primarily internal (e.g., maturity and problem solving) and secondarily external (e.g., friends and parents) to draw on.

## **Optimal case for the adolescent with ‘Self-Initiated Forms of Support’: ‘Jamal’**

*Jamal described himself as a “bright kid” who generally does well at school. He reported that he does not like writing because it bores him sometimes.*

*At home, Jamal reported that he has a younger brother who can become aggressive sometimes during play. He described that he manages his response to his brother’s problematic behaviour by ignoring him or calming down until his brother stops misbehaving. Jamal described that his father works nights doing shift work and so he and his brother need to be careful and quiet around the house so that his father can sleep during the day.*

*Jamal shared in the interview that outside of school he is a semi-professional sports player and subsequently has an income stream which he is able to contribute towards the household. He reported that one challenge of having a job outside of school is that sometimes he is taken out of school to attend professional engagements or there is less time for homework when he is in school due to time traveling. Jamal reported that he felt that the private tuition he received whilst he was away from school was better than what he receives in school. His parents support him with his career by arranging and paying for portfolio pictures and participating in skill-building workshops. He explained that such training has helped improve his confidence overall.*

*Sometimes he finds that his peers did not believe him about the events he is involved in, so he finds that a “downside” to his job outside of school. He articulated, “They think it’s great, some people think that I am not doing it, like, they think, they just don’t believe me, and some people just think it’s great. So, I get, I get the bad and the good side of saying that I am a footballer.”*

*At school, Jamal reported that he feels that the experience can be “disheartening” if he does not achieve the grades he hoped to achieve. Jamal explained, “So, my dad was just a bit like... disappointed. Like, he understands like why, and I explained the whole report to him, so in the end we figured, like, we figured out something. But he just said, ‘I want you to work harder next time’.” On this topic, he described that he feels confident that he can work harder to improve his own grades independently. “Yes, sure, I can do work harder to do whatever I like, so I guess I just need to work harder in Year 8.” He described that he finds the workload “hectic” and balancing multiple commitments difficult. “Yes, it can get a bit hectic sometimes, because homework can, like, pile up, as I am going out quite a lot”*

*Jamal explained that if he has a problem, he will discuss it with his mum, and he described their relationship as close in that he feels able to tell her anything. Jamal explained to the researcher that his mother then relays information to his father: "Yes, because my mum really understands about everything, she just understands, so then she can also explain to my dad."*

*In terms of his relationship with his mother, Jamal discussed that sometimes his mother shares things with him that he felt were not appropriate to share with a kid, but he described that he felt it contributed to him maturing earlier. He said, "And, to be honest, they are not things that you should share with a kid, but as she shared that with me, she has been able to tell me quite a lot of stuff and I have understood that, so I have matured from a young age, like, knowing this."*

*Jamal described that the close relationship with his mother affords him a lot of freedom and that he does not feel "restricted," which he views positively. "Like, if I want to go out to my friends, even if it's to [Shopping Mall] by myself, my mum can trust me, because she knows I am a smart kid and I understand, so, I think it's a good thing."*

*Finally, Jamal reported that he dealt with problems primarily by himself. If things become too much he will talk to his mother, but he described that when experiencing difficulty, on balance, he can manage it by himself. Jamal explained that "I have been able to, like, keep myself together when anything is hard. So, like, I just keep it to myself, and it won't affect me either. I will be able to concentrate fine, even though there's things going on in my mind. And even if there is, like, and it's overwhelming, I will just go straight to my mum and tell her."*

### **Other cases in the 'Self-Initiated Forms of Support' (SIFS) type**

Stronger cases in the SIFS ideal type (cases that closely resembled the optimal case above) composed of participants that referred to a pre-eminence of self-initiated strategies in relation to stressors. For instance, a fairly strong case in the SIFS ideal type was provided by Doug who described the protective factor of spending time outside with his friends to help him avoid and manage problems at home. Doug did not discuss any adult sources of support throughout the interview. In this instance, his coping strategy was self-initiated, and reported to be effective.

Weaker cases in the SIFS ideal type (cases that were less similar to the optimal case but who nonetheless still represented this type) described only a few self-initiated strategies or the role of themselves in instigating support was less prominent, or the level of effectiveness of their self-management was less clear. For example, a weaker case was provided by Yusuf, who described the use of self-initiated strategies such as resolving conflicts, participating in extracurricular activities, and using cognitive strategies to overcome negative emotions. However, Yusuf also discussed times when he struggled to manage his own emotions, describing “shouting” or his anger “leaking” out. In this case, he qualified for the SIFS ideal type, but due to some of the strategies not being effective, his was a weaker case.

### **5.3.3 Ideal Type 3: The adolescent with ‘Multiple Sources of Support’ (MSS) in relation to mental well-being and the risk of psychopathology**

The adolescent with ‘Multiple Sources of Support’ ideal type referred to a cluster of participants who reported receiving a range of effective support from school, parents, and/or other external sources in either the presence or absence of reported risk. A total of 21 cases (35% of total sample) represented the adolescent with ‘Multiple Sources of Support’ ideal type, which comprised 12 male adolescents (57.14%) and nine female adolescents (42.85%). Of the MSS cluster, 11 participants reported that they had received some type of HeadStart intervention (52.38%), nine participants reported that they had not received a HeadStart intervention (42.85%) and one participant was unsure whether they had received a HeadStart intervention or not (4.76%). Interventions included peer mentoring, psychoeducation programmes, participating on a Youth Panel and Supportive Education programmes.

#### **Ideal type description for adolescents with ‘Multiple Sources of Support’**

The adolescent with ‘Multiple Sources of Support’ ideal type was characterised by participants’ reports of receiving or drawing on a range of types of support or a prominent type of support from parents/family. Other types of support included that from siblings and extended family, friends, school, and school staff, HeadStart interventions, mental health services or social services, or other types of support provided from the community, such as ECA (sports, creative activities, or Scouts), and places of worship (churches or mosques). Participants in this type reported a type of support, activity or

strategy as positively associated with increased mental well-being. For instance, a female participant reported that she felt happiest spending time with her family. Other protective factors reported by the MSS type adolescent included factors that were perceived to be effective at removing, reducing, or helping them to cope with a stressor, such as a teacher resolving bullying at school or learning support assisting with difficult schoolwork.

The MSS type included adolescents who reported experiencing chronic stressors (and this could be severe, such as long periods of bullying, difficulties with a caregiver and difficulties controlling anger), minor stressors (e.g., occasional sibling conflict or difficulties in a given subject in school or not liking a particular teacher), as well as those who reported either no stressors (no difficulties reported). As compared to other ideal types, participants reported fewer or less severe stressors in this type. An absence of perceived risks and stressors (according to the adolescent's perspective) was assumed when a participant stated "I have no problems in my life" or if an equivalent statement was made that suggested overall feelings of happiness and well-being (e.g., "I am happy with my life").

### **Optimal case for the 'Multiple Sources of Support' (MSS) type: Isobel**

*Isobel reported that she generally enjoyed school and succeeded academically but, at times, felt under pressure from tests: "The tests are a little bit pressurising to me 'cause I don't work well under pressure." Isobel described that she felt like she has achieved something if she has helped another person with a subject that she is proficient in. Towards her schoolwork, she divulged an attitude of perseverance. Isobel described the important role of a teacher early on in primary school that she attributed to her current confidence at school and keenness to participate in activities: "My teacher really boosted my confidence, and then now I like getting involved in different things."*

*In addition to school, Isobel described how being in a school orchestra previously gave her a sense of pride and achievement: "So, yeah, we, we were really proud of that, and, yeah, it was just like having that feeling that you'd done something and achieved it."*

*Isobel reported that adjusting to secondary school and giving up her role in the orchestra (which was part of her primary school) was difficult, as was making new friends following the transition to secondary school. She described, "It was difficult because, like, we didn't have*

*anything to talk about because of you came through from different schools.” In contrast, at the time of interview, she described that her life is very different to how it was during the transition, as she now has an established a group of friends that she likes and feels close to.*

*In terms of life at home, Isobel reported a positive experience of family life. She viewed her parents as supportive of her as a person, her schoolwork, and her extracurricular activities (ECA), she said, “My parents are extremely supportive, so, and, they have... even though they're really supportive, they obviously have boundaries and I'm very loved in my home. I have no problems at home at all.” Isobel described that she talks to her mother about her daily life, and if her mother is busy, she will talk to her father or her friends.*

*Regarding handling difficult situations, Isobel described that sometimes at home she gets angry and then will go up to her room and be quiet on her own. Sometimes she receives disciplinary consequences from school for not doing her homework and explained that these consequences were appropriate as she described doing her homework as “her responsibility”. Isobel reported that her parents have supported her in participating in ECA and trips. In addition, she has been a member of a particular EC group for a long time and describes a sense of belonging from the group, describing the group as her “second family”.*

*On the topic of HeadStart, Isobel reported that she found the HeadStart mentor [an older student that met with Isobel for a set period of time to provide support and problem solving on a regular basis organised through the HeadStart programme] helpful for sharing instances when she got into trouble at school and did not want to share it with her mother: “I don't necessarily wanna tell my mum because then it'll just make it a big thing.”*

*Overall, Isobel reported that she did not have any “big problems” in her life. Isobel reported that she had found that the HeadStart mentoring helped her to express herself and to have more confidence: “It just helps me, like, with confidence, or if I wanna talk about something.”*

*With regard to problems or difficulties, Isobel reported that peer conflicts, both in person and on social media, could be difficult to manage. Isobel then commented that when she finds herself in a peer conflict, she handles it by avoiding it or trying to resolve it. “I'll just either leave the argument or try and sort it out. If they don't listen to me, I'll just be, like, look, bye, I don't wanna talk to you, you're upsetting me”.*

### **Other cases in the ‘Multiple Sources of Support’ (MSS) type**

The adolescent with ‘Multiple Sources of Support’ ideal type included a range of cases unified by participants referencing a range of sources of support in relation to risk

and/or mental well-being (that included parental support). Stronger cases in the MSS type reported support from several of the following sources: parents, siblings, school staff/pastoral staff and/or teachers or head teachers (or Heads of Year), friendships, staff linked with extracurricular activities, adults as part of a religious institution or from the wider community and staff related to HeadStart interventions. Participants in the MSS type referred to their own strengths and generally effective coping strategies or effective support in relation to difficulties.

Weaker cases in the MSS ideal type comprised those for whom there were either not many sources of support or wherein some of the sources of support were mixed; some were effective, but others were not, or where parental support was less prominent. For example, one boy, Sam, discussed finding HeadStart support helpful and described that being part of a youth panel and making decisions made him feel happy. Sam also described enjoying spending time at home. Yet, Sam also described struggling with disruptive peers at school and had had to end a friendship with a boy who was increasingly involved in deviant activities. Sam reported that he could not speak with his parents about his concerns about the bad behaviour of his peers at school because doing so might cause undue “worry” to his mother. Sam’s case represented a weaker type because although he qualified for the MSS ideal type, he was not drawing on parental support and expressed worry, unlike stronger cases who would be more forthcoming about, for instance, seeking support from parents or other sources.

## **5.4 Discussion**

This study developed a typology, using ideal-type analysis, of experiences of protective factors in relation to mental well-being and the risk of psychopathology, as reported by a large community sample of adolescents. The typology, after refinement and input from relevant stakeholders, consisted of three types: The adolescent with ‘Uncertain Sources of Support’, the adolescent with ‘Self-Initiated Forms of Support’ and the adolescent with ‘Multiple Sources of Support’. This section will first situate the findings in the wider literature on protective factors in relation to mental well-being and the risk of psychopathology before considering limitations of the study.

The adolescent with 'Uncertain Sources of Support' ( $N = 35, 55.55\%$ ) was the most prevalent ideal type in the sample. The USS ideal type refers to adolescents who reported protective factors in relation to stressors being absent, variable, or serving as additional sources of risk. This type included adolescents who reported any of the following factors: multiple stressors, insufficient support, a lack of help seeking, a lack of coping and maladaptive coping. When comparing the USS ideal type to other typologies of protective factors, due to the number of stressors that can be construed as risk factors reported by the USS adolescents (e.g. behaviour issues, difficulties regulating emotions, interparental conflict, low SES), this type resembles the 'high-risk' category frequently used in extant typologies, where risk is ranked from low to high (Clark, Cornelius, Kirisci, & Tarter, 2005). The adolescent with 'Uncertain Sources of Support' category might also resemble the 'vulnerable' category in other typologies. In previous studies, 'vulnerable' adolescents refer to young people with an absence of support from parents, school and peers (Copeland-Linder et al., 2010; Solberg et al., 2007).

However, in the USS type in the current study, a distinction is made from 'high-risk' categories found in other typologies because the emphasis is not only on the amount of risk (which is often high), but also on the *perceived quality of support* in relation to stressors. A substantial evidence base has found evidence for the negative, cumulative effects of risk, with the number of identified risk factors being counted to calculate cumulative risk (Evans et al., 2013; McLaughlin & Sheridan, 2016). However, there is less research on adolescents' qualitative experiences of stressors and the extent to which adolescents perceive support to be helpful in relation to a range of stressors and mental well-being. Within the USS ideal type, support is reported as either absent or ineffective in relation to reported stressors that are specific to each participant. Existing research has brought attention to the fact that sometimes mental health support, such as therapy, that are externally provided may be unwanted, unhelpful or resisted by adolescents (O'Keeffe, Martin, Target, & Midgley, 2019; Ungar et al., 2018). Studies also find that adolescents may not seek help when feeling distressed or ask for support with managing stressors (Haavik, Joa, Hatloy, Stain, & Langeveld, 2019; Suka, Yamauchi, & Sugimori, 2016).

The USS type brings attention not only to the tendency of a subset of adolescents that do not to seek help or support, but also to the lack of available or suitable support

for this group. Some reported protected factors can be construed as sources of risk, but also of sources of protection due to reported inconsistencies and ambiguities. Some factors such as parents, caregivers, service providers and friends can be both sources of support and sources of risk or possible harm. Studies have found that whilst support is intended to be helpful and alleviate distress, support provision can inadvertently generate feelings of “inadequacy, indebtedness, and inequity” and extend feelings of distress in the “helped” (Rafaeli & Gleason, 2009). There are other studies that have found that protective factors can also be a source of risk. For instance, a qualitative study with Australian female adolescents found, first, that peers could be dually sources of emotional support and influence adolescents to engage in deviant behaviour (Bottrell, 2009). Secondly, peer networks for adolescents from deprived areas could provide opportunities for belonging and competence that they could not obtain at school (Bottrell, 2009).

Within the USS category, it is possible that some support was received and not helpful, or received and not remembered, or received and not discussed in interview. For these different permutations of support, the concept of *support visibility* is helpful. The idea of support visibility has been advanced as a theory underpinning when support is not noticed or registered (Bolger & Amarel, 2007; Zee & Bolger, 2019). Support that is perceived as helpful is visible, whereas support that is not perceived as helpful is invisible (Zee & Bolger, 2019). Visible support is support that is interpreted as direct support, whereas invisible support is more indirect such as a friend giving an example of how their sister dealt with the same problem (Zee & Bolger, 2019). Drawing on the notion of support visibility (Zee & Bolger, 2019), it is possible that there was an absence of highly visible support for the adolescents in the ‘Uncertain Sources of Support’ ideal type. The visibility of support is also distinct from the positive appraisal of support by the adolescents, but it is likely they are linked.

Resilience research has found that both ‘informal’ and ‘formal’ support systems foster resilience (Pinkerton & Dolan, 2007). *Informal support* systems refer to family, extended family and friends; *formal support* refers to institutions, such as mental health interventions and social services who provide support when informal support systems are lacking (Pinkerton & Dolan, 2007). For USS adolescents, there are potentially shortcomings in available support in both informal and formal systems around the

adolescent, as well as in the adolescent's capacity to negotiate resources from such systems. Pinkerton and Dolan (2007) suggest that the concept of *social capital* is useful for understanding adolescents' access to support. One definition of social capital views it as 'the set of resources that inhere in family relations and in community social organization and that are useful for the cognitive or social development of a child or young person' (Coleman quoted in Field 2003, p. 24). According to social capital theory, adolescents with high levels of social capital can draw on support as needed, and those adolescents with low levels of social capital are less able to cope with stressors and more likely to have lower well-being (Pinkerton & Dolan, 2007). It is possible that adolescents classified as USS had lower levels of social capital as evidenced by reduced reports of effective protective factors and reluctance towards help seeking.

The second type identified in this study was the adolescent with 'Self-initiated Forms of Support' ( $N = 7$ , 11.11%), which was the least prevalent type, comprising five males and only two females. SIFS adolescents drew on their own resources in coping, problem-solving and managing stressors. The SIFS ideal type concurred with current literature in some ways and diverged from it in others. On the one hand, SIFS can be likened to the 'resilient' type found in other typologies (see Solberg et al. (2007) and Ungar et al. (2018)). For example, in Solberg and colleagues' (2007) typology, the 'resilient' category described adolescents who had higher levels of family support, self-efficacy and exposure to violence. SIFS is comparable to the 'resilient' type because the SIFS type had high levels of self-efficacy and more exposure to risk than the MSS type in the current study. However, adolescents in the SIFS type were not characterised by reported higher family support and so in this respect are quite different. Interestingly, this type had some overlap with a definition of resilience that involves the capacity of individuals to navigate their way to support and resources from external systems (Ungar et al., 2008). However, SIFS also diverged from such a definition of resilience because rather than drawing on support from external systems, this adolescent preferred to solve problems alone or drew on their inner resources first.

The autonomous aspect of the SIFS type has some similarities with the 'low-risk, low-resilience' type identified in Ungar et al.'s (2018) study. For example, "a careful read of multiple interviews with Q4 [low risk, low resilience] youth revealed this nuanced pattern of resisting engagement with the supports they needed even when supports

were available.” (Ungar, Hadfield & Ikeda, 2018, p. 287). Some adolescents in the SIFS category in the current study did not take up support (HeadStart or otherwise), seek out support or find support helpful from adults or did not report the experience of support. However, a lack of help seeking was not unique to this type. A lack of help seeking was also found in the USS category, suggesting that there can be a cross-cutting sense of not needing, seeking, and wanting specific types of support (that may be available). Moreover, resisting engagement was not a defining characteristic of SIFS, instead this type was characterised by self-initiated strategies, which makes it qualitatively distinct from Ungar et al.’s (2018) work. In the current study, the main difference between the SIFS and USS type was the self-efficacy of the SIFS adolescent. The SIFS adolescent was characterised by reporting positive traits, such as maturity, and future goals, such as career aspirations. This contrasted with the USS type, who described both a lack of support and a lack of coping with a range of risks and often career and future aspirations were not described.

Within the SIFS type, gender differences were most marked: the majority were male. This finding potentially corresponded with studies that suggest that girls are more likely to engage in help-seeking behaviour than boys (Haavik et al., 2019; Hong, Hwang, Liu, & Peng, 2011). More males within the SIFS type could reflect previous research, which has found that boys are more likely to engage in individualised action towards the stressor (problem-solving) or avoidance coping (avoiding the stressor) (Seiffge-Krenke & Persike, 2017). Females, on the other hand, have been found to be more likely to engage in rumination and emotion-focused coping and drawing on support from others (Eschenbeck, Kohlmann, & Lohaus, 2007; Frydenberg, Lewis, & Frydenberg, 2009). Evidence suggests that *gendered socialisation* (exposure to gendered norms and expectations during childhood and adolescence) encourages males to be more self-reliant, whereas females are encouraged to attend to their relationships with others (Seiffge-Krenke, 2011).

The third type found in the dataset, the adolescent with ‘Multiple Sources of Support’ ( $N = 21$ ), was the second most prevalent type, comprising 12 males and 9 females. The MSS type was generally in agreement with extant literature that links increased support to greater mental well-being (González-Carrasco et al., 2019; Pinkerton & Dolan, 2007). Support has been conceptualised as those acts that meet an

individual's needs, and the links between social support and well-being have been well researched (Cutrona, 1996; McGrath, Brennan, Dolan, & Barnett, 2009). Participants within the MSS type discussed either positive relationships with parents (such as valuing spending quality time with parents), or experiences of positive support from their parents. This finding is in agreement with the notion that the family are the most likely helpers, and can provide support that is dependable and durable (González-Carrasco et al., 2019; McGrath et al., 2009).

In reference to other typologies, the MSS type bears some resemblance to the 'moderate risk/high protection type' found in other typologies of risk and protection (Copeland-Linder et al., 2010). In the 'moderate risk/high protection type', adolescents were found to be exposed to a degree of risk but have high levels of external and internal protective factors to counteract risk (such as high levels of parental support; Copeland-Linder et al., 2010). The MSS type fits with models in the literature that posit that greater numbers of protective factors better protect adolescents against risk and that there are added benefits that result from *cumulative protection* (Hamby et al., 2018; Yoshikawa, 1994). Similarly, it mirrors the *protective-protective* model in which the presence of one protective factor enhances the effect of others (Fergus & Zimmerman, 2004). Many of the adolescents discussed the important role of helpful and positive family support, particularly from parents within this type, in addition to a range of other supports.

Finally, it is worth noting that some protective factors were described by adolescents as helpful for increasing feelings of well-being or reducing stressors such as feeling sad. Participants described coping with feelings through talking to a friend, playing with slime, engaging with colours as a source of happiness, helping a parent at home and spending time outside with large groups of peers. Key themes of a range of coping strategies as articulated by adolescents participating in the HeadStart QLS have been published in a recent thematic analysis of this data (Stapley et al., 2019).

#### **5.4.1 Implications for researchers**

The three ideal types of protective factors in relation to mental well-being and the risk of psychopathology identified here provide a possible new emphasis when

considering the use of language in relation to risk and protective factors. The shift is from a focus on the level of risk (high-risk v. low risk) to a focus on the individually perceived level of support in relation to stressors by adolescents. In many of the current studies on risk and protective factors, the focus is on the adolescent's level of risk (Cleveland, Feinberg, Bontempo, & Greenberg, 2008; Cluver & Gardner, 2007; Cross et al., 2015; Newcomb et al., 2014; Zolkoski & Bullock, 2012). Granted, studies of risk and protective factors are a prestigious and essential body of work in the pursuit of understanding the correlates of positive and negative outcomes in relation to mental health disorders. The terminology of risk factors is arguably also vital in the study of mental well-being, the study of the aetiology of mental health disorders and the identification of factors to address in preventative interventions (Fritz et al., 2018; Gladstone et al., 2011; McGorry, Hartmann, Spooner, & Nelson, 2018; Patalay et al., 2015; Thapar et al., 2013). However, in the context of qualitative studies or studies that work with adolescents, there may be advantages to the use of terms that may be closer to the language that adolescents themselves use. Such terminology could be used in the context of working with adolescents, such as difficulties, difficult situations, coping and support and getting help. Indeed, a 'high-risk' designation may not be appropriate language to use with young people themselves, and scholars have noted that the language of "high-risk" can be deterministic with regard to negative outcomes in the areas of mental well-being and psychopathology (McGorry et al., 2018). Thus, it is extremely important to pay attention to the use of language when both classifying adolescents in terms of levels of risk, and how this may be communicated to adolescents or adolescents that are part of the research process. The approach of focusing on how support is perceived and how much support an adolescent perceives in relation to their difficulties, is an alternative framing from high risk and low risk that can complement existing uses of language within this field.

The other implication is that there may be a discrepancy between the support and difficulties an adolescent identifies and the risk and protective factors identified by parents, teachers, and researchers of relevance to a given adolescent. This discrepancy is potentially important and consideration of both sources of knowledge of risk and protective factors are important areas of scholarship particularly because what may be identified by adolescents may be overlooked by adults. Conversely, adolescents

may be exposed to particular risk factors that they might not be aware of or receive sources of protection that may be beyond their own subjective experience.

#### **5.4.2 Implications for HeadStart and clinicians**

The typology has the potential to serve as a framework to guide a dialogue with adolescents about what support they perceive to be available to them and their perceptions and understandings of what types of protective factors reduce their difficulties in life (Eisenstadt, Stapley, & Deighton, 2019). This type of approach has been proposed by Ungar in his recommendations for the *diagnosis of resilience*. A similar approach has been implemented in some areas within the context of the HeadStart programme within some regions (Eisenstadt, Stapley, & Deighton, 2019; Ungar, 2015). For example, in HeadStart Kent's Resilience Conversations, HeadStart staff have conducted conversations with some adolescents. They have discussed areas of an adolescent's life such as feeling secure, health, emotions and behaviours, education, friendships and talents and interests. Young people have rated themselves within these domains using a Red Amber Green (RAG) scale as a basis for a conversation about support needs (Eisenstadt, Stapley, & Deighton, 2020).

Adolescents that have been found to have characteristics of the 'Uncertain Sources of Support' type may lack sufficient support in relation to stressors or experience barriers to accessing support, particularly when contrasted with the other two ideal types (Eisenstadt, Stapley, & Deighton, 2020). With regard to the adolescents with 'Self-Initiated Forms of Support', an implication for working with this group is that support providers may need to seek out this type and to carefully provide additional support if required. This may entail collaborating with the adolescent to build on current protective factors and help them to explore additional coping strategies or sources of support should it be necessary to manage particular stressors or difficulties (Eisenstadt, Stapley, & Deighton, 2019).

#### *Experiences of HeadStart Support*

In terms of adolescents' experiences of HeadStart support, just over half of the participants in the 'Uncertain Sources of Support' cluster did not report receiving

HeadStart interventions. It is possible that these adolescents with reportedly few reliable protective factors would potentially benefit most from HeadStart support or tailored support. For those in the 'Self-Initiated Forms of Support' ideal type, five males did not report HeadStart support (71.42% of total number of SIFS cases) and the two females in this category did report receipt of HeadStart support (28.57% of total). For those in the 'Multiple Sources of Support' category, a number of these adolescents reported receiving HeadStart support ( $N = 11$ , 52.38% of total) and for some, HeadStart was reported as a helpful protective factor in relation to managing emotions and stressors such as managing peer conflicts. For those that did not receive HeadStart support in the MSS category ( $N = 9$ , 42.85% of total and one individual was unsure if they had received it or not, 4.77%). These MSS adolescents still reported a range of effective protective factors, such as positive and close relationships with parents, connection to school, ECA and others, such as positive self-perceptions.

Whilst the typology requires further testing it does show evidence of potential beneficial application with adolescents. Using the typology, a clinician, a teacher, a resilience practitioner, or a school mental health worker could consider which type an adolescent resembles based on their own knowledge of the adolescent and through conducting an interview with the adolescent. A member of staff could conduct an informal interview seeking to ascertain the adolescent's perceptions of their stressors and protective factors, and then use the typology provided here to allocate the adolescent to a type and to guide support provision. Using this typology entails asking questions directly from adolescents in order to understand their perceptions and experiences of stressors and protective factors, such as:

- *Quantity of support:* How much support does the adolescent perceive to be in place?
- *Quality of support:* How effective does the adolescent perceive the support to be in relation to stressors?
- *Support in relation to stressors:* What stressors are experienced, what protective factors are in place?
- *Adolescent's own role in support:* How does the adolescent perceive their own role in relation to that support (e.g., are they self-initiating it or is support being provided to them)?

- *Coping strategies*: How do they cope and manage difficult feelings and do they feel these coping strategies to be effective?
- *Help-seeking*: If they do seek support, how and where would they go?
- *Alternatives to external support*: Who do adolescents communicate to when support is not perceived to be effective (if at all)?

### 5.4.3 Limitations

Whilst the language of the ideal types was checked with a young person, further work could be done to understand how adolescents perceive the typology and the extent to which they perceive the types to fit with their experience, as a form of member checking (Lincoln & Guba, 1985; Thomas, 2017). As this study was part of a broader study where the necessary ethical permissions for this were not obtained, nor were participants' contact details obtained, it was not possible to send case reconstructions or the typology to participants for member checking.

Another limitation concerns the fact that the research team's knowledge of participation in HeadStart interventions (and indeed all other types of support) was limited to what participants self-reported in their interviews. This meant that the team did not know for certain that what support participants reported (HeadStart or otherwise) represented what they had actually received. Indeed, this study did not aim to collect reports from other sources about all of the types of stressors and protective factors in an adolescent's life and so is based only on adolescents' accounts. The advantage of examining adolescent accounts in isolation was that the data was limited to how an adolescent perceived their support at one point in time, so it provided a sense of the lived experience of an adolescent. However, it was also a limitation because it only provided a partial view, and there may be support that participants received but forgot to mention or did not want to discuss. A related point is that participants could have been experiencing risks that were too sensitive to discuss with a researcher. Such difficulties might be absent from the data, analysis, and type allocation. The implication of this is that other sources of data about the adolescent would be required in the precise assessment of risk assessment, needs and support provision.

Another limitation is that without further confirmatory evidence of these types applied to other groups of adolescents, it would be difficult to generalise the findings from this study to other samples. Qualitative research is not expected to be generalisable in the statistical meaning of using a representative sample to apply results to a broader population (Leung, 2015; Smith, 2018). However, scope remains for other types of transferability (Smith, 2018). Some researchers have suggested that the issue of generalisability should not be ignored in qualitative research, and instead, a naturalistic type of generalisability is possible (Smith, 2018; Tracy, 2010). This type of generalisability would involve the study of testimonies and reports that could have relevance to other populations (Smith, 2018; Tracy, 2010).

In line with standards of quality in qualitative research, the research design for this study is replicable (Shenton, 2004). Another study could administer the same interview schedule, apply the same definitions of risk, protective factors, and mental well-being, use the same format for writing the case reconstructions, follow the same procedures to generate the ideal types and process of independent sorting. This study followed the steps of Werbart et al., (2011) for conducting ideal-type analysis. The study could be replicated with other samples to find whether the same ideal types of the present typology could be applicable to other groups (Silverman, 2009).

As described, many studies take a narrower approach to the study of risk and protective factors in that they examine one or a small number of variables or only look at these variables in relation to one specific outcome. However, because the focus here is on adolescents' perceptions of support, coping and help-seeking in relation to well-being, taking a broad view to the study of risk and protective factors was a unique aspect of this study. It is possible that protective factors that reduce risk and increase subjective well-being are not neatly separable, as often studied, because in reality the relationship between factors that promote well-being and those that mitigate against risk of poor mental health is overlapping and intertwined.

#### **5.4.4 Future research**

It is well-established that adolescents who are resilient at a given point in time may have difficulties in adaptation at other times and in other contexts protective factors are

contextual and dynamic (Hawley & DeHaan, 1996; Ungar, 2015; Werner & Smith, 2001). From accounts provided at one point in time, it was difficult to ascertain how temporary or enduring a given protective factor is and, indeed, variability in protective factors over time has been established (Ungar, 2015). Understanding how enduring a protective factor is requires a longitudinal approach examining more than one timepoint. Future studies could, therefore, examine whether the typology of reported protective factors would describe case constructions of the same cohort a year later to explore patterns of stability and change. Longitudinal studies are well-suited to examining developmental changes and how these influence patterns in risk and protective factors (Laursen & Hoff, 2006).

Moreover, if, as has been proposed within this study, in subsequent timepoints in the QLS, we could anticipate positive outcomes for the MSS ideal type. This is based on the notion that multiple protective factors have a cumulative protective or a *protective-protective* effect (where the effect of one protective factor has a positive effect on another factor) (Brook, Brook, Arencibia-Mireles, Richter, & Whiteman, 2001). Thus, future studies could examine if this hypothesis is correct or a range of subjectively reported protective factors are not associated with increased mental well-being over time. Equally, understanding factors that may disrupt patterns in reported protective factors and observance of changes in either a positive direction (e.g., more protective factors that are effective) or a negative direction (e.g., fewer, and less effective protective factors) would be helpful to potentially explore the antecedents of changes in well-being and the precipitates of psychopathology over time. Indeed, it would be helpful to understand if reported protective factors change with the passage of time and development, or in relation to particular stressors or external events. It is known that as adolescents become older, the role of peer support becomes more significant, for example (Keijsers, Branje, VanderValk, & Meeus, 2010; Rice & Dolgin, 2008).

It would also be interesting to explore further the possible benefits of self-initiating strategies and whether this derives from the individual adolescent or a consequence of actual support available in the surrounding environment. From one perspective, these adolescents could be more precocious, displaying more maturity and autonomy. From another perspective, their avoidance of external support suggests that they could lack support-seeking skills. External support such as parental support and teacher support

and help seeking skills are generally linked with greater well-being (González-Carrasco et al., 2019; Lambert et al., 2014; Oberle, 2018). Thus, there may be benefits to support seeking for these adolescents that they may not be accessing, thus, further inquiry into the SIFS type could be illustrative.

## 5.5 Conclusion

This study applied ideal-type analysis, a person-centred, qualitative approach, to form three ideal types of protective factors in relation to mental well-being and the risk of psychopathology. The typology groups and highlights adolescents' different perceptions of their reported stressors and protective factors that encompass help-seeking, coping, support and relationships, and activities that are reported to help or increase feelings of mental well-being. The typology shifts the emphasis from the number of risk and protective factors, or level of risk and level of resilience, towards the overall experience and perceived quality of protective factors in relation to mental well-being and risk of psychopathology. An emphasis away from risk, towards stressors and support, may have the potential to be less deterministic, and more adolescent-centred when speaking with adolescents themselves.

The three ideal types derived in this study comprised: the adolescent with 'Uncertain Sources of Support', the adolescent with 'Self-Initiated Forms of Support' and the adolescent with 'Multiple Sources of Support'. The typology draws attention to the quality and subjective experience of existing forms of support that could potentially have utility in identifying gaps in perceived support provision. The case reconstructions demonstrated that the profiles of risk and protective factors are unique to each adolescent, as are the specific factors that are perceived to be most helpful, yet broad patterns can be identified across adolescents' experiences.

The typology potentially adds a new conceptualisation to extant literature on risk and protective factors in relation to mental well-being and the risk of psychopathology in adolescents by focusing on adolescent perceptions. Currently, many typologies are geared towards risk and protective factors in relation to a specific outcome such as the risk of substance use or peer and dating violence perpetration (Clark et al., 2005; Foshee et al., 2011). Existing typologies also focus on classifying adolescents as having

high or low levels of resilience or vulnerability (Copeland-Linder, Lambert, Chen, & Lalongo, 2011; Solberg et al., 2007). Within the study of risk, the focus is often on counting or measuring risk factors using quantitative methods (Appleyard et al., 2005; Evans et al., 2013; Hebron et al., 2016; McLaughlin & Sheridan, 2016).

Finally, through a development of an ideal types typology, this study has suggested that an emphasis on adolescents' perceptions of protective factors in relation to stressors is beneficial. It is proposed that a departure from designations of adolescents according to high, medium, and low risk may be helpful to use language that is closer to adolescents themselves, as well as assess adolescents own appraisal of support. The proposed alternative involves classification of adolescents at risk of poor mental well-being and psychopathology based on their own self-report of how much support is available and attitudes towards the uptake and quality of support.



Chapter 6. A Qualitative Study of Changes in Reported  
Experiences of Protective Factors in Relation to Mental Well-  
being and the Risk of Psychopathology over the Course of One  
Year for  
10- to 13-year-olds.

## **6 A Qualitative Study of Changes in Reported Experiences of Protective Factors in Relation to Mental Well-being and the Risk of Psychopathology Over the Course of One Year for 10- to 13-year-olds**

### **6.1 Introduction**

In the previous chapter, a person-centred typology of protective factors in relation to mental well-being and the risk of psychopathology was constructed using ideal-type analysis. It was postulated that further study, building on the previous research, could seek to understand if the ideal types maintain over time or no longer applicably describe the data of the same cohort of adolescents. This may enable understanding of, firstly, changes in reported protective factors over time after one year. Secondly, it may enable insight into the factors that contribute to mental well-being and the perceived role of protective factors in abating poor well-being and the risk of psychopathology. Consequently, the aim of the current study was to address the following research question: How do adolescents' experiences and reports of protective factors in relation to mental well-being and the risk of psychopathology *change* over the course of one year? This study set out to describe patterns of stability and change in adolescents' lived experiences of protective factors (in relation to mental well-being and psychopathology) over a one-year period.

Within existing literature, researchers have recommended that the study of protective factors benefits from longitudinal study (Eriksson et al., 2010). For example, Eriksson and colleagues stated, "The only way to truly study the development of individuals, including understanding protective factors, is to conduct prospective longitudinal research." (2010, p. 481). However, there is an absence of adolescent perspectives in the literature on this subject using data from qualitative longitudinal studies (Bellis et al., 2017; Ungar, 2015). This is despite the fact that adolescent voices are a rich repository of information about their experiences of their lives (Claveirole, 2004; Morrow & Richards, 1996).

Evidence suggests that specific types or domains protective factors may exert a more protective effect for different age groups over the period of adolescence (Cleveland, Feinberg, Bontempo, & Greenberg, 2008; Hawkins, Catalano, & Miller, 1992). For example, Cleveland and colleagues (2008) studied risk and protective factors linked to drug use in a sample of an American high school students (grades 6, 8, 10 and 12) and found that factors relating to school were more protective against risk of alcohol and marijuana use for the older adolescents (grades 10 and 12), as compared to the younger adolescents (grades 6 and 8). Further, the study found that community level protective factors had no effect for the older grades, but they did for the younger students, in relation to binge drinking and marijuana use (Cleveland, Feinberg, Bontempo, & Greenberg, 2008). This study brings attention to the ways that protective factors can be effective for specific age groups, as well as how protective factors can be situated in a specific domain (such as school) in relation to risk of the outcome under study.

Research has investigated changes in protective factors across adolescent development (Kim et al., 2015; van der Put et al., 2011). An American study used data from the Community Youth Development study that was a community randomised trial of Communities that Care (an intervention to prevent problem behaviour in American youth) (Kim et al., 2015). The study used a control sample of 2,002 participants from 7 states to examine the normative development of adolescents in 5<sup>th</sup> to 12<sup>th</sup> grade (ages 10- to 18- years-old) as part of a community randomised trial (Kim et al., 2015). Multi-level models were used to examine the change in protective factors over time. Kim and colleagues (2015) found that protective factors reduced in number towards the end of primary school but started to increase in secondary school. Further, a greater number of protective factors were reported by females than by males (Kim et al., 2015). Whilst connection to school was found to decrease amongst older adolescents, a number of new protective factors were associated with the transition to secondary school, such as: “opportunities and recognition; school opportunities, recognition, and academic success; prosocial involvement; and interaction with prosocial peers.” (Kim et al., 2015, p. 17).

The study of changes in protective factors in relation to mental well-being and risk of psychopathology is particularly relevant to the period of early adolescence (Deighton,

Yoon, & Garland, 2020; Kessler et al., 2007), the population of interest in the current study (the age range of participants is 10.07 to 13.90 years). Over this period, early adolescents are transitioning from childhood to adolescence, entering puberty and experiencing new stressors (Berg, Simons, Barr, Beach, & Philibert, 2017; Schaffhuser, Allemand, & Schwarz, 2016). The associated morphological and physical changes (Benjet & Hernández-Guzmán, 2002; Ebling, 2005), changes in the brain (Fuhrmann, Knoll, & Blakemore, 2015b; Paus, Keshavan, & Giedd, 2008), changes in self-perception (Hyde, Mezulis, & Abramson, 2008), and transitions mean that adolescents are potentially more vulnerable to stressors and the development of psychopathology (Gunnar, Talge, & Herrera, 2009). Accordingly, new protective factors, such as an increased range of coping strategies, may be required to manage new stressors (Kim et al., 2015).

In parallel, early adolescence involves increased autonomy and new emotional ties to others, particularly peers outside of the family — this is considered a developmental task of adolescence (Allen & Loeb, 2015). Studies have found that adolescents increasingly prefer to spend time with friends as they grow older — such friends take on increased significance to adolescents and contribute to their happiness (Allen & Loeb, 2015). The heightened influence of peers can lead to both positive and negative outcomes, such as a sense of belonging, but also engagement in risky behaviours and managing conflicts (Allen & Loeb, 2015; Gardner & Steinberg, 2005; Steinberg, 2007). Relationships with adults within the family can have an influence on how adolescents navigate closer peer relationships (Allen & Loeb, 2015).

Research has explored the differential effects of protective factors, including the impact of various types of support (e.g. parent, friend, teacher) on outcomes such as depressive symptoms (Pössel et al., 2018). Studies have examined whether support can buffer the effects of specific stressors or whether support is helpful for adolescents regardless of the types of stressors that they experience (Dumont & Provost, 1999; Pössel et al., 2018). Overall, further research is needed on the subject of age-specific stressors, with particular attention paid to the ways that stressors may link with mental well-being and change over time (Anniko, Boersma, & Tillfors, 2019).

To explore change over one year in early adolescents' experiences of protective factors and thus address the aim of the current study, this study will use the typology developed in the previous study as a starting point for longitudinal analysis. The typology consisted of three overarching types of adolescent experiences of protective factors in relation to mental well-being and the risk of psychopathology:

**Ideal Type 1: The adolescent with '*Uncertain Sources of Support*':** These adolescents tended to report having highly uncertain forms of support in their lives and/or a lack of support or coping strategies in relation to a range of stressors that negatively affect mental well-being, or they may be receiving support but they do not find it helpful or effective. They may report sources of support that are at times supportive and unsupportive or a source of risk at other times, such as a close friend that diverts them into acts of misbehaviour. They often report a lack of coping strategies, or a lack of help seeking, or describe finding coping with specific stressors difficult and may report coping strategies which can link to negative outcomes, such as aggression towards peers.

**Ideal Type 2: The adolescent with '*Self-Initiated Forms of Support*':** These adolescents tended to describe having a range of self-initiated protective factors in relation to risk, and a degree of agency or self-reliance in the way that they approach problems or how they cope with specific stressors. In their accounts, there was a prominence of self-initiated coping (such as changing one's behaviour or removing oneself from the situation), as opposed to receiving support from external sources such as school (e.g., teachers) and family (e.g., parents and caregivers). Friends may or may not be a key source of support for adolescents in this type, with some adolescents spending a lot of time with friends and potentially drawing on them for support, or, supporting relationships between their friends, such as helping to resolve conflicts. Adolescents in this type may report some positive self-perceptions or positive internal characteristics, such as maturity, and may report positive mental well-being.

**Ideal Type 3: The adolescent with '*Multiple Sources of Support*':** These adolescents tended to report receiving or drawing on a wide range of types of support or a prominent type of support from parents/family, siblings and extended family, school and/or friends, HeadStart interventions, or other types of support provided from the community, such

as extracurricular activities. These adolescents generally reported positive relationships with parents and school. They may experience some stressors, but they reported that they have support in place that may help them to manage this, or the risk is small relative to the wide range of protective factors that they report.

The definitions of risk factors (Kazdin et al., 1997), stressors, protective factors, mental well-being (Ryan & Deci, 2001) and psychopathology (American Psychiatric Association, 2000) provided at the outset of this thesis have been adhered to within this study, retaining consistency of terminology use (these definitions can be found in the glossary).

## **6.2 Method**

### **6.2.1 Setting for the Study**

This study uses data from the first and second timepoint of the QLS of the evaluation of HeadStart. Please refer to Chapter 2 for further details about the evaluation.

### **6.2.2 Participants**

Semi-structured interviews were conducted with 63 young people in the first year of the QLS (May to July 2017; Time 1), ranging from 12 to 16 per HeadStart partnership. By the second data collection point (April to July 2018), three participants had left the study due to attrition leading to a total of 60 participants. As per the previous year, participants were asked to self-report their age, gender, and ethnicity in a brief demographics questionnaire at the end of their interviews. At Time 1, the participants' ages ranged from 9.10 to 12.9 years ( $M = 11.49$ ,  $SD = 0.92$ ). Participants who did not take part in the study a year later at Time 2 (e.g., because they chose not to or were uncontactable by the research team), and thus only had interview data from Time 1, were not included in this study ( $N = 3$ ). In the Time 2 sample, participants' ages ranged from 10.07 to 13.90 years ( $M = 12.35$ ,  $SD = 2.95$ ), with one instance of missing age data. In the sample, 28 participants (46.66%) were female and 32 (53.33%) were male. Ethnicity data for the sample at Times 1 and 2 is presented in Table 2.2 in Chapter 2.

### 6.2.3 Data collection

As per at Time 1, all interviews at Time 2 were conducted by a member of the QRT and were held in private rooms at participants' schools. Members of the QRT were matched with participants that they had interviewed the previous year to provide continuity of rapport and relationship. The same core interview schedule was used with additional questions and prompts added and some rephrasing. The updated interview schedule is found in Appendix U. At Time 1, the mean length of interview was 39.72 minutes ( $SD = 10.24$ ), and at Time 2, the mean length was 37.15 minutes ( $SD = 12.21$ ).

### 6.2.4 Data analysis

As per the previous study, this study applied ideal-type analysis, using the typology developed in Study 3 to the Time 2 dataset, drawing on the ideal-type analysis methodology described in the previous chapter, originally developed by Gerhardt (1994) and described by Werbart and colleagues (2011). This typology consisted of the three types outlined above: the adolescent with 'Multiple Sources of Support' (MSS), the adolescent with 'Self-Initiated Forms of Support' (SIFS) and the adolescent with 'Uncertain Sources of Support' (USS). The typology provided a framework within which to sort the case reconstructions of the interviews at the second timepoint. Through making comparisons at Time 2, with the type to which each participant had been assigned at Time 1, it was possible to observe patterns in whether an adolescent remained assigned to the same type in terms of their overall profile of stressors and protective factors or to record if they had changed to a new type. For those participants who had shifted type, similarities and differences were recorded, with participants in the same categories having reported the same overall profile of protective factors at both timepoints.

Case reconstructions were written for each of the Time 2 transcripts, as per the guidelines outlined in Study 3. To recap, a case reconstruction is a description or summary of relevant content from each interview transcript. The extracts from the transcripts were selected according to the definition of protective factors from the thesis, i.e., as variables that are perceived to increase mental well-being or decrease the negative effects of stressors. Case reconstructions for each participant were written in the same format as at Time 1 in the previous study, with each stressor and protective

factor written with a supporting quote to provide evidence that it had been reported (please refer to the previous study and to Appendix Y). It was important that each stressor or protective factor was well illustrated by the data. For example, Alex reported that her friend helped her to de-stress when she is feeling under pressure, such as when she has a homework assignment to complete. She explained, “like, if I am stressed about something... let’s say if I can’t do my homework, and it’s like, due in the next day, some of my maths homework, you get that. Like, she’d help me. And like, de-stress me.”

To check that all the relevant stressors and protective factors were extracted from each transcript, I re-read the transcripts and checked them against the case reconstructions. This was to check that all relevant stressors were collected from each transcript. Such an additional check helped to mitigate the risk of omitting particular stressors and protective factors through oversight. My supervisor, Dr Emily Stapley (ES) and a research assistant at EBP, Rosa Town (RT) and I cross-checked the content of the case reconstructions to make sure that they accurately reflected the stressors and protective factors within the transcripts. Where there were any differences in opinion as to what constituted a stressor or protective factor, these instances were discussed and resolved. In some cases, additional stressors or protective factors were selected upon the second reading of the transcript or the paraphrasing in the case reconstruction was sharpened to be as close to the original phrasing as the participant as possible, following the procedure of Werbart et al. (2011).

From reading the case reconstructions, each participant was then allocated to one of the three types in an Excel spreadsheet. Cases that were difficult to classify or a new type were allocated as a separate category. As a credibility check, ES then read the case reconstructions and allocated each participant to the three ideal types. If any of the cases did not fit with the criteria of the type descriptions, these cases could be left unsorted. To minimise bias, the original assignment of the case reconstructions was not provided to ES, so cases were sorted blind. Once ES had allocated all of the case reconstructions to the three types, ES and I discussed any types that we had reached different type classifications for. Rationales for each allocation were given, and a discussion then followed with reference to non-matching classifications. A written record of the rationale for each case allocation was kept including any differences in allocation.

Cases that were either difficult to classify or for which agreement was not easily reached, were designated to a third researcher, Prof Jessica Deighton (JD), for the purpose of an additional perspective on allocation. JD then sorted these cases using the type descriptions (again without knowledge of their previous allocation) ( $N = 4$ ). I then deferred to JD's classification for all cases as the final allocation. Thus, the 'difficult to classify' cases were allocated by at least two out of three reviewers as the same type. As in the previous study, the cases that were most difficult to classify included those where the participant did not explain a given stressor or protective factor clearly, insufficient detail was provided, or there remained a level of ambiguity as to whether a protective factor was helpful, or as to whether risks experienced were indeed problematic for the adolescent's mental well-being. For example, an adolescent may have described a stressor (separation from parent) but not described it as a problem or a difficulty affecting their mental well-being or elaborated on it in detail in the interview, was included under uncertain sources of support. This was decided on the basis that in cases where reported stressors were known to be risks for poor mental well-being (e.g., parental absence, parental mental health disorders, parental substance use addiction) with no clear protective factors described, then an uncertainty of support (but not a lack) was inferred.

Once all of the participants from Time 2 had been allocated to their respective types, the numbers of cases that had remained the same versus the numbers that had shifted type were compared. An optimal case for each cluster of cases (e.g., MSS at Time 1 and MSS at Time 2, or MSS at Time 1 and USS at Time 2) was selected. The optimal case represents a singular case that is the epitome of the type, in that it displays the key characteristics (Lewis-Beck et al., 2004).

### **6.3 Results**

Whilst it was possible that new types would emerge from the sorting of case reconstructions into ideal types, no new types were needed because all of the case reconstructions ( $N = 60$ ) fit within the three existing type descriptions. From examination of which type a case was allocated at Time 1, to which type it was allocated to at Time 2, there were a total of nine possible combinations (three types that stayed the same,

and six types of changes), relating to patterns of continuities and change across the timepoints using the typology. A summary of these combinations is provided in Table 6.1.

**Table 6.1**

*Frequency Table with Numbers of Participants Allocated as Ideal Types of Protective Factors at Time 1 to Allocation at Time 2*

		T2 Ideal type			
		SIFS	MSS	USS	Total
T1 Ideal Type	SIFS	2	3	2	7
	MSS	2	16	2	20
	USS	7	14	12	33
	Total	11	33	16	60

*Note.* SIFS= 'Self-Initiated Forms of Support', MSS= 'Multiple Sources of Support', USS= 'Uncertain Sources of Support.' T1= Time 1, T2= Time 2 of Qualitative Longitudinal Study.

Half of the participants ( $N = 30$ ) shifted from one type to another, though the combinations of these shifts varied. The most common shift within this group was from 'Uncertain Sources of Support' to 'Multiple Sources of Support' (USS-MSS) ( $N = 14$ ). The least common shifts were from 'Self-Initiated Forms of Support' to 'Multiple Sources of Support' (SIFS-MSS) ( $N = 3$ ) and 'Self-Initiated Forms of Support' to 'Uncertain Sources of Support' (SIFS-USS) ( $N = 2$ ), and 'Multiple Sources of Support' to 'Self-Initiated Forms of Support' (MSS-SIFS) ( $N = 2$ ) and 'Self-Initiated Forms of Support' to 'Self-Initiated Forms of Support'. The numbers of cases assigned to each ideal type at Time 1 and Time 2 are shown in Table 6.2.

**Table 6.2**

*Numbers of Cases Allocated at Time 1 and Time 2 Showing an Increase or Decrease in Numbers per Type*

	Time 1	Time 2	Difference	Direction
USS	35	16	-17	decrease
SIFS	7	12	+6	increase
MSS	21	32	+11	increase
Total	63	60		

*Note.* The total number of participants was reduced by 3 at Time 2 due to attrition. (SIFS= 'Self-Initiated Forms of Support', MSS= 'Multiple Sources of Support', USS= 'Uncertain Sources of Support').

**Table 6.3**

*Shifts and Stasis in Types from Time 1 to Time 2 with Number of Female and Males*

Ideal type	Males	Females	Total
SIFS-SIFS	2	0	2
SIFS-MSS	2	1	3
SIFS-USS	1	1	2
MSS-MSS	7	9	16
MSS-SIFS	2	0	2
MSS-USS	2	0	2
USS-USS	7	5	12
USS-SIFS	4	3	7
USS-MSS	5	9	14
Total	32	28	60

*Note.* (SIFS = 'Self-Initiated Forms of Support', MSS = 'Multiple Sources of Support', USS = 'Uncertain Sources of Support').

In the next section of this chapter, cases that remained the same or changed ideal type across the two timepoints are outlined. Explanation is offered for why they either remained stable or transitioned type. An optimal case presented for each subtype.

### **6.3.1 Continuities: Cases that remained in the same ideal type from Time 1 to 2**

#### **6.3.1.1 ‘Uncertain Sources of Support’ - ‘Uncertain Sources of Support’ (USS-USS)**

In total, there were 12 cases (20.00%) that remained ‘Uncertain Sources of Support’ (USS-USS) across the two years that included seven males (58.33%) and five females (41.67%). Amongst these cases, individuals reported either ineffective support, ambivalence about their existing support, or a lack of support or coping strategies in relation to the number of risks faced. These adolescents tended to report having the least support in place, did not report experiencing many self-initiated forms of support and are characterised by a lack of help seeking behaviour.

Within this USS-USS type, three participants had received a HeadStart intervention (25.00%), eight participants had not received an intervention (66.67%) and one participant (8.33%) was unsure if they had received a HeadStart intervention or not. Interventions received included peer education social and emotional learning programmes, peer mentoring, and HeadStart group work at school.

#### **Optimal case that particularly represents the USS-USS cluster:**

##### **“Joseph” (Male, 13.05 at Time 2)**

*The optimal case for this type, Joseph, reported feeling that some of his sources of support were “double-edged swords”, meaning that there was a degree of ambivalence towards protective factors such as parents and school, at Time 1, and again, at Time 2. A sense of ambivalence was reported in both interviews about his relationship with his parents. Nonetheless, this adolescent described a number of areas in his life that he considered to be positive at Time 2, such as having new sources of support, new accomplishments, and participation in HeadStart activities. For example, he described positive feelings from his participation in several HeadStart activities, “It’s also good that we’re helping out the HeadStart team at the same time and it’s really fun to do it,*

*because it doesn't just feel like some just boring work, you know, it just feels like we're doing something fun and beneficial” (Time 2).*

*However, at Time 2 Joseph still expressed some worries that he felt that he could not share with his parents that he attributed to their preoccupation with work commitments and health issues. Moreover, at both timepoints he described concerns about his parents. At Time 1, Joseph reported:*

*For example, my dad drinks a lot of alcohol and I think it's bad for him. Like...*

*Because it's the thing that you like feel upset about and you feel turmoil about but it's the kind of thing that you can't really like talk about because one, it can be very awkward to talk about family. (Age, 12 years, 5 months).*

*At Time 2, Joseph described concerns about his parents once again. He explained, “Because I mean my parents are already pretty preoccupied with, like, different stuff so, like, both my mum and my dad aren't exactly in, like, very good health and they have busy careers.” (Time 2). At both timepoints, Joseph also described having some difficult feelings that he finds hard to manage. At Time 1, he described feelings of loneliness. At Time 2, he reported feeling, “very sad and unenthused and not really able to, like, pick yourself up.” In addition, he indicated at Time 2 that he was reticent to seek professional help such as therapy, recounting that he had had a mixed experience of therapy in the past (in the second interview).*

*In summary, Joseph did report some changes in improvements in his protective factors at Time 2 but they did not remove some of his ongoing stressors. The fact that Joseph consistently raised experiencing a level of uncertainty about supportive structures (e.g., his parents, his worries, and therapy), as well as being unsupported with difficult feelings at both Times 1 and 2, resulted in him being categorised as remaining as Uncertain Sources of Support (USS-USS).*

## Summary of the cases in the USS-USS cluster

Other cases in the USS-USS category included those adolescents who reported a wide range of support that either they did not perceive to be effective, or they were not numerous enough for the number of stressors encountered. These examples differed from the optimal case in that they were not reporting many factors relating to extracurricular activities, engagement in other activities at school or accomplishments at school in many areas of their lives at Time 2. Other cases diverged from the optimal case due to several reasons, behaviour issues (either specific instances or having an ongoing behavioural difficulty) or having experienced maltreatment at home.

Another USS-USS case was provided by Gemma (Female, 13.2 at Time 2) who was classified as USS across both timepoints even though that she reported several protective factors at Time 2. Gemma described that she had a fairly good relationship with her father and her stepmother, and that she enjoyed attending dance class. In terms of support, she found teachers at school to be helpful and that she could talk to a social worker about the conflict between her biological parents. However, she also outlined a large number of stressors at Time 2. For instance, she had not seen her mother in a few months due to an argument, she was involved in violent conduct with peers at school, and she reported that her stepfather and biological mother had been abusive towards her. Therefore, Gemma continues to be classified as USS, due to the high level of stressors experienced and an absence of protective factors, such as a lack of coping.

In other USS-USS cases, the same stressor was often described across the two timepoints. An example of the continuity of stressors is provided by Max. Max described that since the Time 1 interview the situation with his sister was “exactly the same” in that they still had big fights over “stupid things”. He explained, “Like the other day I used the last bit of sugar and she had a go at me and pushed me down the stairs.” Max reported improvements in other areas of his life, but that his behaviour at school had become worse since Time 1. He said, “I’ve been put in the [behavioural support unit] permanently. But the reason I was up there is because I’m going up for a few lessons to get back into class. But other than that, yes, it’s been alright.” (Male, 11.0).

### **6.3.1.2 'Self-Initiated Forms of Support' - 'Self-Initiated Forms of Support' (SIFS-SIFS)**

This category describes a small subgroup of male adolescents ( $N = 2$ ) who reported a preponderance of self-directed protective factors at both timepoints. Whilst support from parents or school was sometimes reported, this was often secondary to their own types of support. Instead, this category was characterised by a continued reliance on adolescents' own capacities or perceived strengths in managing stressors.

Within the SIFS-SIFS type, one participant had received a HeadStart intervention, that included psychoeducational groups and assemblies at school (50.00%), and one participants had not received a HeadStart intervention but had heard of it (50.00%).

#### **Optimal case that particularly represents the SIFS-SIFS cluster:**

##### ***"Jamal" (Male, 13.5)***

*Jamal was the optimal case for the SIFS ideal type at Time 1 whereupon he had described his maturity and frequent instances of his own behaviours to cope with or manage difficulties. At Time 2, he described that whilst he recognises that he does have some support from his mother, he feels very independent, mature and is able to spend time with his friends in his free time. Jamal articulated that he was doing well at school in the sense of achieving high grades at Time 2, in spite of the fact that he feels that the teachers are not rewarding him for good work and he expressed dissatisfaction with the disciplinary and reward systems at school. Nevertheless, he reported excelling at school, he described that, "I have been getting calls home, saying I'm one of the top 10 students in our year, so that was nice."*

*At Time 1, he reported struggling to manage the combined demands of schoolwork with his training for competitive sports outside of school (that was also a source of income). At Time 2, he reported that he was working on the competitive sports much less and is more focused towards his academic studies and described his goal to attend university.*

*Due to Jamal's continued self-reliant behaviour and identification of personal strengths and qualities that assist him with managing stressors and life, Jamal remains*

*the optimal case for this type and reported positive outcomes at Time 2 (such as achieving high grades and absence of peer conflict). At face value from his accounts, he appeared to be generating these outcomes through his hard work and an attitude of setting standards of attainment for himself that present a challenge. For example, he reported, "Where all of a sudden I've set like, the standard for me, and all the teachers think I have the standard, and it's really hard to maintain."*

*Jamal also reflected on his own internal traits at Time 2. Specifically, he explained that at Time 2 that his character maturity is something that contributed to his independence, helping behaviours, and attainment. He said, "Yeah I like, I mean, I'm happy that I'm like this [mature], cause, it helps me like, to be independent, more of to help my mum, and I think it helps me in my education." He perceived himself to be different ("I've just turned out to be different") but viewed his own maturity as affording him certain benefits. He said, "I feel like I have more knowledge, and like, more understanding, into, like, if anybody's saying something, I probably understand it, a lot quicker. It's just... I really like having the benefit, (both laugh) that I'm like this."*

*In both interviews he described spending time with his brother and small arguments. In his Time 2 interview, he continued to speak about valuing time with his brother, "we're together all the time, so like, we eat together, we sleep together, play together." At Time 2, he discussed the possibility of his brother coming to his secondary school and wanting to support him to succeed with his studies, Jamal explained, "I'm just trying to tell him like, you don't need it. Because, firstly, I'm... here to support him, I'll teach him whatever he needs to learn."*

*In the previous interview, Jamal had described his competitive sports work and the extra tuition he received when he was involved in competitive sports and missing school. Now that he is less involved in this, he described that it had a positive effect on his confidence. He described,*

*You get to meet new people. That, that helps, as well. Like, you meet new people, and you feel more open to people that you don't know, which helps. Like, I could probably do that in any other situation now. For example, you, like I've probably*

*met you twice in my life. But it's like, like, it's okay to talk to you, I feel like it's, I don't have to hide anything.*

*In his second interview, Jamal was more focused on the curriculum and challenge set by schoolwork. Whilst he had misgivings about the some of the disciplinary structures at school, the role of achievement at school through his own hard work was more prominent in his narrative. There were some changes in his protective factors (competitive sports now less prominent and achievement at school more prominent), as well as some internal protective factors that were stable over time, such as perceived maturity and independence.*

*In summary, the optimal case for SIFS-SIFS was characterised by reports of positive self-perceptions, setting personal standards or goals and a willingness to solve problems independently, rather than reliance on external sources of support (and at times external support was described as unhelpful) over two consecutive timepoints. Despite the fact the optimal case may have some forms of support that are externally driven (e.g., parental or school support), they are less prominent within Jamal's narrative. There are some changes in the individual circumstances but the reference to perceived maturity and independence is a constant.*

### **The other case in the SIFS-SIFS cluster**

The other case in this cluster, Daniel (Male, 13.04) also succeeded at school, but unlike Jamal he was more closely connected to the school and involved in multiple school ECA, rather than engaging in a range of activities outside of school. Regarding his achievements, he commented, "I felt like I was at the top so, like, nothing could knock me down. I was really happy." He has been involved in HeadStart and, at his Time 2 interview, perceived that his participation in HeadStart has improved his friendships: "I guess make better bonds or friendship bonds." Unlike the optimal case, Daniel did not describe himself as being mature or independent, or acknowledge particular traits, but he did reference his accomplishments. Daniel viewed himself as fortunate overall and pointed out that he benefits from speaking several languages, he commented that he is perceived by others as, "one of the lucky ones" (Time 2).

### **6.3.1.3 'Multiple Sources of Support' - 'Multiple Sources of Support' (MSS-MSS)**

This type described cases who were characterised by reports of a number of effective types of support in the first instance, which continued to be reported as in place in the second timepoint ( $N = 16$ , 7 males and 9 females). Types of support included reports of support from parents, caregivers, siblings, teachers, friends, school staff, staff within the community, HeadStart staff and included the adolescents' own strategies and capabilities. Whilst the precise description of the support or exact form of support may have changed across the two timepoints, reported support needed to be effective in relation to stressors experienced (as according to the adolescent) to be designated as MSS at the second timepoint.

Within this MSS-MSS type, the majority of participants had received a HeadStart intervention either at Time 1 or Time 2. For example,  $N = 10$  reported in the interview that they had received a HeadStart intervention (62.5%), five participants reported that they had not received an intervention (31.25%) and one participant (6.25%) was unsure if they had received a HeadStart intervention or not. Interventions received included peer education social and emotional learning programmes, peer mentoring, HeadStart group work and one participant attended a HeadStart residential.

#### **Optimal case that particularly represents this cluster: "Lydia" (Female, 12.10)**

*Lydia provided the optimal case for participants who remained MSS over two timepoints. Lydia described a broad range of protective factors at both timepoints. Protective factors included positive relationships with family, school, friends, involvement in extracurricular and community-based activities, and positive self-perceptions across the two timepoints. Lydia reported some stressors at both timepoints, such as peer conflict or stress regarding schoolwork, but she described that she had support or effective coping strategies in place to manage these. Across both interviews, she reported enjoying her life, with an absence of stressors, she said, "I mean, I have always been lucky to have quite a nice, um, easy-going life. I don't go through like really bad things." (Time 2). She spoke about her family life positively at both timepoints, e.g. "My parents are extremely supportive... even though they're really supportive, they obviously have boundaries and I'm very loved in my home." (Time 1) and "Like, they [her parents] support everything I do". Lydia also emphasised the role of her friends as both a source of support, acceptance, and fun at both timepoints, "I feel like I can just forget everything and just have fun with my friends. And I feel like they would understand me for me,*

*and just like put up with the crazy self I am, just have fun.” (Time 2). She also discussed the role ECA at both timepoints, viewing ECA as akin to a family.*

*In terms of changes in reported protective factors, at Time 2, whilst still continuing to report a wide range of support, Lydia also described some additional protective factors, not previously discussed at Time 1. For example, in her second interview, Lydia described the role of prayer and her religious belief in feeling protected: “when I pray, I am just blessed to be on this earth and to live another day”, and “God has protected me” (Female, 12.10). Lydia also described experimenting with journaling as a way to de-stress and write down her feelings about difficulties with peers.*

*In summary, Lydia was assigned as MSS at both timepoints due to a wide range of protective factors reported consistently (including parental and school support and EC activities), but with some small changes to her protective factors, such as her spiritual belief becoming more prominent. For example, at Time 2, Lydia described using additional strategies, such as reflective journaling, and that she no longer had a HeadStart peer mentor.*

### **Summary of the cases in this cluster**

In total, 26.66% of the sample were classified as adolescents with ‘Multiple Sources of Support’ at both Time 1 and 2. Allocation was based on their descriptions of stressors and protective factors and perceived effects on mental well-being across both interviews. Whilst the exact form of support may have changed (and some did), the underlying characteristic of many different forms of support reported positively by the adolescents remained constant across the two years (in the sense of contributing to overall mental well-being or mitigating the effect of a particular stressor). These participants described having a range of support structures that could be identified from how they described different aspects of their lives (home, school, community). This group is not characterised by the complete absence of stressors, but by effective support or coping in relation to stressors, and therefore a given stressor may have change with time. For example, for one young person at Time 1 peer conflict was reported as a difficulty, and, at Time 2 peer conflict was no longer reported as a problem. However, at Time 2 an instance of family illness was reported, but both difficulties were discussed both with different effective protective factors.

Across this cluster, parental support was described in different ways both between participants and across the two timepoints, sometimes as someone to talk to and a source of company, someone who provides care and affection, someone to spend time with and someone to bring difficulties to for support or problem solving. In a few cases, participants described enjoying helping their parent. For example, “I feel good, because sometimes, my mum gets busy. So, I want to help them.” (Male, 13.05). Within this cluster, many participants reported positive relationships with their parents and caregivers (such as a stepparent), however, this varied across the cluster.

In the MSS-MSS cluster, a range of views towards school were articulated. Some views resembled the optimal case in that they were doing well at school and/or enjoying school, others found school more difficult or found specific subjects or completing homework difficult. On balance, participants reported that they had the resources or support to help them manage schoolwork and comply with the academic and behavioural demands of school at both timepoints. A positive or non-problematic relationship with school was inferred from statements such as, “Like, there’s, there’s nothing for me to really complain about. No one’s being horrible to me. I haven’t had an argument with anyone. I’m just here to learn.” (Female, 13.0).

Within this MSS-MSS type, some adolescents reported positive relationships with friends, and others reported some peer conflicts, and then described support or effective coping strategies. Some participants discussed detailed micro interactions between friendships, others briefly described enjoying having someone to play with and spend time with, for example, “I can go any time. Or sometimes, he calls me then, I call him, yeah, because sometimes, he’s not at home” (Male, 13.5).

Some participants in the MSS-MSS cluster positively described HeadStart or other interventions at Time 1 but found that by Time 2 they no longer needed the intervention, “I still enjoyed it and I’d probably still do it again but it’s just that I find that like maybe, it began to get a bit repetitive.” (Female, 13.0). Others, at Time 2, reported a recent and positive experience of a HeadStart residential. For example, “I felt happy that I could like, um, get away from home ‘cause all I do at home is do chores and play games and so I could do something like more fun.” (Male, 12.5).

### 6.3.2 Cases that have that have changed types over the two timepoints

#### 6.3.2.1 'Uncertain Sources of Support' - 'Multiple Sources of Support' (USS- MSS)

This cluster, USS-MSS, is characterised by cases of adolescents who reported a lack of support/and with stressors at Time 1 and more effective and multiple strands of support at Time 2. A total of 14 cases (five males, 35.71% and nine females, 64.29%) moved in this direction. This was interpreted as a positive shift due to more positive experiences of support reported. In some cases, this was accompanied by reported changes in outcomes at the level of the self (such as new positive self-perceptions and self-regulation capacities), improved relationships (such as an improved relationship with a parent), and wider factors (such as school achievement and application towards studies).

Within this USS-MSS type, 10 participants reported that they had received a HeadStart intervention (71.49%), three participants reported that they had not received an intervention (21.43%) and one participant (7.14%) was unsure if they had received a HeadStart intervention or not. Interventions received included peer education social and emotional learning programmes, peer mentoring, and HeadStart group work.

#### **Optimal case that particularly represents the USS-MSS cluster:**

##### **“Kieron” (Male, 11. 2 at Time 2)**

*At Time 1, Kieron (10.5 years) discussed being negatively affected by a catastrophic event in his town and described several protective factors that he did find helpful for his mental well-being. For example, Kieron explained that he found that the HeadStart intervention had not helped him like he had anticipated. “**What did you expect from (HeadStart Intervention X)?”** That it could, like, help you, if you get hurt, they would do something, and they will help, yes, but it didn't.” Kieron also reported that he was reluctant to ask others for help when he needed it. In contrast, at Time 2, Kieron discussed a range of support that he had been receiving at school and through HeadStart interventions and experienced positive effects on his mental well-being. In the second interview, he expressed that he was completely “over” the event that occurred in his town and that he has become more “confident” and “resilient” through weekly sessions with the HeadStart staff member. Kieron described a range of protective factors including positive self-perceptions, confidence, enjoying spending time with friends and family gatherings, receiving HeadStart support and spending time with his mother at the second timepoint. At Time*

*2, support is both more numerous and perceived to be effective as compared to Time 1 and he reported some feelings of positive mental well-being. These changes render him eligible to shift from USS-MSS at Time 2 and, based on his own accounts of increased confidence and helpful support, represents an improvement.*

### **Summary of other cases within the USS-MSS cluster**

In the USS-MSS cluster, there were a number of participants who described different types of support received and commented on the extent it was effective for increasing their mental well-being. For example, like the optimal case, there were some participants who reported benefiting from preventative interventions, such as HeadStart, support from school pastoral workers or from participating in specialist interventions.

Another participant that followed this trajectory, Michael, recounted that a HeadStart peer mentor improved his behaviour at school through helping him to manage his emotions, particularly anger. “Instead of getting really angry and shouting and arguing and fighting, I could just go outside for five minutes, take deep breaths, and come back inside” (Time 2). At Time 1 he had recounted his father physically hurting him, but also described his mother’s care and support for him. In the second interview he expressed that the relationship with his parents had improved. He reported, “I feel more safe with them”. When asked, he states that things with his parents were at Time 2 he said, “perfect [...] me and my parents are having a good relationship” (Male, age missing).

Other participants in the USS-MSS cluster did not receive HeadStart or preventative support but discussed other factors, such as pastoral and family support in relation to risks. For example, Vanessa, (age: 13.0 at Time 2) reported that her mother had passed away, and described some distress in relation to this, but also described that her school had been particularly helpful in considering her needs in relation to her grief. Vanessa’s case contrasted from the optimal case because Vanessa did not report any positive self-perceptions and she described that her coping was “alright” at Time 2. The optimal case did report positive self-perceptions, describing herself as more “resilient” and “confident” at Time 2. Vanessa reported that counselling was helpful for her for a period of time, she described, “That was alright. Did that for a while and then felt like I didn’t need it anymore, so I stopped with that”. This case also diverges from

the optimal case as she was coping with a particular stressor, bereavement, as well as some risks that were more common amongst the cluster, such as difficulties at school.

Within the USS-MSS cluster there were also adolescents that reported to benefit from specialist interventions. An illustrative case is provided by “Megan” (Female, 12.10 at Time 2) who described a specific intervention that was geared towards her specific condition. The intervention, held outside of school, provided support for both her and her family and other adolescents with the same condition. Megan contrasted this intervention with a preventative intervention she participated in at school:

Now when I think about it, it didn't really like, it helped me, I benefitted from it a little bit, but not really a lot [Preventative intervention 1]. But now I've been on [Treatment intervention 1], that's helped me more than what it did at [Preventative intervention 1]. (*Female, 12.10*)

At Time 2, Megan reported that she had improved at managing intrusive thoughts and worries. Megan explained, “It's better.... 'Cause they always used to take over me and tell me like, tell me to do stuff, like and. Now I just ignore it.” (Time 2). In addition, Megan reported feeling happier and more comfortable in her own skin, “I feel, I feel like better in myself as well. I feel more like happier.”

### **6.3.2.2 ‘Uncertain Sources of Support’ - ‘Self-Initiated Forms of Support’ (USS-SIFS)**

The USS-SIFS cluster referred to adolescents that were characterised by an uncertainty or absence of effective support at Time 1, that by Time 2 shifted towards addressing difficulties through drawing on inner resources. A modest number of cases in the sample fit with this shift from USS-SIFS ( $N = 7$ ), four males (57.14% of total SIFS cases) and three females (42.86% of total).

Within the USS-SIFS type, four participants reported that they had received a HeadStart intervention (57.14%) and three participants had not received an intervention

(42.86%). Interventions received included peer education social and emotional learning programmes, peer mentoring and art therapy.

### **Optimal case that particularly represents the USS-SIFS cluster:**

#### **“Robbie” (Male, 12.11)**

*At Time 1, Robbie was classified as USS on account of describing a number of stressors, such as incidents with peers and behaviours, including fighting, and a lack of effective support or coping strategies. At Time 2, he reported a number of changes: he had a popular social media channel and produced videos publicly, in addition to completing schoolwork and gaming with his friends. Robbie expressed at Time 2 that he has matured and this influenced him to apply himself more in his studies, “I’m more mature now. So, I realised that I have to behave in class, so I behave” – although he conceded that he still gets detentions for “laughing” in a lesson. Robbie described that fights continue to take place at school but that he actively tries to avoid being involved in these and other heated exchanges, “I don’t like to get in people’s business a lot.” In summary, Robbie was classified as USS at Time 1 due to several sources of severe risk and a degree of uncertainty in his protective factors. At Time 2, he reported increased maturity and improved behaviour, as well as avoidance of deviant peers. He does not reference parental support with these changes, but his own agency and thus he is designated as SIFS at the second time point.*

### **Summary of cases in the USS-SIFS cluster**

In this cluster, some participants reflected that they had undergone some type of change at the level of the self or an improvement in their character or behaviour since the previous timepoint. For example, one participant described that he felt that he is became a new version of himself, “I’ve upgraded from myself ‘cause I’m not as annoying as I was” (Male, 12.09). However, not all changes could be considered ‘adaptive’, even if perceived by participants as helpful for their mental well-being. For example, this particular participant discussed releasing strong emotions as a new coping strategy at Time 2. He said:

I went on a lit- on a literal rampage. It was quite fun, actually... I was so happy at the end of it because I’d got rid of all of this worked-up anger and sadness [...] and

now that I know that I can do that, it's so much easier to cope. I don't have to hide it away and I know that I'm not weak.

Another participant, Eleanor, reported many changes since Time 1. Eleanor, described a significant change where her mother's physical health issues had improved and her mother had a new romantic partner and this had led to a number of positive changes in both her mother's and her own life. Eleanor expressed that she felt she had been helped by a specific member of staff that had represented her interests, who contrasted with other counsellor support she had received. She explained, "*well I've never felt like I can trust like counsellors and all that... and she's [...] it just... (sighs) feels like it's better to talk to her than anyone else, cause she understands.*" Further, at Time 2, she felt a previously difficult relationship with her stepmother had improved, "Our relationship has gotten a lot better. We still have a small argument every now and then, but... it's improved a lot."

Eleanor explained at Time 2 that she was less worried, felt more able to work harder at school and had more leisure time to spend time with friends and she too had a new boyfriend (and thus she linked protective factors to outcomes). In this case, her mother's illness (a stressor) had reduced (her mother was less unwell and had new medical treatments). At Time 2, she reported more protective factors (her mother has a new romantic partner who provided more care and support), and Eleanor had the support of a counsellor that she trusted and found helpful and Eleanor reported a range of positive effects on her mental well-being (less worries and duties caring for her mother). The effect that she described was that she now had more time for peer and romantic relationships and improved academic attainment at Time 2. Eleanor described:

I feel like I've improved a bit, in my learning. And... in science and maths, I actually got one of the best. So, learning's a little better now that I'm not worrying, and I haven't got stuff on my mind. (Female, 13.01).

Another example of USS-SIFS at Time 2 is provided by Ellie (Female, 13.07), based on her accounts of stressors and protective factors at Time 1 and 2. Ellie differed from the optimal case because she described help seeking behaviours that involved

friends and teachers. She said, “I try and sort it out myself, but if I can’t then I’ll ask, like, a friend sat next to me or something. And then, if they can’t help me, then I’ll ask a teacher.” Ellie also reported a positive relationship with her parents. The reason she was later designated as SIFS was due to the fact that she reported self-initiated coping in her second interview. For example, she resolved some peer conflicts of her own accord and she spent time alone in her room to manage feelings of stress. She said, “I just like, sit in my room, and just think.”

### **6.3.2.3 ‘Self-initiated Forms of Support’ - ‘Multiple Sources of Support’ (SIFS-MSS)**

This was a small category with three participants (two males and one female) classified as shifting from ‘Self-Initiated Forms of Support’ to ‘Multiple Sources of Support’ (SIFS-MSS). These were adolescents who provided evidence of self-initiated support at Time 1 and then they reported a range of effective support at Time 2 and support from parents and school was more prominent in their narratives at the second timepoint.

Within the SIFS-MSS type, two participants reported that they had received a HeadStart intervention (a peer mentor) (66.67%) and one participant reported that they had not received a HeadStart intervention (33.33%).

#### **Optimal case that particularly represents the SIFS-MSS cluster:**

##### **‘Claire’ (Female, age: 13.07)**

*Claire represented the optimal case for this shift due to moving from reports of self-initiated strategies applied at Time 1, to describing a range of sources of support at Time 2. For example, in the second interview, she referenced positive parental support, a positive experience of a friendship group, participating in an extracurricular activity and time with a social worker. At Time 2, she also reported that listening to music made her feel happy, “I listen to music all the time to like, boost myself up and just feel happy, but most of the time, I go to mum, or my friends.” At Time 2, there were still aspects of self-initiating support in her narrative, for instance, she actively stopped a relationship with a friend that she found difficult, and she reported trying out strategies to feel more comfortable with her body and body-image related issues (she reported not liking particular parts of her body). However, overall, she was classified as MSS at Time 2, due to reporting a range of several effective supportive factors, including parental support. For example, she described “me and mum, we talk about everything”. Claire*

*also described that her friends increased her “confidence” and that she valued one-to-one support from a social worker.*

### **Summary of other cases within the SIFS-MSS cluster**

Two other participants were classified as shifting from ‘Self-Initiated Forms of Support’ to ‘Multiple Sources of Support’ (SIFS-MSS). At Time 2, whilst these adolescents still reported some self-initiated forms of support, the range of helpful support, including support from family, school, and extracurricular activities, rendered them eligible for the MSS type.

A further example is provided by Toby (Male, 13.4 at Time 2). Toby explained that since Time 1, school was going smoothly and his previous episodes of behavioural difficulties had improved. For example, he explained that he had: “not been getting in trouble as much, been pretty laid back. Work’s been easy.” Toby then described that previously he would misbehave, “I used to backchat a lot, get angry... not go to lesson.” Toby articulated that the process of reflecting on, “thinking about” his behaviour and the costs of it influenced him to work hard. He said, “Er... just thinking about what’s the point of not doing your work. Just put your head down, it’ll just be easier, quicker, not with the hassle from anyone.” He also described that at Time 2 when he became aggrieved he would try strategies to calm down. “When I feel angry, I normally just count to 10 or put my head down.”

In his second interview, Toby explained that support from his Head of Year and his mother was helpful in contributing to improved outcomes. The reason he differed from the optimal case (yet has the same classification: SIFS-MSS) is that his description of protective factors involved a combination of external support: support from staff and his parents as well as his inner strengths, such as own internal motivation and processes of reflection. Toby reported,

In Year 7, when I like used to do a lot of stupid things, she just used to tell me there’s no need for what you’re doing, or I’m trying to help you but you’re not helping me back, like stuff like that. Er, I listened to it and then went home, thought about it.

Similarly, he explained in his Time 2 interview, that when he is stuck with his work he now relies on working it out himself, “just think about the work and just like try to understand.” Toby referenced in the past year that he had difficulties with anger that led to him being excluded from school. But he now felt that he managed his anger better in the current year, he said “I...

when I used to deal with my anger I normally would... like last year I got excluded because I got really angry at a teacher and I smashed up the computer.” Toby did not find HeadStart support helpful, describing it as a “waste of time”.

#### **6.3.2.4 ‘Self-Initiated Forms of Support’ - ‘Uncertain Sources of Support’ (SIFS – USS)**

This cluster was an uncommon shift with only two cases following this trajectory (one male and one female participant). The SIFS–USS shift described adolescents whose narrative involved self-initiating protective factors at Time 1, but, at Time 2 the support they described was less certain and they described external factors that ought to have had a protective role but could also be a source of risk. Both cases either discussed reductions in feelings of mental well-being and possible symptoms of psychopathology such as feelings of persistent sadness or symptoms of behavioural difficulties.

Within the SIFS-USS type, one participant reported thought they might had received a HeadStart intervention in the previous year but did not remember (50.00%) and one participant reported that they had not received a HeadStart intervention (50.00%).

#### **Summary of the two cases in the SIFS-USS cluster**

“Molly” provided an example of a participant that made this transition towards increased uncertainty in levels of protective factors. (Female, 12.11). Relative to the first interview, Molly, reported more uncertain protective factors and a lack of support in at Time 2. Some factors that she might have perceived as protective, were also potentially stressors. For example, she discussed the role of a new best friend that frightened other peers and crying and retaliating to manage victimisation from other peers. This contrasted to Time 1 where she discussed more self-initiated forms of support and less complicated coping behaviours, for example she described that she used to play with slime (a goeey substance sold as a toy) to manage her feelings at Time 1. At Time 2, Molly discussed struggling with managing bullying at school. She felt one teacher was complicit with and she felt targeted by him in class.

In addition to being teased and victimised, Molly described friendship issues across both interviews. For instance, she reported that she did not understand why she was often deserted by her friends and felt that her friends perceived her to be inadequate; she described that she had, “this thing where like people think I’m not good enough”. Molly reported that she was confused as to why she did not feel accepted, “like I say to them, like don’t you like me ‘cause I am from a different country? And they’re like no, no, it’s not that.” Molly explained that when her friends “ditch” her she felt distressed, reporting feelings of being, “sad, like broken.” At Time 2, she described the role of her new best friend in gaining confidence with the opposite sex. She described that her new friend, “helps me like with boys, and that. ‘Cause all boys used to hate me in Year Seven, but now they actually quite like me.” At Time 2, Molly described that she continued to have a difficult relationship with her stepfather. Whether she has support in relation to this issue was unclear (none described).

In summary, although Molly reported some new protective factors, many of these could pose a level of risk. For example, whilst she felt protected from bullying by the intimidating best friend that the other peers were frightened of, she did not have the support of school with bullying. In her Time 2 interview, her reported coping behaviours involved crying, retaliating and avoidance. Molly described some stressors without support (school difficulties, difficulties with peers, sadness, and a difficult relationship with her stepfather). On this basis, she was eligible for the USS category at Time 2. The SIFS-USS shift is a notable cluster as it is a negative shift towards more stressors and less support or coping that could have effects on mental well-being and the risk of psychopathology.

The other case in the SIFS-USS category is provided by Tom (Male, 12.11) who was classified as ‘Uncertain Sources of Support’ at Time 2. His protective factors were construed to be more uncertain due to having been excluded from school based on a number of stressors comprising of behaviour difficulties and being disrespectful to the teachers at school, being separated from his mother and moving in with his father. Tom and his sibling had received counselling (a potential protective factor) but expressed that it was not helpful for either of them. “Like me and my [sibling] did because we were going through a time. But [it] didn’t really help us”. Tom had some elements of the SIFS and MSS types due to some of his behaviours that exemplify self-management and

support from teachers and parents. For example, he explained that hearing praise from his teachers “does make me a bit happy”, and, based on his accounts, he seemed to be comfortable with a recent transition to living with his father, “So I’ve gone to live with dad for, like, now, or however long. But it’s okay.” From Tom’s description, he is not aware of how permanent the transition to live with his father is.

Tom’s account included at least two protective factors that were either perceived to be ineffective (counselling) or unclear (parental support). However, it was difficult to assess the extent that he perceived protective factors to be helpful, partly because he did not provide detailed answers, only hinted at the effects of his stressors (for example separation from his mother). Thus, whilst the level of risk he experienced was unclear, it was apparent that some of the stressors that he reported at Time 2 were fairly severe. Stressors included, school exclusion, ongoing behaviour difficulties at school, separation from his mother and a lack of protective factors to manage these stressors. Further, whilst it is difficult to assess his mental well-being (and this is not the focus of this study), some negative outcomes, such as exclusion from school, have occurred since Time 1.

#### **6.3.2.5 ‘Multiple Sources of Support’ ‘Self-Initiated Forms of Support’ (MSS – SIFS)**

The MSS-SIFS was another rare cluster ( $N = 2$ ), where participants shifted from reporting a range of types of support with a preponderance of support from parents at Time 1, to emphasising their own role in initiating support, such as solving problems themselves, at Time 2. Only males were found in this category.

Within the MSS-SIFS type, one participant reported that they had received a HeadStart intervention, a psychoeducational group at school, (50.00%) and one participant reported that they had not received a HeadStart intervention (50.00%).

#### **Summary of the two cases in the MSS-SIFS cluster**

Due to the fact that there are only two participants in this cluster, an optimal case is not relevant, instead each individual case is described. At Time 1, “Carlos” (Male, 13.05) described support from his parents, particularly his mother, and support from the school and a HeadStart intervention. Carlos also described assistance from school and

HeadStart staff with improving his English and settling into the new school. Due to the range of supports that he described at Time 1, he was classified as MSS. In the second interview, although Carlos described having several sources of support, ultimately, he felt that the management of his problems were his own responsibility. Carlos explained:

I don't ask for help most of the times, so I'm just trying to solve it myself [...] if I can't do anything, I am just asking for help then. But first I am trying to do it myself, most of the times.

Carlos explained that as long as he was succeeding in school (which he reported that he was), his parents permitted him to play video games. Carlos described that he could become quite angry if he lost at a game. "I start screaming, em, maybe gonna kick something. Erm, I'm going to go and play again."

The other example in this cluster was provided by 'Danny' (Male, 12.11), who discussed improvement in his behaviour and grades that he attributed mainly to his own volition and actions. He said, "I haven't got like one bad comment or detention this year, so I'm doing quite well [...] last year I had, like, 20." Danny attributed this change to him having better friends and to him trying harder to then feel better with his achievement. He reported: "Cause last year, I was a bit disappointed... I wasn't getting like, as good grades as I was in primary." Danny was also classified as SIFS at Time 2 because he described that he would not seek out teachers for support at school but reported that he might go to older peers for help with a problem. Danny said, "I like people in older years as well. They'll help you with an issue sometimes."

#### **6.3.2.6 'Multiple Sources of Support' - 'Uncertain Sources of Support' (MSS- USS)**

The MSS-USS was another uncommon cluster ( $N = 2$ ) and involved a shift of participants that had reported a range of effective support at Time 1, to less numerous and less effective support at Time 2. Due to the reduced support reported, this could also be regarded as a negative shift towards deteriorating mental well-being and in one case, a participant reported an increase in behavioural issues. Only males were found in this transition from MSS-USS. Due to a small number of cases, there is no optimal case for this subtype.

Within the MSS-USS type, one participant reported that they had received a HeadStart intervention, a psychoeducational group at school and art therapy (50.00% of the total) and one participant reported that they had not received a HeadStart intervention (50.00%).

### **Summary of the two cases in the MSS-USS cluster**

The first case in this cluster was provided by 'Jonathan' (11.02 at Time 2). From his reports, Jonathan's behaviour deteriorated across the two timepoints. In the first interview (at age 10. 9), Jonathan described that his behaviour had deteriorated, "It just went a little bit downhill, my teacher said, because my behaviour's getting worse since I got on report card." In the first interview, Jonathan also recounted undertaking some art therapy sessions but found them unhelpful. In terms of support that he did find helpful, he described a HeadStart intervention and voiced that he would like more of it. Jonathan added that at Time 2 that his mother helped him be motivated to work hard at school, encouraged by the fact that she "believes in him". In this case, in spite of his mother's support and the positive effect of this, his behaviour remained a challenge and he described it to have worsened. Jonathan had received various types of support, but the support was not quite enough to address his behaviour problems. Jonathan struggled with being persistently "naughty" despite good intentions. He described, "Sometimes determined to like be good, but sometimes it doesn't work because I just generally am naughty most of the time. And I can't stop laughing if my friend tells me a joke, and then I get in trouble." Jonathan described that he was punished at school for misconduct. From his account of his deteriorating behaviour at school, there was no evidence from his interview that this approach reduced subsequent episodes of misconduct.

The other case in this cluster, 'Sam' (Male, 13.06), continued to have a range of supportive structures across Time 1 and 2 but the extent they were supportive was less certain. Sam's descriptions were markedly different to the previous example in this cluster because he was performing well at school and had no issues with his behaviour. However, what they have in common is that the protective factors were not clearly linked to well-being or reducing stressors. Sam described that conflicts with his younger

brother has escalated, describing his brother “hitting me or slapping me.” Sam expressed feelings of regret about his approach towards managing conflict with his brother, “why I’ve had to live with him all of my life when I could just have concealed myself away, tried not to get close to him.” In terms of his athletics practice, he felt tired and disappointed that he had become slower in races and was now overtaken by his brother. At home, he discussed that he felt lonely sometimes and worried about a family member’s deteriorating health. Sam reported that he felt, “Slightly sad knowing that it’d be the last Christmas I would spend with my [family member].” Though this case was a much weaker example of the shift from MSS-USS than the previous example, there was a shift towards more stressors and uncertainty that was not present in his first interview.

## 6.4 Discussion

This study found evidence of both continuity and change in reported protective factors in relation to mental well-being and risk of psychopathology, derived from interviews with a large community sample of adolescents at two timepoints ( $N = 60$ ). The research generated five key findings:

- Stasis in type from Time 1 to Time 2 for half of the sample.
- A shift towards reports of more positive experiences of support for  $N = 24$  participants (40.00% of the sample).
- A shift towards reports of less or worse support for six participants (10.00%).
- A shift towards reports of more self-initiated forms of support at Time 2 ( $N = 12$ ; 20.00% of the sample).
- Changes in reports in types of protective factors over one year.

### 6.4.1 Stasis in type from Time 1 to Time 2 for half of the sample

Stasis was observed in type membership for participants suggesting a degree of continuity in the overall profile of protective factors. There were higher numbers of participants who were classified as USS at both timepoints ( $N = 12$ ) and MSS at both timepoints ( $N = 16$ ) than the SIFS type ( $N = 2$ ). The stability of MSS over two timepoints, entails a continuation in a range of support, including parental support and general reports of positive mental well-being. This fits well with the evidence base around the

positive effects of enduring support provided by families and surrounding social support networks that correlate with increased well-being (González-Carrasco et al., 2019; Oberle et al., 2011; Pinkerton & Dolan, 2007). Further examples of the links between support, and specifically family support and well-being are provided by a qualitative longitudinal study of well-being of adolescents aged 9-16 in north-east Spain. The study found that adolescents with higher subjective well-being scores viewed their surrounding environments (school, family and friends) in more positive terms than adolescents with lower subjective well-being scores and may perceive their surroundings differently to those that have lower overall levels of well-being (González-Carrasco et al., 2019). Regarding change over time, the same study found that factors that were perceived to contribute to wellbeing were found in both timepoints, but that more factors were identified in the second year and they found less negative factors reported which they discussed that were not able to explain based on current literature (González-Carrasco et al., 2019). González-Carrasco and colleagues (2019) also found that adolescents reporting higher well-being, discussed double the number of factors that positively contributed to their greater well-being, than adolescents reporting lower subjective well-being.

Similarly, a study of a large nationally representative sample of adolescents in New Zealand ( $N = 9107$ ) found that relationships with family, school and friends (including family meals and sports) were positively associated with happiness (Lambert et al., 2014).

In contrast, the USS-USS group continued to experience uncertainty in the support available and in relation to both changing and enduring stressors over time. This may reflect that the effect of one or two interventions/protective factors may not be enough to significantly change an adolescent's experience of a high stressor load that influences their mental well-being and risk of psychopathology. Theories of cumulative risk and allostatic load, due to a high perceived load of stressors, continue to remain of relevance here in explaining the link between a high number of stressors and poor mental well-being (Danese & McEwen, 2012; Evans et al., 2013; Hebron et al., 2016). In these theories, repeated exposure to stressors negatively affects and overwhelms an individual's physiological and psychological systems, and leads to negative health and psychological outcomes (Christensen et al., 2019). Therefore, even if one or two

protective factors are in place (that are perceived as helpful), if there remains a number of chronic stressors, without protection, the adolescent will remain at a higher risk of poor mental well-being or psychopathology.

Within the USS-USS type, stressors were most severe, most frequent, and chronic. Chronic stressors included parental disability and chronic illness, socio-economic difficulties, parental addiction, interparental conflict, conflict between separated parents, maltreatment, and difficult relationships with stepparents, exclusion from school and behaviour difficulties. A number of adolescents in the USS-USS ideal type were reluctant to seek help or support, and some did not anticipate that they would be helped by surrounding adults such as teachers or parents. Similarly, in Ungar and colleagues' typology of service-users engagement with therapeutic services, the 'high-risk, low resilience' category was reluctant to engage with service providers, or, when they did, they preferred non-professional contact or phone calls after hours (Ungar et al., 2018). Whilst a number of barriers to accessing support may be located at the level of the individual adolescent, it is important to acknowledge that some barriers to seeking support may be due to a lack of support available in the individual adolescent's wider social ecology, and that individual preferences interact with what is available (Masten, 2001; Ungar, 2015).

Existing research on help-seeking finds a range of barriers to help-seeking for adolescents, including low self-esteem or lack of trust in services (Raviv et al., 2009). Adolescents who remained as having 'Uncertain Sources of Support' in the current study *may* share similar characteristics with 'hard-to-reach' populations. Hard-to-reach is a contested term applied both in research and within service delivery and mental health services because it may infer a judgement (from services or within society) that particular groups are difficult to access, when in fact there may be barriers within the service that prevents specific individuals or groups accessing services (Flanagan & Hancock, 2010). A qualitative study of British voluntary sector professionals referred to hard-to-reach to signify, "groups and communities who aren't accessing a particular service for whatever reason" (Flanagan & Hancock, 2010). The study suggested that such groups did not access services due to lack of information, belonging to a narrow group and a lack of education (Flanagan & Hancock, 2010).

Taking a broader perspective, the continued USS-USS membership may relate to the lack of informal and formal support such as a lack of mental health services that are culturally relevant in the surrounding social ecology (Masten, 2001; Ungar, 2015). Appropriate support for adolescents experiencing a wide range of individually held stressors may not be available and what support is actually available is difficult to assess from interview data alone. Evidence suggests a shortage of mental health services in the British context (Crenna-Jennings, & Hutchinson, 2018). Thus, it is possible that sufficient services were not available in these adolescents' local environment of school, HeadStart provision, and local authority service provision, despite high levels of need.

Finally, the continuation of the SIFS group was a much smaller minority than the other types. This could be interpreted that it is rare to be consistently self-reliant, or that some adolescents were more precocious and described themselves as autonomous and drawing on themselves for support at Time 1, well before the rest of the sample. From the current data, it is not clear why the SIFS group was such a small group across the two timepoints.

#### **6.4.2 A shift towards more positive experiences of support for 40.00% of the sample**

A total of 40.00% of the sample reported more positive experiences of support and/or coping at Time 2, for example they reported experiencing more numerous protective factors or more effective (in their opinion) protective factors. Positive change was equated with the following shifts: USS to MSS ( $N = 14$ ), USS to SIFS ( $N = 7$ ) and SIFS to MSS ( $N = 3$ ). This could be due to the fact that more numerous sources of support and support from parents and school is linked to increased mental well-being (Calmeiro et al., 2018; Hamby et al., 2018; Lambert et al., 2014; Patalay & Fitzsimons, 2016). The other type of positive shift was interpreted when reports of uncertain support in relation to stressors (USS) were replaced by reports of problem solving and positive self-perceptions for those that were classified as SIFS at Time 2. Problem solving, as a type of coping behaviour, has been found to correlate with greater mental well-being relative to avoidant coping or a lack of coping strategies that involves avoidance or

distraction from the problem (Spence, Sheffield, & Donovan, 2002; Zimmer-Gembeck & Skinner, 2011, 2016).

Adolescents who shifted to MSS reported experiencing higher numbers of protective factors, in relation to supporting their mental well-being and reducing the negative effects of stressors. This concurs with existing research that found that Spanish adolescents aged 9 to 16 years old that felt supported by their parents and could seek help reported higher levels of wellbeing than those that had less parental support and less able to seek help and that participants that scored higher in terms of their well-being, identified a greater number of contributing factors (González-Carrasco et al., 2019). Multiple protective factors fit with the notion of *polystrengths*, that refers to the total number of strengths that cumulatively contribute to mental well-being (Hamby et al., 2018; Yoshikawa, 1994). Some participants also reported increased feelings of mental well-being, such as feeling more resilient or more 'confident' or 'calmer', that they attributed to HeadStart interventions or to other forms of support. This provides some tentative evidence of HeadStart support being helpful for the mental well-being of some participants, as participants within the MSS type sometimes directly attributed the improvements to the experience of HeadStart support.

#### **6.4.3 A shift towards reports of less and worse support for a minority (N = 6, 10.00%)**

Another key finding was that there were instances where there was a negative shift towards less support and, at the outcome level, an increase of behavioural issues, or symptoms of distress, as reported by participants. These were found in the shifts from MSS-USS, or SIFS-USS. Less or worse support was interpreted in this study based on participants moving towards 'Uncertain Sources of Support', in the sense that there was a new absence of perceived effective protective factors in relation to stressors. Whilst only a small number of cases represented this pattern, they provide evidence of deterioration in mental well-being and risk of increased psychopathology over time. Perhaps this reflects extant research, which shows an increase in the number of new stressors experienced during early adolescence, such as greater academic demands, forming new peer groups and greater risk of bullying as part of the shift to secondary school (Eccles et al., 1993; Kim et al., 2015; Pellegrini, 2002).

#### **6.4.4 Shifts towards 'Self-Initiated Forms of Support' (SIFS) at Time 2**

Another key finding from this research was an increase in the number of adolescents who were subsequently classified as 'Self-initiated Forms of Support' at Time 2. The shift towards SIFS could suggest that either that adolescents in this category may have changed developmentally to be more autonomous and/or mature (as a recap, the SIFS type included references to being mature or independent), or, they may have been supported externally to learn strategies to manage difficulties and emotional states (without narrating this aspect) and to solve problems independently. Reported strategies included self-regulation (time alone to calm down or removing oneself from the situation), problem-solving (fixing a problem for themselves) and managing emotions (counting to 10 to calm down when angry).

This shift towards a SIFS designation through increased use of self-initiated strategies could reflect previous research, which suggests that adolescence involves the developmental transition of increasing autonomy from parents and the increased role of peers in adolescents' lives (Berndt, 2007). Autonomy is conceptualised as a developmental process of independence from parents and the development of self-reliance (Soenens, Berzonsky, Vansteenkiste, Beyers, & Goossens, 2005). Autonomous adolescents have been defined as those who are values-driven, self-governing and act in pursuit of goals (Soenens et al., 2005). During adolescence, young people begin to take more responsibility for their own health, which would have been undertaken by parents during childhood and early adolescence (Rickwood, Deane, Wilson, & Ciarrochi, 2005).

The current study found a marked internal dimension to adolescents' reports that became characterised as SIFS. Participants emphasised their own role in developing solutions to problems or coping with difficult situations and many identified a particular inner strength or capacity that was helpful, such as maturity or capacity to problem solve. In some cases, adolescents had a specific goal in mind, such as pleasing parents or teachers, or pursuit of a career ambition that they perceived led to a positive change in behaviour. This finding is congruent with research on the cognitive or internal aspects of resilience that enable adolescents to manage risk, which include a sense of agency, a high degree of cognitive control, flexibility and the ability to self-regulate emotional

activity (Kochanska, Coy, & Murray, 2001; S. Parsons, Kruijt, & Fox, 2016). It also fits with the idea of goal setting and the pursuit of goals, and self-efficacy (self-belief in own capacities to achieve goals) are protective factors linked with well-being (Afzal, Atta, & Malik, 2016; Messersmith & Schulenberg, 2010; Moksnes, Eilertsen, Ringdal, Bjørnsen, & Rannestad, 2019). This is because, in some cases, the shift to SIFS was perceived to be linked by adolescents with a reduction of misbehaviour at school and increased academic attainment because adolescent reported a decision to do so.

#### **6.4.5 Changes in types of protective factors experienced over one year**

Specific reported protective factors, including coping strategies, also changed over time and in relation to specific stressors. New protective factors and coping strategies were described at Time 2, as compared to Time 1. Both adolescents within the ideal types that remained the same and those that changed types discussed trying out new ways of coping at Time 2, such as journaling or talking to an adult. The precise repertoire of protective factors and coping strategies was unique to each participant. In some cases, it was not clear if a protective factor was newly reported (and not mentioned in the previous interview) or was new in the participant's life. In other cases, a new protective factor or coping strategy was described as a new experience or recent experience, such as having recently received support from a HeadStart mentor or staff member, parent, or member of staff at school or begun a new hobby. Some new protective factors described, such as religious belief, or a sense of gratitude or "feeling lucky", are factors that are established to link with mental well-being in the literature (Froh et al., 2009; Meltzer et al., 2011; Waters, 2011). Problem solving was also described, which is considered a form of active coping (Frydenberg et al., 2009). Coping strategies that are proactive or adaptive by attempting to solve the problem are linked with positive outcomes regarding mental well-being (Seiffge-Krenke, 2004; Thompson et al., 2010).

Given that some research suggests that protective factors are found to increase over adolescence (especially after transition to secondary school) (Kim et al., 2015), there is some evidence from this study that adolescents tried out or learned new coping strategies, some of which they kept, and others they abandoned over time. A range of coping strategies that adolescents qualitatively reported at Time 1 has also been

recently published by the QRT working on the HeadStart evaluation (see Stapley et al., 2019). However, the finding in the present study that adolescents adopt and reflect on new protective factors adds to this research by showing some of the ways that new protective factors and coping strategies were adopted or discontinued or helpful for a specific time and then no longer required.

Participants discussed coping strategies in relation to their well-being and whether they found them effective, with some making links to feeling better, or feeling more confident or the stressor being resolved (such as a peer conflict). Within the coping strategies reported, some could be classified as adaptive (e.g. going for a walk to manage emotions) and others could be classified as maladaptive (e.g. shouting or being aggressive towards an antagonistic sister with potential harm to self or others) as per the distinction provided by Thompson and colleagues (2010). Some researchers have emphasised the context specificity of coping or have suggested that coping may be adaptive in the short-term but confer risk for psychopathology (maladaptive) in the longer term (Wadsworth, 2015). For example, externalising behaviours (such as breaking things) may have had short-term benefits of emotional release or self-defence, but if often repeated can resemble symptoms of behavioural difficulties (Zimmer-Gembeck & Skinner, 2016). Or, to take another example, avoiding a stressor can have a positive effect on mental well-being, but leaving a lesson to avoid a classmate or a difficult assignment could have negative repercussions for the adolescent. However, research has also explored some of the benefits of deviant behaviour at school for students that are struggling with meeting school expectations (Kaplan, Martin, & Robbins, 1982; Khoo & Oakes, 2003).

Within the USS category, an absence of coping in relation to stressors was often reported, or experience of a stressor without a reported coping strategy. This could reflect an individual's lack of knowledge about how to manage a particular stressor, or it also may reflect participants not choosing to share ways of coping that can be linked with poor mental well-being (e.g. bad moods, aggression, rumination) and the role of social desirability bias (Krumpal, 2013). A lack of protective factors or coping strategies are risk factors for poor adolescent mental well-being (Zammuner, 2018; Zimmer-Gembeck & Skinner, 2016). When an individual does not try to deal with a situation (and instead avoids it), research has found this avoidant coping is both a risk factor for and a

symptom of depression in adolescents (Kaminsky, Robertson, & Dewey, 2006; Wadsworth & Compas, 2002).

#### **6.4.6 Implications for HeadStart**

The current study found that half of the sample ( $N=30$ ) changed ideal type based on their reports of protective factors. Of these adolescents that shifted type, 18 (60%) received some type of HeadStart support and nine (30%) did not receive HeadStart support and three (10%) were unsure if that they had received HeadStart support or not. Of the adolescents who had changed type from USS to MSS, the majority had received HeadStart support (71.43%) and a lower number of participants had either had not received it (21.43%) or were unsure if they had or not (7.14%).

Of the shifts that could be interpreted as most positive, the USS-MSS, due to a wider range of protective factors as contrasted with uncertainty in protective factors in the first timepoint provides examples of where HeadStart is a protective factor in relation to mental well-being and was reported as linked to improved outcomes. For all 10 participants that received a HeadStart intervention and their protective factors were reported to improve, it cannot be said to what extent HeadStart led to a perceived shift, but there are a number of examples in the data where individual adolescents directly attribute HeadStart as leading to a change in outcome.

To elaborate on this point, some adolescents discussed positive mental well-being-related outcomes directly from participating in HeadStart, such as increased confidence, feeling more resilient, and reporting that they were better able to manage problems at school, such as peer conflicts. Some adolescents talked about HeadStart as fun or enjoyable and this could be interpreted as contributing to a hedonic aspect of mental wellbeing. Others discussed that HeadStart helped them to manage emotions, talk about emotions with others, having someone to confide in and discuss difficulties with and reduce some the perceived effects of stressors, such as managing bullying and peer conflict, and difficulties completing schoolwork and concentrating in lessons. Clearly, a number of adolescents experienced HeadStart as a protective factor, either in reducing stressors or increasing their well-being.

Within the USS-USS group, a number of adolescents reported to experience uncertainty in their support in relation to stressors again at Time 2. These adolescents had either had not received or were not aware that they had received or did not remember receiving HeadStart support. Whilst these adolescents may have not received HeadStart in the first year (when they were classified as having uncertain support), it is notable that at the second timepoint they still had not received HeadStart for additional support. Adolescents assigned as USS-USS described stressors that they reported to lack support with, or it was unclear if they had support or were coping with their profile of stressors. Reported stressors that persisted included family-level stressors (e.g., domestic violence (DV), interparental conflict, financial strain, conflict between separated parents, conflict with a stepparent, as well as separation from a parent or both parents, family financial difficulties, and sibling conflict). Stressors at the school-level also were described to persist, (e.g., peer conflict, bullying, episodes of misbehaviour and difficulties concentrating and performing schoolwork) and individual-level stressors (e.g., as difficulties controlling anger or behaviour difficulties). The range of stressors described were not alleviated or addressed through HeadStart support. As discussed, a high number of stressors contributes to an increased risk for poor outcomes and this subset of adolescents can be anticipated to be at highest risk for poor mental well-being and psychopathology (Evans & English, 2002; Evans et al., 2013; McLaughlin & Sheridan, 2016).

A notable feature of this study was that amongst participants allocated to USS, there were a few examples of participants (such as the optimal case) who had received and enjoyed HeadStart related activities and ECA but still reported some chronic stressors and worries that persisted and were a source of difficulty (despite the HeadStart support). In these cases, whilst activities were reported as enjoyable and helpful, HeadStart did not reduce the negative effects of some chronic stressors or increase the certainty of support in other domains.

Within the sample, there were also adolescents who did not receive HeadStart support and were not familiar with what the programme involved; this has been documented in the HeadStart Evidence Briefing (Stapley, et al., 2020). In the briefing, it was described that some adolescents who described a number of difficulties had not accessed HeadStart interventions (Stapley, et al., 2020). In the briefing, possible

reasons included that they may not have been identified, may not have been selected and may not have wanted to take up HeadStart support, or forgotten receiving it (Stapley, et al., 2020). It is possible that, in some cases, these adolescents had received HeadStart support but had not remembered or realised that a particular type of support or intervention was in fact HeadStart support. However, it is worthy of comment that some adolescents were reporting a deterioration of protective factors, and their current support was not sufficient. In some of these cases, participants described some outcomes that could be linked with poor mental well-being and risk of other outcomes such as anti-social behaviour, such as school exclusion (Parsons, 2005; Valdebenito, Eisner, Farrington, Ttofi, & Sutherland, 2018).

The identification of this cluster of adolescents who, based on their reports, were found to deteriorate in their protective factors, has a wider significance for the HeadStart programme or the task of preventing psychopathology in early adolescence. This is because these adolescents are potentially most at risk of psychopathology or other outcomes due to identifying a range of stressors, a lack of coping, and a lack of protective factors (Björkenstam et al., 2015; Evans et al., 2013). There were also examples of adolescents who reported a number of severe and/or chronic stressors. Such stressors included custody battles, maltreatment and parental addiction, which have been found in a range of studies to reduce mental well-being and increase the risk of psychopathology (and other negative outcomes) (Doyle & Markiewicz, 2005; Forehand et al., 1989; Hussey, Chang, & Kotch, 2006; Martinez Jr. & Forgatch, 2002; Mills et al., 2013; Spigelman, Spigelman, & Engleson, 1991; Ungar, 2013).

In this study, there were also instances where particular adolescents reported that HeadStart was less effective when compared to the experience of other mental health interventions. In one example, an adolescent with a pre-existing mental health disorder described that she favoured participating in a CAMHS intervention for children and their families relative to a HeadStart intervention. This was an isolated example, but there were also participants in the sample that had been prescribed medications for ADHD and described existing treatment and support for some types of psychopathology that was entirely separate from HeadStart provision.

There were also a few examples of specific adolescents who had markedly improved in their reported protective factors and support from surrounding systems at Time 2. This group is important to note in regard to HeadStart because either they had not received (or did not mention receiving) HeadStart support or did not find HeadStart to be helpful. In these cases, a given stressor had reduced in Time 2. For example, one participant described her mother's health improving and her medical treatment improving, as well as a mother's new partner and as well as a supportive adult that reduced her caring responsibilities. In these cases, the participant had undergone a number of significant changes in her protective factors and stressors, but this was unrelated to HeadStart provision. In this particular case, the surrounding systems around the adolescent had effectively identified risk for the adolescent and the mother. In another example, a male adolescent discussed his behavioural issues improving and he was better able to manage his anger but reported that he found HeadStart unhelpful.

The other subset to note was heterogeneity in participants' specific preferences in relation to HeadStart. This includes how much they reported to benefit from HeadStart support. Some adolescents described that having a HeadStart peer mentor was helpful for a period of time but no longer required at Time 2. Others, speaking of a different intervention, spoke of benefiting from HeadStart support at Time 1 but were unsure why they were not selected to receive it at Time 2. Enjoying HeadStart was interpreted from statements such as "I like it" or "I enjoyed it" or "it was fun." The implication here was that many (but not all) participants valued HeadStart support and some found the support helpful for managing emotions. There were proportion of adolescents in the MSS category did not have HeadStart support and, from their reports, already had a range of effective protective factors in place. Other adolescents within the MSS category reported to appreciate an additional layer of support, despite having a range of effective protective factors (parental support, school support and or connection, friends). These adolescents often described everyday stressors that were manageable (e.g., instances of peer conflict or school stress as opposed to more severe stressors).

#### **6.4.7 Implications for researchers**

This study has demonstrated that a typology, derived from qualitative interviews with adolescents across two timepoints, can be a useful device to understand the ways

that reports of protective factors change over one year. The typology could be used as a tool to explore change pre- and post-intervention to understand whether the intervention was linked to changes in reported protective factors, again using qualitative semi-structured interviews, and generating case reconstructions for both timepoints. Further applications of the typology to datasets with different characteristics, such as a specific demographic or other age groups would be valuable to compare the findings of the current study (e.g., with a sample of early adolescents not in receipt of preventative interventions).

The following avenues for further research are provided below. These comprise of opportunities for studies to constructively build on this piece of research to expand on findings or points to address further questions raised by findings from the thesis:

- i.** A follow-on study that allocates the same sample of participants from the QLS to the typology for the Time 3 and subsequent years of the HeadStart QLS. This could show the extent to which the types have changed and provide further evidence of the trajectory of stasis or change for each case.
- ii.** Linking self-reported protective factors with quantitative measures of mental well-being related outcomes would enable further qualitative and quantitative evidence to be generated on whether MSS and USS are linked to positive and negative outcomes, respectively.
- iii.** A next step for the typology would be to convert it into a survey and compare type membership derived from the qualitative typology using ideal types, to types derived from a survey using a type of quantitative measure.
- iv.** Data quality varied with particular adolescents in the sample. It is possible that in some cases an absence of response in relation to specific probes was due to traumatic or difficult experiences that participants may not want to discuss in their interview. Colouring and drawing were used as aids to dialogue in the interview settings to great effect, but potentially more methods are needed for those that find verbally discussing sensitive stressors difficult but may respond better through play or a physical activity (such as taking a walk).
- v.** Understanding the origins of protective factors, such as coping and help-seeking would be a useful line of inquiry, for example, are some protective factors learned from family members or acquired in other ways? What is the role of parents in

learning coping behaviours? It is possible that adolescents are influenced to adopt certain coping behaviours early on by exposure to parental coping styles. This has relevance for intervention in early adolescence and in helping adolescents to reflect on their protective factors and ways of dealing with difficulties. Within the literature there are numerous studies on types of coping, but less literature on where coping styles come from.

#### **6.4.8 Application of the typology amongst practitioners**

The typology of protective factors in relation to mental well-being and risk of psychopathology can be used to assist with the task of identifying adolescents who may be most in need of support through tracing type membership over time. Identification of adolescents at-risk of mental disorder is important to provide interventions that are appropriate and well-timed (Koning, Büchner, Vermeiren, Crone, & Numans, 2019). However, it is acknowledged that further research is required to explore possible links between the types and mental health outcomes. The current study did not explicitly measure mental well-being and symptoms of psychopathology and there are limitations on any inferences that can be drawn objectively about adolescents' mental well-being in relation to type membership.

Furthermore, in theory, examination of the reported stressors and protective factors for a given adolescent may provide useful input to service providers seeking to support to adolescents. This may be particularly relevant to adolescents with the greatest number of stressors that are chronic, severe or both. Understanding what adolescents with limited support have found helpful before, and the types of support that they find to be unhelpful may be essential before considering additional support. Various studies have shown that not all help is perceived as helpful and there is a risk of support not being taken up or drop-out from therapeutic interventions occurring (O'Keeffe, Martin, Target, & Midgley, 2019; Ungar et al., 2018).

#### **6.4.9 Limitations**

Some of the limitations that were proposed in the previous ideal type study remain relevant to the current study, such as the lack of member checks by participants. Moreover, it is important to note that a number of factors could have affected

adolescents' reports in this study, including mood and microevents on the day of interview, rapport with the interviewer, how the interviewee chose to represent themselves in the interview, which risk and protective factors the interviewer raised from the previous interview, or the extent to which the interviewer followed the "flow" of the interviewee's narrative in the interview itself versus keeping to the interview schedule.

It is also worth considering that for adolescents who portrayed all their support positively, such as some participants in the MSS category, there may have been a bias towards positive self-portrayal, which has been termed a *self-relational bias* or a *self-serving bias* (Blaine & Crocker, 1993; Brown & Rogers, 1991). Or, whilst the actual reasons are unknown, it could be hypothesised that particular adolescents may prefer to portray their family support or support available to them in a positive light due to not wanting potentially to embarrass the family, appear vulnerable, or provide information to the QRT that would suggest parents are not supportive. Adolescents in the SIFS or MSS ideal types may seek to represent themselves to the interviewer as competent in managing difficulties or competent at seeking help from authority figures such as school or intervention staff (Løvgren et al., 2020).

## 6.5 Conclusion

This study has considered change and stasis in three ideal types of reported protective factors in relation to mental well-being and risk of psychopathology over one year for early adolescents aged 10 to 13 years old ( $N = 60$  at the second timepoint). With regards to adolescents that may be at risk of psychopathology, the typology identified those who continued to have insufficient support and those that had deteriorated in their perceived support over one year. The typology could also be used to identify those who are responding the least to services or to HeadStart support. When the typology shows some initial evidence of deterioration over one year, these adolescents potentially require the most monitoring and support. Such adolescents are most in need of support that addresses multiple stressors through highly tailored interventions.

The study yielded five findings through analysis of changes in ideal type membership. First, stasis in ideal type across two timepoints for half the sample.

Second, a shift towards more positive experiences of support as demonstrated by change in type membership for 40.00% of the sample. Third, a shift in a negative direction for a small subset of the sample (10.00%). Fourth, shifts towards 'Self-Initiated Forms of Support' based on reports of increased autonomy, maturing and independent problem solving and fifth, changes in types of protective factors reported over one year that included new coping strategies and forms of support. The implication of this study is the need to monitor those adolescents that report continued levels of uncertain support in relation to stressors, as well as those that reported at Time 2 experiences of less or worse protective factors in relation to managing stressors. Some of these stressors were chronic and were reported at both timepoints, such as difficult relationships with parents, absent parents, behaviour difficulties and conflict between separated parents.



## Chapter 7. Thesis Discussion

## 7 Thesis Discussion

### 7.1 Thesis aims and research questions

The overarching aim of this thesis was to examine how qualitative investigations into adolescent experiences of stressors and protective factors can further our understanding of adolescent mental well-being and the prevention of adolescent-onset psychopathology in England. This final chapter synthesises the key findings by addressing the four research questions posed at the outset of the thesis and considers the contribution the research makes to the wider field of adolescent mental health. This discussion chapter also provides commentary on the methodologies applied within the studies of the thesis, reflecting on the advantages and disadvantages of the chosen methods. Based on these findings, directions for future research and key implications for translating research into policy and practice are proposed.

The thesis addressed four main research questions:

1. *What types of stressors do adolescents report and what are the perceived effects on their mental well-being and risk of psychopathology?*
2. *What types of protective factors have been found to increase adolescent mental well-being and reduce the risk of psychopathology in current research?*
3. *What patterns exist in adolescents' experiences and reports of protective factors in relation to mental well-being and the risk of psychopathology?*
4. *How do patterns of protective factors in relation to mental well-being and risk of psychopathology as reported by adolescents change over the course of one year?*

#### **Research question 1. What types of stressors do adolescents report and what are the perceived effects on their mental well-being and risk of psychopathology?**

The thematic analysis undertaken in Chapter 2 based on data from interviews with 54 adolescents identified six main themes of types of reported stressors: (1) Negative mental states and/or emotions, (2) Peer difficulties, (3) Behavioural difficulties, (4) Bullying, (5) School difficulties and (6) Family difficulties. The new aspects that

contributed to the current literature were the frequency of negative mental states, new reported stressors such as secrets and peers criticising a participant's choice of boyfriend or girlfriend, and specific reported chains of stressors linked to a range of outcomes that included worry, distress, behavioural difficulties, truancy, and exam failure. The final finding consisted of preliminary qualitative evidence of participants descriptions of internal stressors interacting with external stressors to contribute to specific negative outcomes.

The six themes reflected the most prevalent themes from participants in receipt of Phase 2 HeadStart interventions. While some aspects of their responses are likely to be particular to this context, drawing on other quantitative and qualitative studies of stressors in the English context, all of these themes corresponded with extant research. The main difference, however, was the fact that only a few studies focus on internal stressors (Farrell et al., 2007). Negative mental states and emotions included feelings of anxiety and worry, low self-esteem, and difficulties with emotional regulation. In the majority of studies only environmental stressors have featured (internal stressors are not included in the definition of stressors) (Christensen et al., 2019; Grant et al., 2003, 2014). Instead, the internal dimension of stressors, particularly cognitive processes, are studied under the rubric of coping (Lazarus & Folkman, 1984; Lowe et al., 2003).

However, studies that have incorporated both internal and external components in their stressor definitions have noted how common these internal stressors can be. For example, research from a qualitative study of the stressors experienced by adolescents in North America found that internal problems, such as emotional dysregulation, generalised worry and low self-esteem, were the most frequent stressors reported (Farrell et al., 2007). Similarly, in my study on stressors, I also found that these same types of internal stressors, worry and difficulty managing emotions, were reported by participants as stressors with negative effects on mental well-being overall. The participants in the study on stressors had recently received interventions for their mental well-being, and so may have been more able to speak about difficult mental states and emotions (and potentially more difficulties with them) than those that had not received interventions. Of the 12 geographic sites in the study, participants from nine sites had been selected for targeted interventions, and so would have been identifiable to HeadStart providers based on particular risk factors and possible symptoms. The

interesting element of the focus on internal stressors was that they were then discussed as part of a chain of stressors that included both internal and external stressors.

A focus on adolescents' experiences of stressors yielded highly individual *chains of stressors*, whereby stressors in different domains interacted to contribute to a negative outcome. Thus, the experience of stressors was crosscutting across mental well-being (including mental states) and behaviour, relationships with parents and siblings, school, and friendships and peers. The chains of stressors were consistent with the notion that stress can be a link in a causal chain (Aneshensel, 1992). Given the number of interconnected stressors that adolescents described both internally (mental states), within the family and within relationships, the theory of social stress was highly applicable, as adolescent conceptualisations of chains of stressors imply that they are connected and influencing each other rather than isolated variables (Aneshensel, 1992). The interaction of stressors showed how stressors were perceived to lead to negative effects on mental well-being and symptoms of psychopathology, such as episodes of anxiety, symptoms of depression or feeling unable to attend school. Emotional responses to stressors without support have been found to link with the development of disorders such as depression (Shapero et al., 2014; Shapero, Stange, McArthur, Abramson, & Alloy, 2019).

An important feature of the first study on stressors was that when reporting the effects of stressors on mental well-being, different participants described different links between particular stressors and specific outcomes. For example, some reported stressors, such as bullying or school stress, were linked in participants narratives to engaging in truancy and internalising symptoms. One young person linked maternal illness with a range of outcomes that included leaving school early and poor mental health. The range of outcomes stated and the range of pathways fit with established theories of equifinality and multifinality (Cicchetti & Rogosch, 2002; Mitchell, Kaufman, & Beals, 2004). To recap, equifinality is the notion that different experiences or stressors can lead to the same outcome and multifinality is the notion that the same stressor can be experienced, e.g., bullying, or parental conflict, leading to different outcomes (Cicchetti & Rogosch, 2002; Mitchell, Kaufman, & Beals, 2004). The notion of *differential susceptibility* is also relevant: different individuals can vary in that they are positively or negatively affected by environmental influences, and this is moderated by

temperament, such as having a high level of negative emotionality (being prone to emotions such as anger or fear) (Belsky & Pluess, 2009; Morgan, Shaw, & Olino, 2012). Particular stressors led to a range of effects on mental well-being such as avoidant coping (distancing from the stressor itself), such as avoiding the bully to not attending school and worrying about stressors (Frydenberg et al., 2009). Such types of coping may have abated stressors in the short-term but they could be maladaptive in the longer term, in the sense that truancy and school avoidance could likely confer a negative effect on adolescents' outcomes. As discussed previously, scholars have differentiated between maladaptive and adaptive coping and the context-specificity of coping behaviours on mental well-being and mental health outcomes (Schneider, King, & Delfabbro, 2018; Thompson et al., 2010; Wadsworth, 2015).

The study of stressors within this thesis found additional reported effects on mental well-being and risk of psychopathology from adolescent accounts. Some adolescents spoke about minor and gradual effects on mental well-being and others about larger effects, such as the experience of a sudden reduction in self-esteem following peer conflict, difficulties controlling emotions or symptoms of anxiety, and engagement with deviant peers and risky behaviour. Within the wider literature, both major life events, such as parental divorce, and smaller daily stressors have been linked with symptoms of depression and anxiety (Zimmer-Gembeck & Skinner, 2011). Other participants described symptoms of anxiety in relation to exams and school and difficulty regulating emotions at school. Whilst the Phase 2 dataset contained less detailed data on the effects on well-being and reported protective factors, the design of the Phase 3 dataset was explicitly designed to capture protective factors and the reported effects on mental well-being which will be later discussed.

Bullying and peer conflicts were other commonly reported stressors. Bullies often targeted differences in physical appearance (but also other differences) and leading to a range of negative effects on mental well-being that included sadness, low self-esteem, truancy, and instances of aggression towards the bully. Bullying and interpersonal conflict have been established within the literature as stressors that negatively affect adolescent mental well-being and increase psychopathology risk (Duke, Pettingell, McMorris, & Borowsky, 2010; Kochenderfer-Ladd, 2004; Pellegrini & Bartini, 2000; Persike & Seiffge-Krenke, 2016; Przybylski & Bowes, 2017). Possible responses to

bullying, such as reactive aggression and truancy, are also associated with a range of outcomes such as poor exam results and social and emotional difficulties (Dembo, Wareham, Schmeidler, Briones-Robinson, & Winters, 2016; Egger, Costello, & Angold, 2003). Stressors were not always connected to coping behaviours but to behaviours that followed or responded to the stressor in each adolescent's own terms.

The first study on types of stressors also identified gender and age differences that were, in some ways, congruent with the wider literature. For example, boys were found to report more school difficulties, anger and aggression in the period of school transition (transition usually occurs at Year 6 or 7 in the English context) (Crick & Dodge, 1996; Pellegrini, 2002; Pellegrini & Bartini, 2000). Girls described peer difficulties much more frequently than boys and described issues such as secrets and gossip, which reflects research that finds girls are more likely than boys to use indirect aggression such as gossip and rumours in their conflicts (Huntley & Owens, 2013; Owens, Shute, & Slee, 2000). In a qualitative study of girls' conflict using a sample of 75 girls aged 14- to 15-years-old, researchers found that adolescent girls were aware of negative behaviours such as rumours and gossip but felt that they lacked the coping skills to resolve conflicts and did not want to lose their place in the group (Huntley & Owens, 2013). Fear of speaking up was not a pattern within my study. However, a lack of coping or knowing how to resolve peer conflicts directly (beyond seeking support from adults or talking to friends) was found. Not knowing what to do about bullying was found again and in later reports of peer conflict in the later studies in the thesis examining the Phase 3 data.

The use of thematic analysis in the first study enabled understanding of the prevalence of reported stressors across the sample (Braun & Clarke, 2006). It became possible to explore some of the variation in the themes discussed and was a suitable method for this research question. However, it was not possible to explore each participant's individual set of circumstances in-depth as the aim was to focus on the most prevalent themes from the large dataset ( $N = 54$ ). This in-depth and biographical aspect to stressors was expanded in the later studies that focused on protective factors, however.

The types of stressors identified in Chapter 3 were further elaborated on in Chapters 5 and 6, which examined patterns in reported protective factors in relation to

mental well-being and risk of psychopathology. Heterogeneity in the ways that stressors were experienced by adolescents were echoed in these later studies and expanded upon along with many of the same stressors described. Whilst a thematic analysis was not performed in the later studies, the same themes were also found latterly: 1) Internal mental states and emotions 2) Peer difficulties 3) Behavioural difficulties 4) Bullying 5) School difficulties and 6) Family difficulties.

However, there were also stressors described in the later studies in this thesis that were not reported in the first study. Some adolescents in the studies examining HS3 data described difficulties with concentration and difficulties associated with the condition of ADHD, such as peer difficulties. The condition of ADHD has been found in previous research to be a risk factor for poor mental well-being, as well as difficulties with peers and parents (Peasgood et al., 2016; Wehmeier, Schacht, & Barkley, 2010). Some participants also described parental substance misuse or worries about this issue. Parental substance misuse has been found to increase risk of psychopathology in adolescents (Bountress & Chassin, 2015; Henry, Liner-Jigamian, Carnochan, Taylor, & Austin, 2018). In addition, some participants described concern about their parents' finances, alcohol consumption and parental employment. Worries about family economic strain have been associated with depressive symptoms (Mistry, Benner, Tan, & Kim, 2009). Incidents of racist bullying were also reported by one participant and xenophobia by another participant in the later studies.

In terms of what specific stressors were reported and the extent that they reflect the actual experiences of participants, there were some interesting gaps in the dataset that I have reflected upon. For example, in the first study, there was a subgroup of adolescents who, at the time of interview, were receiving a targeted intervention based on previous experiences of domestic violence at home and did *not* discuss domestic violence or maltreatment in their interviews. Thus, clearly there were some limits to what stressors could be obtained through the interview due to what adolescents were willing to talk about in an interview context. Theorists have proposed that qualitative research is not intended to be an accurate reflection of reality. For example, Polkinghorne (2007) stated, "descriptions given by participants of their experienced meaning is not a mirrored reflection of this meaning. Participants' stories may leave out or obscure aspects of the meaning of experiences" (p. 480). Thus, thinking about the findings

means that adolescent reports in an interview with an adult researcher cannot be assumed to be an accurate reflection of participants' reality and their entire lived experience. For a range of reasons, participants may omit important aspects in their narratives in relation to the effects of stressors on their mental well-being. Treating adolescent narratives gained from interviews with adult researchers with a level of caution ties in the critical realist (CR) approach adopted by the thesis. A CR approach suggests that whilst we might strive to uncover objective knowledge, the data is not an accurate reflection of reality, and further that there are number of structures that influence the data that requires playing the role of detective (Willig, 2012). The other approach of considering issues of positionality is relevant also, as there may be limitations in what adolescents choose to share with an external, adult researcher with a different social identity.

Furthermore, when conducting research specifically with children and young people, it is widely understood that it is appropriate that adolescents only share what they are comfortable with talking about and that it is the adolescent's right not to share, or indeed to withdraw from the interview at any time (Greene & Hogan, 2011; Greig, 1999; Kirk, 2007). Part of the consent process and UCL ethical approval for the qualitative studies in the thesis was provided on the basis that participants felt free to leave the study or not answer questions that they did not want to speak about. Thus, the omission of discussion of domestic violence (DV) as a stressor for adolescents that had experienced DV is a reminder of the limits of what can be gained from semi-structured interviews without other data sources, and that what can be gained within the interview is determined by the choices of the participant, as well as what they can recall and how they may understand the question posed.

Nevertheless, other participants across the sample (that were recipients of other interventions) did discuss previous instances of DV, abuse and maltreatment in both the HeadStart Phase 2 and 3 samples. Some of these participants made explicit connections with these stressors and subsequent negative outcomes. One participant discussed an incident of parental maltreatment at Time 1 in the QLS but not at Time 2. Others discussed parental maltreatment at both timepoints (and subsequent support in relation to it) as current events at the time of interview, and another discussed receiving treatment in relation to parental maltreatment at Time 2. Therefore, it cannot be

concluded that stressors that incorporate sensitive topics such as DV are not possible to access through semi-structured interviews, but it is a reminder that there may be stressors that participants are not be willing to discuss at the time of the interview for a range of reasons that may remain unknown to the interviewer.

At the outset of the thesis, part of the rationale for this body of work stemmed from evidence that found an increase in the rate of mental health difficulties and reduced mental well-being of English adolescents (Deighton, Yoon, & Garland, 2020). Following other authors, it was suggested that mechanisms that lead to poor mental well-being and the risk of psychopathology are not sufficiently understood to understand the causes for these trends in the English context (Costello et al., 2011). From the thesis, the role of stressors in contributing to poor mental well-being and heightened risk for psychopathology becomes more apparent particularly for adolescents that experience multiple stressors or lack protective factors, such as coping strategies or types of support that they can engage with. The ways that both internal and external stressors interact shows the complexity of how mental well-being is influenced both internally and externally and fits in with a Social Ecological approach (Cross et al., 2015; Decker, Gutmann-Gonzalez, Lara, & Brindis, 2019).

The Social Ecological approach stipulates that an adolescent is situated within nested systems and that there are interactions between specific factors within this system that have a more direct or distant effect on the adolescent (Castillo et al., 2019; Ungar et al., 2013; Bronfenbrenner, 1979). From the qualitative studies within the thesis, a diverse range of the subjectively perceived mechanisms that link stressors with states of poor mental well-being and some reported symptoms of psychopathology have been provided. The negative effects on mental well-being of adolescent-identified stressors have been illustrated from adolescents' own narratives. In these reports, they have often explained how they perceive that different stressors interact. This is important as it is widely discussed that there is a need for evidence of the mechanisms that link stressors and other risk factors to the increased risk of psychopathology (Rutter, 1987; Ungar, 2003). It is also a reminder that whilst a stressor may occur in one domain, such as difficulties within the family or being bullied at school, it can affect multiple domains around the adolescent, including the individual adolescent's mental well-being and behaviour, the family, school, friends, and peers.

## **Research question 2: What types of protective factors have been found to increase adolescent mental well-being and reduce the risk of psychopathology in current research?**

From conducting a scoping review on the factors that increase the outcome of adolescent mental well-being, 145 individual protective factors were identified from 104 studies, provided in Chapter 4. The sheer volume of studies brought attention to the rich and varied number of factors that associate with mental well-being. The wide range of factors provided evidence of the diverse and detailed influences on adolescent mental well-being that are multi-layered, extending from the individual adolescent to social relationships and to the adolescent's wider community, both online and offline. Masten and Powell's (2003) example framework was selected to cluster and organise protective factors found. An updated and expanded version of the framework was produced. The review was comprehensive, with subdomains of protective factors found for each of the domains initially proposed by Masten and Powell (2003): Individual, Social Relationships, and Community Resources and Opportunities. The review highlighted protective factors that were commonly studied, such as 'self-efficacy' and 'parental support', and those protective factors where the evidence base is more scant or preliminary, such as 'fun' and 'reciting mantras' (Coholic, 2011; Nidich et al., 2011). The review also demonstrated the specificity of some protective factors identified that were only found to be protective for a particular age group or particular gender.

The factors that were found in the framework were then underscored in many ways in the subsequent chapters that included reports of protective factors from adolescents in the QLS. For example, adolescents in the 'Multiple Sources of Support' ideal type discussed a range of factors that were found in the scoping review, including parental support, school connectedness and teacher support, religiosity, and extracurricular activities such as Scouts or sports (Black & Lobo, 2008; Calmeiro et al., 2018; Holt et al., 2017; Oberle et al., 2011; Ruvalcaba et al., 2017; Tiet et al., 2010). Equally, adolescents in the 'Self-Initiated Forms of Support' type were characterised by protective factors such as self-efficacy and positive self-esteem (Keyfitz et al., 2013) but made fewer references to teacher support or parental support. Finally, adolescents in

the 'Uncertain Sources of Support' were characterised by uncertainty in or an absence of parental support, sibling support, teacher support, and friendship support that are known to link with reduced mental well-being and an increased risk of psychopathology (Ikiz & Cakar, 2010; Newland, 2015; Noller, 2005; Wenk, Hardesty, Morgan, & Blair, 1994).

Despite an extensive search of several databases as part of the scoping review, there are likely to be more protective factors linked to the outcome of mental well-being within the evidence base. This is due to the fact that different studies adopt different terminology in the study of protective factors (which may diverge from search terms applied in the review). For example, many studies do not use the term "protective factor" (or equivalent term such as "resilience factor" or "promotive factor") in the title but instead focus on the protective factor itself, such as 'self-esteem' or 'physical exercise' and so would not have been detected by the search terms applied. Therefore, there are likely to be many more than 145 factors associated with mental well-being that are not described as "protective factors" within the study itself (or title and abstract). Equally, studies that only studied risk factors (as given by the title) were not included in the selection of studies, and these studies likely included some protective factors. The broader field of protective factors would benefit from convergence on common language and definitions or referenced alternative terms and definitions, as previously noted by Luthar (2000). It was beyond scope to conduct a separate literature search for every protective factor found in the review: self-efficacy, self-esteem, and indeed this was not the purpose of the review.

However, whilst more protective factors can be identified, the studies retrieved in the review provided a broad, initial overview of existing literature. Which protective factors were less commonly studied was also highlighted. The potential remains for separate reviews to be undertaken for each specific protective factor (though some have already been conducted). For instance, a review of school and teacher connectedness was recently undertaken by García-Moya, Bunn, Jiménez-Iglesias, Paniagua, and Brooks (2019). Or, to take another protective factor, reviews have been conducted on spirituality and religiosity and psychological capital (in relation to mental health) (McPherson et al., 2014; Wong et al., 2006).

Another important finding was the specificity of protective factors in relation to mental wellbeing and psychopathology. Some protective factors were only protective to specific age groups and genders or in particular contexts, such as a two-parent family structure that was found to be protective for boys only (Levin & Currie, 2010). Similarly, easy communication (with parents) was found to be protective for girls only (Levin et al., 2012), and playing video games and watching TV reduced anxiety for boys but not for girls (Ohannessian, 2009). The gender and age specificity of protective factors suggested that more research is needed to explore and explain gender and age differences in the effectiveness of protective factors and differences in mental wellbeing and mental health outcomes. Knowledge of specificity is important for interventions seeking to increase mental well-being and reduce the risk of psychopathology in adolescent boys and girls.

A particular challenge of the review was extracting specific protective factors from intervention studies. From the intervention studies found (e.g. Johnson et al., 2007; Leventhal et al., 2015; Tunariu et al., 2017), it was often not completely clear which precise component of the intervention increased the outcome of mental well-being. Therefore, in order for researchers to understand which aspects of interventions lead to a change of outcome (or which combination of aspects) studies would benefit from testing separate component parts of specific interventions. Exploring relevant mechanisms would also be necessary to understand the protective factors and processes that lie within other activities found to be protective in the review, such as Scouts, mindfulness, yoga, and repeating mantras (Coholic, 2011; Khalsa, Hickey-Schultz, Cohen, Steiner, & Cope, 2012; Ruvalcaba et al., 2017). Certainty about which component parts contributed to which mental well-being outcome is important to correctly identify a protective factor and to be able to apply that knowledge in the design of interventions (Tomy, Weinberg, & Cummins, 2014). Researchers have suggested that identification of the active ingredients should be prioritised to place the focus on the components that have most influence on the outcome and save costs (Brunwasser, Gillham, & Kim, 2009; Tomy et al., 2014). Other scholars have stressed the importance of testing the underlying theory in contributing to a change in outcomes in interventions (Toth et al., 2015).

The scoping review identified very few qualitative studies. Importantly, it added renewed impetus to conducting qualitative studies on protective factors. It also demonstrated the ways in which a wide range of protective factors have been found to increase levels of mental well-being. The review found scope for further qualitative inquiry to add further detail and illustration to the mechanisms underpinning protective factors and the lived experience of such variables. Qualitative research is widely understood to be able to complement the quantitative evidence base (Court, 2013; Ungar, 2003). Court (2013) argues, “We need ways of discovering new variables and new relationships between variables that become visible only when we view a lived situation in all its complexity” (p. 9). Thus, the review underscored the need for further qualitative research on protective factors to add to the evidence base of primarily quantitative studies.

### **Research question 3: What patterns exist in adolescents’ experiences and reports of protective factors in relation to mental well-being and the risk of psychopathology?**

Using ideal-type analysis (Gerhardt, 1994; Wachholz & Stuhr, 1999), three ideal types or patterns of protective factors in relation to risk and mental well-being were constructed. The adolescent with ‘Uncertain Sources of Support’ (USS) was found in a total of 35 cases (55.55% of the sample). The second type, the adolescent with ‘Self-Initiated Forms of Support’ (SIFS), was found in seven cases (11.11%). The third ideal type was the adolescent with ‘Multiple Sources of Support’, 21 cases in the sample fit with this type description (33.33%).

Type descriptions were formulated as part of the ideal-type analysis. The USS type referred to adolescents that reported a range of stressors. These participants reported a lack of protective factors and, in particular, few sources of support and/or strategies to cope or manage stressors. The second type, the adolescent with ‘Self-Initiated Forms of Support’ (SIFS), included adolescents who described a range of self-initiated supports and strategies for managing perceived stressors and promoting mental well-being, before describing external support. These self-initiated strategies included playing video games, part-time work, developing skills or spending time outside with friends.

Adolescents within the SIFS ideal type described that they would generally manage difficulties and/or emotional states independently (of adults). The third ideal type was the adolescent with 'Multiple Sources of Support', who reported receiving a wide range of generally effective support. Types of support included support from family (such as emotional support and positive communication with parents and family members), school (such as teachers and staff) and/or other external sources (such as community-based activities). Adolescents in the MSS type described a small or moderate level of risk, such as peer conflict or worries about schoolwork, but also described that they had support in place to manage their stressors. Some adolescents reported enjoying their life or having an absence of serious problems.

The patterns or ideal types were constructed using ideal-type analysis. Ideal types analysis has also been called "qualitative cluster analysis" due to the identification of clusters (Wachholz & Stuhr, 1999) and was a suitable method for the identification of patterns in a large qualitative dataset. Ideal types serve as "orientation points" for comparing participants within the dataset (Werbart et al, 2011, p. 101). More broadly, within the study of risk and protective factors, patterns are often elicited through quantitative methods such as Latent Profile Analysis (LPA) and so identification of patterns using qualitative methods is less common (Aldridge & Roesch, 2008; Bowen et al., 2007; Copeland-Linder et al., 2010). Ideal-type analysis enabled clear patterns to emerge from highly heterogeneous descriptions of risk and protective factors reported across the sample. Ideal-type analysis aims to use language close to the language that participants use (Werbart, et al., 2011). As might be expected, participants did not use the language of protective factors (and this language was not introduced to them in the context of the research interview). Instead, the use of the constructs of "support" and "coping" were used as it was often referenced by participants and researchers in the interview setting.

Ideal-type analysis enabled identification of three patterns of protective factors in relation to mental well-being and the risk of psychopathology. At the point of conducting the first ideal types study, it was not clear if the ideal types developed would be applicable to describe the data at later timepoints (or if further ideal types would be needed). When applied to the Time 2 data, the typology still described the data; however, the participants had moved type and therefore yielded new types of a shift

from one type to another, e.g., USS to MSS. It remains to be seen if these patterns would be found if applied to other samples of adolescents. Thus, the transferability to other samples is currently unknown. However, to ensure trustworthiness, I followed strategies for increasing credibility outlined by Lincoln and Guba (1985) and Shenton (2004). This involved making sure case reconstructions reflected the data and that identification of stressors and protective factors was reviewed by my supervisors and a research assistant. I kept a careful audit trail to ensure that the process of my research was transparent and that the same method could be replicated elsewhere (Shenton, 2004; Tobin & Begley, 2004).

While the ideal-type analysis was used to derive categories from the interview data, the types that emerged could be seen to reflect a continuum, as noted in previous research. For instance, existing typologies have included a scale of greater support and fewer stressors/risk factors on one end and more stressors/risk factors and less support on the other, which broadly fits with other typologies (Copeland-Linder et al., 2010). For example, a typology of risk and protective factors in relation to violence exposure and mental health outcomes found the classes: 'Vulnerable', 'Moderate Risk, Medium Protection' and 'Moderate Risk, High Protection' (Copeland-Linder et al., 2010). The ideal types typology and reports of more positive mental well-being and coping in the MSS ideal type versus uncertain mental well-being and a lack of coping in the USS ideal type was also in agreement with the notion that more support is associated with increased well-being and cumulative protection (Heerde & Hemphill, 2018; Yoshikawa, 1994), as well as the fact that social support is a protective factor linked with mental well-being (Aneshensel, 1992; McGrath et al., 2009).

The third ideal type provided support for the cumulative risk model. For those adolescents that were designated as 'Uncertain Sources of Support' (in the sense of reporting a given source of support as positive at one point, but negative or absent at another point in time) or overall absent support *and* a multiplicity of stressors, the typology provided some agreement with the cumulative stress hypothesis. Like the cumulative risk hypothesis (Evans et al., 2013), the *cumulative stress model* postulates that an increased number of stressors contributes to negative effects on mental well-being and increased risk of psychopathology and poor physical health (Anda et al., 2006; Nederhof & Schmidt, 2012; Umberson, Williams, Thomas, Liu, & Thomeer, 2014;

Appleyard, Egeland, van Dulmen, & Sroufe, 2005; Evans et al., 2013). Many of the USS participants had a *high stressor load*, in the sense that they reported multiple stressors. However, a key difference between my ideal types typology was not only the amount of support received, but how helpful the support was perceived to be and orientations towards receiving support from family and school, versus self-directed behaviour and problem solving.

Some important questions regarding the Uncertain Sources of Support type remain. A remaining question with regard to the USS pattern is to what extent these adolescents had support available but did not draw on it or whether support was absent from surrounding systems, such as the participants' family, school, and local welfare systems. Several possibilities have been explored within the thesis. One explanation is that there was a lack of support available to these adolescents, both at home and within surrounding systems, and that HeadStart was not yet available to a proportion of these adolescents. Researchers have established that there is variation in what mental health and mental well-being support is available in England, with provision varying by local authority (Bywaters et al., 2015; Gilbert et al., 2012). The type and presence of HeadStart interventions varied by local authority and school (Stapley et al., 2019).

Some scholars argue that it is more appropriate to talk about inequities in service provision than variation (Bywaters et al., 2015). This is due to the fact that rather than being attributable to variation in populations, the differences are due to some children being born into more affluent families than others (Bywaters et al., 2015). Due to different socio-economic positions, different adolescents have varying levels of exposure to stressors across local authorities (Bywaters et al., 2015). Bywaters and colleagues (2015) have described that *child welfare inequity* refers to when adolescents and their families have unequal chances to access child welfare. It is the case that some of the sample in the USS ideal type potentially had a number of child welfare-related needs due to a high number of stressors. There are also differences within populations with the level of informal support in different neighbourhoods, separate to what statutory (formal) forms of support are available (Pinkerton & Dolan, 2007). Furthermore, there are resources within the environment that affect mental well-being, for example environmental factors that have been found to correlate with poorer mental

health such as low quality housing and an absence of resources like playparks and recreational activities (Bernard et al., 2007; Curtis et al., 2013).

For some adolescents fundamental sources of support was missing. Whilst particular factors provide a broader context and a reminder of the differences in the availability of formal support across geographies and institutional settings, in my ideal types, what was often missing or uncertain in the 'Uncertain Sources of Support' type was perceived supportive parental support and helpful school support. The parental support was undermined by a range of stressors including financial strain, marital breakups, physical and mental parental illness, and instances of maltreatment. As noted throughout the thesis, positive parental and family relationships confer protection towards adolescent mental well-being and reduce the risk of psychopathology (Calmeiro et al., 2018; Hair, Moore, Garrett, Ling, & Cleveland, 2008; Rodríguez-Fernández, Ramos-Díaz, Madariaga, Arrivillaga, & Galende, 2016).

Bronfenbrenner's (1994) framework is a point of reference in conceptualising the multiple layers around an adolescent, including the adolescent themselves (Belsky, 1980; Ridings et al., 2017). Taking a qualitative approach underscores the considerable heterogeneity in adolescents' experiences of stressors and protective factors within these different spheres of potential influence. Heterogeneity in experience can be found in relation to stressors and protective factors at the levels of the individual, their family and family relationships, their extended family, their school, community, and neighbourhood as well as the services available to them within their school, both from HeadStart and from services as part of the local authority. Whilst resilient adolescents are sometimes described as navigating resources from external systems (Ungar, 2005, p. 425), as discussed, available resources may be highly variable and may not be present for adolescents to navigate through (Bywaters et al., 2015; Crenna-Jennings & Hutchinson, 2018).

Several possible theories may explain differences between the ideal types derived in this thesis that are not as yet confirmed through current evidence. One possible theory is that the differences result from variation in the types of the interaction between internal and environmental factors that fits with the Social Ecological model (Bronfenbrenner, 1994; Eriksson et al., 2018; Hong & Garbarino, 2012). Adolescents

that were allocated to MSS may be more receptive to additional support and forms of coping due to prior positive experiences that involved the interaction of internal and external factors. Conversely, adolescents that reported more uncertainty in the types of support they had available (particularly at home and at school) may be less receptive to external support due to fewer prior experiences of positive or consistent support that could lead to a higher likelihood of poor mental well-being due to a lack of a positive experiences of support. For example, a study found that adolescents were reluctant to go to GPs for mental health-related problems due to a lack of trust, stigma, or embarrassment, and patterns varied by setting and neighbourhood (Mmari, Marshall, Hsu, Shon, & Eguavoen, 2016). Whilst further research would be required to understand the precise interaction that leads to different patterns, considering the interacting levels of individual factors (willingness to seek help or ask for support, perception that support is already available) and contextual factors (availability of resources within family, school, neighbourhood, local authority, and friendship group) would be important to capture the multiple, contextual influences on outcomes.

The focus on *perceived* support is an important consideration that is often overlooked. It is important to consider when assessing adolescent mental well-being and the risk of psychopathology, rather than actual or received support. The rationale for a focus on how support is perceived is because while studies have found that *actual* or *support received* is not consistently associated with increased well-being, sometimes support is perceived as effective, but not always (Thoits, 2011). Thus, in the case of adolescent mental well-being, studies that examine perceived support are useful because studies suggest that the perception of the support determines the nature and the extent of the impact on mental health outcomes (Thoits, 2011). For example, a study found a stronger association with *perceived* support and mental health than *actual* support received (Bolger & Amarel, 2007; Thoits, 2011). In the current work, the focus on perceived support has generated some interesting patterns based on considering perceptions of both stressors and protective factors. There has been variation in the extent that protective factors alleviate stressors and when they are perceived as helpful, preferable to another type, or unhelpful or unmemorable. Therefore, it is advocated here that within research on stressors and protective factors in relation to adolescent mental well-being, there is a value in focusing on adolescent *perceptions of support* or *perceived protective factors* and the connection with mental well-being. Adolescents

may receive support from school staff or interventions. However, if such support is perceived as unhelpful, this prevents it being 'counted' as support by the young person and may not contribute to a change in outcomes. However, such support might be anticipated to affect an adolescent's outcomes if adults involved in the care of the adolescent (such as parents and teachers) were asked to list an adolescent's protective factors.

The uncertainty regarding reported protective factors for the adolescent assigned to USS is complex. Uncertainty in support refers to protective factors, such as a parental relationship, that are perceived to have a protective effect at particular times and could either serve no protective effect or act as a stressor at others. Such ambivalence was described by the optimal case as a "double-edged sword". Adolescents describing the positive and negative effects of a particular protective factor, such as parental support, is an interesting feature of this study. Some variables are reported to be consistently protective but others fluctuated, and may have been risky at times, according to reports. However, capturing this perceived ambivalence is important as in the context of a stressor, it is possible an adolescent will benefit more from a protective factor that is generally consistently supportive rather than fluctuating. Some existing research has explored how some protective factors can be dually risky and protective (Bottrell, 2009; Ungar, 2003). For instance, a qualitative study of inner-city Australian girls from a housing estate in Sydney found that peer social networks could be a source of practical and emotional support, but also a social circle that could lead them into trouble, such as instances of substance abuse (Bottrell, 2009, p. 328). The current findings explore the notion that factors can be both stressors and protective factors within other domains, such as parental support and school staff support that can have this dual risk and protective effect. There are already a range of studies that have shown that adolescent friendships can offer protective benefits but also confer a risk of drawing an adolescent into deviant or risky behaviour (Allen, Porter, McFarland, Marsh, & McElhaney, 2005; DuBois et al., 2002). Ungar and other authors have also discussed the ways that protective factors can be contextually variable and influenced by the specific social ecology, and thus protective factors cannot be assumed to be consistently protective for all adolescents in all places (Bottrell, 2009; Seccombe, 2002; Ungar, 2003, 2006). Some researchers have encouraged studies to take into account the existing inequalities in which processes of resilience occurs (Bottrell, 2009).

The importance of family support for child and adolescent well-being is well established (Calmeiro et al., 2018; Rodríguez-Fernández et al., 2016). The uncertainty of protective factors and the presence of risk factors in the family domain is in alignment with research that finds that many of the stressors that adolescents described in relation to family relationships, such as maltreatment from parents, parental alcoholism, parental mental illness and parental physical illness, are risk factors for adolescent poor well-being and risk of psychopathology (Belsky, 1980; Ohannessian & Hesselbrock, 2008; Sieh et al., 2012; Webb et al., 2017; Weissman et al., 2006). From an ecological approach, the parents' experiences and the factors that influence the parents within the macrosystem influence the well-being and risk of psychopathology of the adolescent (Belsky, 1980). The implication of the finding from this grouping is that some protective factors are not consistently so. However, more data collection points are needed to be able to understand the full extent that these aspects are perceived to fluctuate over time and which variables are most significant within the family and parental domain.

Understanding the perceived nuances and oscillations in relationships with parents, teachers, and supportive adults (as both stressors and protective factors over time) is an important take-away from this thesis. Whilst it is known that a parent that engages in maltreatment is a source of risk, what about a parent that is reported to be mostly supportive but occasionally abusive? What is the best way to classify these types of inconsistent protective factors? This raises a question of how to capture the vicissitudes and nuances of perceived relationships, which can be starkly ambivalent or very subtle depending on the individual adolescent's reports (and may vary with time and with other factors influencing the semi-structured interview). Understanding changes in perceived protective factors highlights the contribution of longitudinal studies, because temporal changes in factors reported to be protective at a given point in time may be missed from cross-sectional studies (Groun, Thomas, & Shoffner, 1992; Sharrer & Ryan-Wenger, 1995).

**Research question 4: How do patterns of protective factors in relation to mental well-being and risk of psychopathology as reported by adolescents change over the course of one year?**

The ideal types typology developed in Chapter 5 was used as a frame of reference to explore changes in patterns of protective factors over time. When comparing ideal type membership at Time 1 and 2, six shifts took place, forming new patterns (or new ideal types). The shifts comprised of USS-MSS, USS-SIFS, SIFS-MSS, SIFS-USS, MSS-SIFS and MSS-USS. The study found that half of the sample changed ideal type relative to the previous year and the other half were stable in ideal type. For instance, 30 participants continued to be classified as 'Uncertain Sources of Support', 'Self-Initiated Forms of Support' and 'Multiple Sources of Support'. Another finding was that based on change in type membership, 14 participants (40.00 %) reported more and more effective protective factors in relation to mental well-being and psychopathology risk at the second timepoint relative to the first, interpreted from shifts across types towards 'Multiple Sources of Support' over one year.

Participants shifting from 'Uncertain Sources of Support' to 'Multiple Sources of Support' (USS-MSS) was interpreted as a positive change in reported protective factors, as participants reported receiving more and better support in relation to risk. Some participants reported changes in outcome, such as feeling *more* resilient, confident, or calmer. Sometimes such outcomes were attributed to participation in specific HeadStart interventions or engagement with other external support (parental, teacher, therapeutic). This finding fits with the literature that specific protective factors, such as the presence of parental support and teacher support, link to increased adolescent mental well-being (Suldo et al., 2009; Wang, Kouvonen, Satka, & Julkunen, 2019).

Most of the participants that were stable in type belonged to the USS and MSS ideal types (USS-USS and MSS-MSS). The former were stable in the uncertainty of their support and continued to lack adequate protective factors (support, coping strategies) in relation to a range of stressors. The stability of adolescents with uncertain support was an important finding in relation to risk identification because it revealed a subset of adolescents who lacked support in relation to a high level of stressors. Even if risk of poor well-being and mental health was identified by surrounding systems, either

provision was not in place, or the provision did not change the overall profile of stressors of the particular adolescent.

The other category that remained the same as at Time 1, the MSS ideal type, continued to report multiple and generally effective protective factors in relation to mental well-being and the risk of psychopathology. In reference to the wider literature, an American study found that after the transition to secondary school, protective factors in the domains of peer, school and individual increase (and parental protective factors decrease) (Kim et al., 2015). The literature on coping finds that adolescents learn new coping techniques and amend coping strategies over the developmental period (Herres, 2015). As adolescents become older, studies find they use more problem-solving techniques and less avoidant coping (Amirkhan & Auyeung, 2007). Some adolescents at Time 2 talked about trying new strategies to manage stressors, for example one adolescent was journaling to de-stress and process conflict between her friends. However, whilst in the MSS category new strategies were applied and protective factors reported, and many continued to emphasise the important role of parental support, or other ongoing supportive protective factors such as support from teachers or friends.

The typology enabled the study of change in the overall profiles of individual adolescents' protective factors. Because the profiles of protective factors changed over time, it became possible to observe a range of shifts. The nine combinations of ideal types provided evidence of the range of shifts adolescents can make both towards more 'Self-Initiated Forms of Support' or 'Multiple Sources of Support', or towards the experience of less support and a lack of coping in relation to stressors. Because evidence was found in the study for every possible shift, it suggests that there are a lot of changes in the types of experiences of protective factors. However, it is difficult to know how long-lasting these reported changes are without further data collection points.

Again, whilst clear changes were observed through change in type membership and stability, there are a number of limitations to note. Whilst a rich source of data, as per the previous study, caution is required because of the fact that how an adolescent portrayed them in the interview at both Time 1 and 2 are not accurate representations of all their stressors and protective factors at both timepoints. Nor is it a systematic record of all possible sources of support in participants' lives, and it very much depends on

what the adolescent opts to speak about. At the start of the second interview, the QRT asked each interviewee to reflect on what had changed since the previous timepoint. Some participants spoke in-depth in response to this question; others could not recall particular changes, and only when they began talking about how life was going with school, home, friends and HeadStart interventions did they begin to reference specific changes or make comparisons with the previous year.

In terms of the accuracy of participants' reports, adolescents that reported severe or chronic stressors over two timepoints or the same protective factors within both interviews (such as continued bullying or ongoing behavioural support in a school unit in relation to behavioural difficulties) could be proposed to lend credibility to accounts, as has been broached by Thompson and Holland (2003). Repeated interviews with the same participants have been described to lead to increased understanding of individual participants amongst researchers (Thomson & Holland, 2003). Drawing on longitudinal data meant that it became possible to capture evidence on protective factors or stressors that continued (such as ongoing conflict between separated parents or bullying over consecutive years), as well as those stressors that were perceived to reduce or disappear (such as peer conflict that was present one year but resolved the next). However, the presence of a stressor over two timepoints does not guarantee that it is an accurate reflection of reality but that there is a continuation of the stressors as part of the adolescent's perspective shared at two timepoints, and, building on Thompson and Holland (2003), multiple timepoints can facilitate more in-depth understanding of participants. Longitudinal data enables comparison of individual cases over time and can substantiate the findings from cross-sectional studies (Grouer et al., 1992; Sharrer & Ryan-Wenger, 1995). It potentially becomes possible to understand how adolescents adapt to changes in circumstances, and therefore is helpful for studying changes in factors that may be construed as stressors over time (Grouer et al., 1992; Sharrer & Ryan-Wenger, 1995).

The stability in types raises questions, and perhaps of most practical importance and urgency are those adolescents that continue to report 'Uncertain Sources of Support' over time. Based on the theory of cumulative risk or cumulative stressors, one could hypothesise that adolescents in this category are most at-risk of poor mental well-being and psychopathology (Björkenstam et al., 2015; Evans & English, 2002; Evans et

al., 2013). Indeed, some of this subset of adolescents already reported distress and a lack of coping with stressors. Due to the number of stressors or risk factors, this group could be described as “high-risk”, but this language is not ideal. Authors have pointed out that the language of “high-risk” has a fatalistic connotation that implies that the developing adolescent will develop a disorder (McGorry et al., 2018). One alternative framing to high-risk adolescents is that these are adolescents that have a high number of stressors (a high stressor load) and a lack of support and could be designated as ‘adolescents with support uncertainty’.

Moreover, adolescents that report chronic stressors and a lack of support require further investigation to understand their support needs. Such adolescents need to have access to tailored support that may be required both at the family level, as well as at the individual level (due to family-related stressors). The fact that support uncertainty was reported over two timepoints may suggest the adolescent’s uncertain support were undetected by surrounding systems at school and through HeadStart support. It could suggest that such adolescents did not receive enough of suitable interventions in relation to the risk factors that they experience. It may suggest that there were possible barriers on the adolescents’ part to help seeking or knowing that help was available. Drawing upon adolescent perspectives without other data sources and existing research on stressors, this subset of adolescents appears to be at greatest risk of poor outcomes without intervention from surrounding systems (whether informal or formal).

From the chosen design of the study of change in protective factors, it was not possible to verify the sources of support available to interviewees, which could be viewed as a shortcoming. However, it did enable a bottom-up, data-driven approach to the study of changes in patterns of protective factors over one year. This approach is currently less common within the literature, and it also prioritises adolescent voices on protective factors in relation to mental well-being and the risk of psychopathology and the stressors that they experience. Whilst the patterns were clear, and individual mechanisms were conveyed, further depth could be captured by taking a trajectory approach that involves longitudinal study of a small group of individuals within the wider sample (Grossoehme & Lipstein, 2016). This may be appropriate for the study of those adolescents that reported a decrease in protective factors over time in the context of

ongoing, personally specific stressors, particularly with regard to the risk of greater distress and risk of development of psychopathology.

The next section describes directions for researchers in the fields of adolescent mental well-being and mental health in the English context and beyond, expanding on the findings of the studies in the thesis.

## **7.2 Implications of the studies for HeadStart**

This PhD was situated within the broader context of the evaluation of HeadStart. Thus, discussion of what the preliminary findings mean for the wider HeadStart programme and the HeadStart evaluation conducted by the Learning Team is relevant to this wider context. Firstly, it is important to note that the approach taken within the thesis was socio-ecological, drawing from the work of Bronfenbrenner and more recent studies that take a Social Ecological approach towards the study of stressors and protective factors (Bronfenbrenner, 1994; Castillo et al., 2019; Hong & Garbarino, 2012; Oberle et al., 2011). The explicit focus on the wider context around the adolescent meant that the studies were not specifically designed to examine the effects of HeadStart support on adolescent outcomes. Thus, the emphasis was broader, examining all types of reported protective factors (coping strategies, parental, teacher, peer, friend and adult support, pastoral support, statutory support, ECA and HeadStart that were subjectively reported to have a positive effect on mental well-being) in relation to mental well-being and psychopathology. Of the range of possible sources of support, HeadStart was one strand. The chosen approach enabled understanding of how HeadStart was received within this wider context of potential protective factors and how this may vary for each participant. This broader approach provided some insight into the potential role of HeadStart in reducing the negative effects of stressors and increasing mental well-being as part of the wider social ecology.

Importantly, not all of the adolescents in the HS3 sample received HeadStart interventions. From the Time 2 longitudinal data, 33 participants reported receiving a HeadStart intervention (55%), 24 (40%) reported that they had not received a HeadStart intervention and three participants were unsure if they had received a HeadStart

intervention or not (5%). Data on whether or not adolescents received HeadStart interventions is based on interview report alone and so it is possible that HeadStart interventions, staff support or activities occurred in Time 1 but were forgotten or not understood to be specifically HeadStart support (Stapley, et al., 2020). In spite of these caveats, some preliminary information about perceptions of HeadStart support as a protective factor in relation to mental well-being and the risk of psychopathology can be discerned.

Within the first study of reported protective factors (Chapter 5), a number of HeadStart interventions were reported as positive. For example, psychoeducation, peer mentoring and one-to-one interventions were described as helpful protective factors that were linked within participants' reports to improved outcomes, such as increased levels of confidence, better emotion management (such as calming down from being angry and feeling upset) and having increased capacities to manage interpersonal conflicts at school and cope with incidents of teasing and bullying.

In contrast to those who positively appraised HeadStart support, the study also found that many of the adolescents who reported 'Uncertain Sources of Support' were not in receipt of HeadStart interventions at Time 1. These adolescents could have benefited from such additional HeadStart support to bolster existing support and abate stressors. Part of these participants' eligibility for the 'Uncertain Sources of Support' category stemmed from the fact that many of these adolescents reported a number of stressors and a lack of protective factors. The implication here was that there were a number of adolescents in the Uncertain Source of Support category that were potentially facing a number of difficulties that were not yet receiving HeadStart support and that could have potentially benefited from receipt of it (Stapley, et al., 2020). This could be due to the fact that HeadStart support was not yet available in the first year of HeadStart within the adolescent's school or was not specifically offered to the adolescent. It is less likely that they were offered it and did not take it as these participants were not aware of the HeadStart programme (unless they had received some type of interaction with the programme but did not recall it in interview).

The study of changes in reported protective factors (Chapter 6) found that half of the sample changed ideal type and that of these adolescents that shifted type, 18 had

received some type of HeadStart support, nine had not received HeadStart support and three were unsure if that they had received HeadStart support or not. Of the adolescents who had changed type from 'Uncertain Sources of Support' to 'Multiple Sources of Support' (USS-MSS), the majority had received HeadStart support (71.43%) and a lower number of participants had either not received it (21.43%) or were unsure if they had or not (7.14%). As per the chapter on the first wave of the longitudinal data, in Time 2, some adolescents described HeadStart support as leading to positive outcomes such as increased confidence and resilience. Notably, there were a number of adolescents who reported 'Uncertain Sources of Support' both at Time 1 and Time 2. For these adolescents, it was not clear whether it was the case that a participant's level of risk had been identified by surrounding systems, or if the support that was provided was not enough or not suitable for their needs and preferences.

As described in both studies using QLS data, there were a number of adolescents lacking protective factors. These were participants who reported a wide range of stressors and the protective factors reported were not substantial enough to address the range or the severity of reported stressors. From taking a longitudinal approach to the study of stressors and protective factors, some adolescents provided reports of chronic stressors that elicited emotional difficulties for adolescents and a level of uncertainty about the effectiveness of the support available. Some of these stressors were at the family level, such as domestic violence, interparental conflict, financial strain, and conflict between separated parents, as well as separation from a parent or both parents. Some reported stressors at school as well, such as peer conflict and difficulties performing schoolwork and concentrating in lessons. Other stressors were individual, such as managing anger and coping with peer conflicts and conflicts with teachers. As previously described, a high number of stressors is linked with an increased risk for poor outcomes and these adolescents can be anticipated to be at highest risk of poor mental well-being (Evans & English, 2002; Evans et al., 2013; McLaughlin & Sheridan, 2016). As pointed out by previous research, adolescents experiencing multiple risks should take priority for receipt of mental health support (Lin & Seo, 2017). The recommendation in the Evidence Briefing that managing anger and coping with difficult relationships with family and peers that are priority areas for support is potentially really important to provide support to the stressors faced by these particular adolescents (Stapley et al., 2020)

Sometimes HeadStart support was not sufficient. An interesting aspect found was that within the 'Uncertain Sources of Support' cohort there were instances where HeadStart was not potentially disrupting the negative effects of stressors on an adolescent's mental health. There were a few examples of participants who had participated in various HeadStart-related activities and extracurricular activities but still reported some chronic stressors and worries about them, despite the HeadStart support. In these cases, whilst activities were reported as enjoyable (and potentially increasing well-being), they did not reduce the negative effects of some chronic stressors for these particular individuals that may render them at greater likelihood for poor mental health and well-being outcomes.

Within the sample, there were also instances of adolescents who did *not* receive HeadStart support and were not familiar with what the programme involved. This finding has been documented in the Evidence Briefing which documented that some adolescents that were reporting difficulties were not receiving HeadStart interventions (Stapley et al., 2020). In the briefing, possible reasons included that they may not have been identified, may not have been selected, and may not have wanted to take up HeadStart support, or they had forgotten receiving it (Stapley et al., 2020). It is possible that, in some cases, adolescents had received HeadStart support but had not remembered or realised that a particular type of support from a staff member or group was in fact HeadStart support. However, it is worthy of comment that a small proportion of adolescents reported a deterioration in their protective factors and described life as getting worse or coping less with difficulties such as bullying or conflict at home. In some of these cases, participants described some outcomes that could be linked with poor mental well-being, such as exclusion from school, not knowing where to seek support and high levels of worry.

Other non-HeadStart interventions were highlighted by some adolescents with mental health difficulties. Another feature of experiences of HeadStart support, was that there were examples where a HeadStart intervention was reported to be a less effective protective factor when compared to other mental health interventions for a particular disorder. In one example, an adolescent with a pre-existing mental health disorder described that she found a tailored CAMHS intervention for adolescents and their

families in relation to her particular mental health condition preferable to a HeadStart intervention that was targeting adolescents only. There was just one instance of this type of report but there were also participants in the sample that discussed in interview that they were taking prescribed medications for ADHD and had some existing treatment and support for some types of psychopathology. In another case, a male adolescent reported that HeadStart was not helpful for managing his anger and behaviour issues.

Relatedly, there were a few examples adolescents who had markedly improved without HeadStart support. These adolescents reported more and better protective factors and support from surrounding systems at Time 2, but they had not received (or did not report) HeadStart support. Instead, perceived changes were due to a wide range of other types of support. In one case, a female adolescent attributed a new medical treatment technology and increased support for her mother, plus more time available for schoolwork and more time with friends increased achievement at school and perceived greater well-being. Furthermore, the alleviation of a risk factor (such as mother's health improving and reduced need to care for mother's health) were reported to be the mechanism that led to a change of outcomes. In her account, this was apparently unrelated to HeadStart provision. In these cases, processes, and individuals within surrounding systems around the adolescent had effectively identified an adolescent's risk (her caring role for other mother and her mother's ill health) and provided adequate support for the mother and the adolescent that was perceived to be effective within the adolescent's narrative.

The other subset to note was heterogeneity in participants' specific preferences in relation to types of HeadStart support and the role of time. For example, several participants appraised HeadStart positively at Time 1 and felt it was unnecessary in the second year (opting out). Others liked specific types of HeadStart support but not all, such as positively appraising some aspects and not others. A few participants spoke of liking the psychoeducation programmes and not the art therapy components, for example. Additionally, within an intervention, participants described finding one allocated peer mentor favourable over another.

Further, there were examples of participants that appraised HeadStart at Time 1 and were unsure why they were not selected to receive it at Time 2. Positive appraisal was interpreted from statements such as, “I liked it”, “I enjoyed it”, “it was fun”, “it was good”, or “I felt happier”. The implication here was that many participants valued HeadStart support and found it helpful. Within those MSS adolescents, there were a proportion of adolescents in the MSS category that did not have HeadStart support and already had a range of effective protective factors (e.g., a combination of parental support, school support, supportive friends, and ECA). There were those within the MSS category that reported that they benefited from an additional layer of support, despite having a range of effective protective factors (parental support, school support and/or connection, and friends). In these cases, HeadStart was helpful either in Time 1 or at both timepoints in managing smaller stressors (e.g., instances of peer conflict or school stress rather than more severe chronic stressors such as custody battles or parental illness). Finally, there were those within the males in the SIFS category that did not receive HeadStart support and reportedly drew on their own resources.

Overall, the implications are that drawing from adolescent reports there was some preliminary evidence that there were a range of experiences of HeadStart. This suggests a complex picture that includes a patchwork of experiences of HeadStart at both timepoints. The variation in experiences of HeadStart interventions across the first two years has been stated by Stapley et al. (2020) in the Evidence Briefing. The implication of the range of experiences is that because there has been varied experiences of HeadStart (via a number of interventions), evaluation of the full range of interventions is necessary (Stapley et al., 2020). Such evaluation could demonstrate which interventions led to a change of outcomes and require further investment (Stapley et al., 2020).

With reference to the thesis, the range of experiences can be grouped across the participants that remained stable in type and those that shifted type. Owing to the fact that some participants reported positive experiences of HeadStart, in some cases HeadStart is linked to improved protective factors. As discussed previously, for cases where it appears that there may have been a deterioration of protective factors (e.g., less reported in the second timepoint), this could suggest that a small number of adolescents were not benefiting from HeadStart but had high levels of stressors. This

could raise questions about the accuracy of identification of adolescents for further support as there may be adolescents with a high level of need that have not received support. It is also possible that local HeadStart programmes as primarily preventative interventions did not have the capacity to support adolescents that were reporting difficulties with a high number of stressors or were experiencing a stressor that required specific and intensive support at both adolescent and family level.

### **7.3 Opportunities for further research**

#### **7.3.1 Further research is needed in the study of how protective factors change over time**

Further timepoints in the QLS (there are five waves in total) examining reported protective factors would be an important extension to this study using ideal-type analysis for the third, fourth and fifth timepoint of the five-year study. From a prevention of psychopathology point of view, tracking participants who reported a deterioration in protective factors and a lack of coping would be essential to monitor their mental well-being and risk of psychopathology. This would enable further understanding of reported factors of what catalyses the onset of disorders (as well as what protective factors can disrupt the events in the chain) as well as having the potential to serve to monitor these adolescents that may be at risk. Equally, if the reported onset of mental health disorder occurs at Time 3 and the adolescent was stable as 'Uncertain Sources of Support' for the preceding two years, this provides further evidence that typology can be helpful in identifying those at risk of psychopathology.

Other research directions could include application of a range of research methods to these questions, such as asking participants to keep diaries, to study the duration of specific protective factors that have been perceived as helpful by adolescents. Another approach would be to analyse a small group of participants that have reported major improvements in mental well-being and/or mental health, using qualitative methods such as Interpretative Phenomenological Analysis (IPA) to study in-depth the mechanisms that have contributed to increase mental well-being and how mental well-being is individually experienced (Smith & Osborn, 2007). The studies within this thesis did not set out to measure the precise duration of protective factors. However, over two

years it was clear that some variables and experiences were temporary and others long-lasting, as well as the fact that protective factors could flip from being protective and then being a source of risk as reported by some adolescents as “double-edged swords”. As discussed, the period of adolescence can involve immense change in many areas of life (Moksnes & Haugan, 2015; Moksnes & Lazarewicz, 2017). Understanding how protective factors ebb and flow with transitions is valuable in terms of garnering further knowledge of adolescent mental well-being. Questions could examine: Which protective factors sustain over the entire course of adolescence or a specific period such as secondary school entry? Which protective factors are reported to be effective in relation to the period of a specific stressor or negative life events (such as exam stress or a bereavement)? Which protective factors are effective for a number of stressors concurrently and how? When a protective factor ends (such as the end of a relationship or the end of an intervention), what is the role of an adolescent in finding a replacement?

### **7.3.2 Establish which ideal type is better for adolescent mental well-being**

The new ideal types typology presented in this thesis raises questions about the patterns of protective factors that are most optimal for mental well-being. A tension has been found between positive engagement with multiple strands of external support and an adolescent’s autonomy in relation to accessing and engaging with surrounding support, exemplified by the adolescent with ‘Self-Initiated Forms of Support’. Drawing on existing evidence, I have hypothesised that ‘Multiple Sources of Support’ is better for mental well-being due to the positive effects of these types of sources of support, as documented in a range of studies (Hair et al., 2008; Hamby et al., 2018; Lambert et al., 2014; Rueger, Malecki, & Demaray, 2008). The other rationale is that the absence of parental and school connectedness has been linked with depressive symptoms (Oberle et al., 2011; Shochet, Dadds, Ham, & Montague, 2006). However, there are other features of SIFS that may have a positive effect on mental well-being, such as autonomy, positive self-perceptions and problem solving.

A long history of research in psychology designates autonomy as a developmental task that is of central importance during adolescent development (Groth, 1972; Karabanova & Poskrebysheva, 2013; Sessa & Steinberg, 1991). Theorists have

considered autonomy on two levels: the individual level of increased confidence and traits such as maturity, and secondly, separation or independence from parents (Karabanova & Poskrebsheva, 2013). Whilst this thesis did not begin with the aim of examining adolescent autonomy, the characteristics of the 'Self-Initiating Forms of Support' category overlap with some of the aspects of autonomy, such as maturity and independence from parents, that is part of adolescent development (Karabanova & Poskrebsheva, 2013). Some of these characteristics are linked with greater mental well-being, as found within the scoping review, such as self-mastery (Ryff, 1989), psychological capital (Afzal et al., 2016; Kaur & Amin, 2017), and self-efficacy (Leventhal et al., 2015; Loton & Waters, 2017). A lack of self-efficacy can be linked with poor mental well-being and difficulties with emotional regulation (Caprara, Steca, Gerbino, Paciello, & Vecchio, 2006). This begs the question of whether the SIFS category represents evidence of an advanced developmental stage, or, if it could be a strategy pursued in the absence of adequate parental and teacher support and a lack of help-seeking behaviours. Further timepoints would be required to understand the effects on mental wellbeing over time.

### **7.3.3 Research into cultural differences in protective factors in the English and UK context is needed.**

The studies on reported protective factors examined differences across a large sample ( $N = 63$  at Time 1 and  $N = 60$  at Time 2). However, it was beyond scope to examine cultural differences in protective factors and this was not part of the research design. However, within the dataset, there were potentially ethnic and cultural differences in reported protective factors. For example, several participants discussed the role of attending a place of worship as a protective factor, as well as learning religious texts and engaging with community members at places of worship. Many studies have pointed out that this is a much-needed direction of research and have drawn attention to protective factors that are more common to non-western cultures such as collectivist values or different norms in daily life (Ronald & Baker, 2000; Schwartz, 2006; Shepherd & Lewis-Fernandez, 2016). Understanding qualitatively the experience of protective factors that are specific to adolescents from minority ethnic groups would be important. This would involve continuing to investigate the ways that

culturally specific protective factors can be protective but also stressors in particularly contexts.

A range of studies have identified and examined culturally specific protective factors in relation to mental health outcomes with racial or cultural minorities (Chao, 2000; Hall, Teten, DeGarmo, Sue, & Stephens, 2005; Sue, Zane, Nagayama Hall, & Berger, 2009; Williams et al., 2014). The scoping review found that religiosity is a protective factor (Meltzer et al., 2011; Van Dyke & Elias, 2007). There may be protective effects of rites of passage at this stage of adolescence that vary between religions (for example coming of age rituals). However, examination into these factors was not possible at an aggregate level. Some adolescents discussed the importance of helping their parents, to take another example that may vary cross-culturally. Understanding more about factors that might be considered to contribute to the hedonic facet of well-being, versus those that are considered to contribute to the eudaimonic aspects of well-being would be interesting. It is possible that there are variations across cultures and specific communities. Given that mental health and mental well-being outcomes vary for ethnic groups in the UK (Patel & Goodman, 2007), it would be important to understand the specific risk and protective factors that lead to such outcomes. This would be important in intervention design as there are different cultural norms in families regarding parenting and monitoring, as well as different gender roles (Gutman et al., 2002).

Studies also find cultural differences in help-seeking and engaging with community support. Research also finds reduced uptake of child adolescent mental health services for specific ethnic groups (Bradby, Varyani, & Oglethorpe, 2007). In the UK context, a qualitative study found culturally specific barriers in seeking services from CAMHS for British Asian families (Bradby, Varyani, & Oglethorpe, 2007). An independent review of CAMHS in England conducted by the Care Quality Commission found that there was an absence of understanding of local need and lack of understanding of the needs of different groups (Crenna-Jennings & Hutchinson, 2018). Further research into culturally specific stressors and protective factors for Black and Minority Ethnic (BAME) groups could inform both policy and interventions that are culturally sensitive and may increase uptake amongst specific demographics.

### **7.3.4 Further research is needed into adolescents' own agency within supporting their mental well-being**

Within research on preventive interventions it is common to designate *modifiable* and *non-modifiable* risk and protective factors (McClure, Tanski, Kingsbury, Gerrard, & Sargent, 2010) with gender oft-cited as a non-modifiable risk factor. It is posited here that it is beneficial to consider further which stressors and protective factors adolescents can modify themselves, such as adopting new coping strategies and which factors are beyond modification for the individual adolescent (e.g., the national curriculum). Interventions could involve discussions with adolescents about how they can modify their protective factors, what they feel able to do to manage stressors, and when to seek support from adults for stressors that they are less able to modify (such as parental health or sitting exams and completing secondary schooling). In a recent systematic review of the available evidence, Wolpert and colleagues found a lack of empirical evidence for strategies for the treatment of depression that are unaccompanied by a professional, suggesting more empirical research is needed for self-care strategies (Wolpert et al., 2019). Given the range of coping strategies that adolescents use that have been qualitatively found (Stapley et al., 2019), more empirical studies are needed in this area to ascertain which factors are found to associate with mental well-being or reduce the risk of psychopathology and why.

### **7.3.5 Further research on the role of mental health and mental well-being literacy in reporting of stressors and protective factors**

Not all research participants feel comfortable to articulate their thoughts and feelings in an interview context. Within all the qualitative research in the thesis, some adolescents could discuss personal stressors and protective factors and effects on their well-being relatively comfortably with an interviewer, and for others it was more difficult. It would be helpful to understand what facilitates adolescents to talk about their mental well-being and mental health. Further, given the samples of the thesis that derive from HeadStart, it would be helpful to know the extent that interventions such as HeadStart support enabled adolescents to be able to reflect on their own mental well-being. An extensive research base on mental health literacy already exists (Bahrami, Bahrami, & Chaman-Ara, 2019; Bjørnsen, Espnes, Eilertsen, Ringdal, & Moksnes, 2019; Jorm et al., 1997; Noroozi, Khademolhosseini, Lari, & Tahmasebi, 2018). As well as more

research into mental health literacy, it would be interesting to further understand the levels of *mental well-being* literacy amongst participants: what adolescents understand or do to increase their own hedonic and eudaimonic wellbeing. This could include the extent that adolescents actively seek out activities to increase their hedonic well-being, as well as what interventions or services promote either mental health literacy or mental well-being literacy (Jorm et al., 1997). It could potentially be possible to trace increased mental health literacy in adolescent narratives over time through changes in their own self reports of mental health and well-being.

### **7.3.6 Further examination of age-specific stressors is needed**

Gaps in adolescent stressor research remain. It would be valuable to be able to classify stressors by age beyond key events such as, puberty, transition to secondary school and GCSEs. Study 1 presented an overview of stressors based on the views of a population already in receipt of preventative interventions. The age and gender differences in stressors presented in this study were tentative due to the limitations of the sample (because there were unequal numbers of participants for each age group), thus more research is needed on gender and age differences in stressors. It is known that mental well-being decreases during early to middle adolescence though it is not exactly known why and that there are gender differences in outcomes (Deighton, Yoon, & Garland, 2020; González-Carrasco et al., 2019). It could be helpful for schools to have an idea of the evidence for stressors that are specific to each year of schooling (Bakker et al., 2010). This is particularly the case given the importance of understanding the underlying mechanisms that account for the increase in emotional difficulties in young women in the UK in the early adolescent period (Deighton, Yoon, & Garland, 2020; Fink et al., 2015). Currently, stressors are studied more at the event level, such as GCSEs in England, Wales and Northern Ireland (Denscombe, 2000) and the transition to secondary school (Benner, 2011; Zeedyk et al., 2003). One of the advantages of delineating age-specific stressors would be to increase the precision of evidence-based interventions.

## **7.4 Implications for risk identification, intervention design and support provision**

### **7.4.1 The use of qualitative narrative data in the identification of risk of psychopathology in early adolescents**

Within this thesis, some risk of psychopathology was identified. The study of change in ideal types of protective factors over one year identifies groups of adolescents that have deteriorated over one year (as given by change in type membership) or remain lacking in protection and may be at greatest risk of psychopathology. The participants who deteriorated due to increased stressors and decreased protective factors are at highest risk and could be said to be *identified* as most eligible for targeted intervention. Current approaches towards risk identification are primarily through a mix of sources: children, teachers and parents, or through a combination called multi-informant approaches (Humphrey & Wigelsworth, 2016). Research suggests that from 7-8 years old children are able to report about the state of their mental health, and therefore could be interviewed (Edelbrock, Costello, Dulcan, Kalas, & Conover, 1985). Researchers have suggested that more risk identification methods are needed for correctly finding which adolescents require targeted prevention (Costello, 2016). The examination of adolescent reported risk and protective factors provides one method of risk identification (Ungar, 2015). Adolescents that are identified as most at risk or with a high number of known stressors by a schoolteacher or pastoral worker, due to visible stressors such as learning difficulties or behavioural difficulties, could then have an informal interview. This would involve a subset of adolescents qualitatively describing their risk and protective factors as per the studies of this thesis, and the effect on their well-being has the potential to supplement the identification of those that are most at-risk and who can be missed from other screening methods. A similar approach has been proposed by Ungar (2015) in his steps outlined in the diagnosis of childhood resilience. However, a note of caution is required as some adolescents that do not want to disclose sensitive circumstances, stressors or mental and emotional states would not be identified by this method. Therefore, whilst this method may detect some adolescents at risk of poor mental well-being, it would not be anticipated to identify all adolescents correctly, and as it is very much reliant on verbal

reports it may be less suitable for adolescents who prefer not to discuss their strengths and difficulties.

Using an interview to record adolescent reported risk and protective factors that are suspected to have a number of stressors would ideally be carried out by a neutral adult that had received appropriate training to conduct the interview. When interviewed by a neutral adult, an adolescent could raise difficulties about family, friends and teachers if needed. Thus, a neutral adult would offer certain impartiality advantages over a class teacher or school staff. Researchers have noted that collecting data on the risk and protective factors may burden teachers as well (Humphrey & Wigelsworth, 2016). Another disadvantage of teachers conducting risk identification is that teachers tend to identify behaviour difficulties and may not correctly identify internalising difficulties (Atzaba-Poria, Pike, & Barrett, 2004; Humphrey & Wigelsworth, 2016). In the thesis, research interviews were conducted at school and this is a suitable place that is familiar to adolescents. Ideally, interviews would be carried out by non-school staff but would require training, strict adherence to safeguarding protocols and prior permission from parents and adolescents themselves.

Both early identification and early intervention is important. Risk identification through qualitatively reported data for a subset of adolescents with a high number of stressors or some severe difficulties may also be particularly important for this period in the life course. In the early adolescent period of 10- to 13-years old there are number of stressful transitions, such as the transition to secondary school (Zeedyk et al., 2003). There is insufficient longitudinal data from the current studies to say whether there are more frequent changes in reported protective factors at these two timepoints relative to other timepoints in previous or subsequent years. However, from the fact that half of the HS3 sample moved type in one year, there is preliminary evidence that there has been considerable shifting in the extent that protective factors are abating risk and promoting well-being. These initial findings reinforce the notion that the period of early adolescence is important both to assess protective factors and to assess eligibility for preventative interventions. Early assessment is important in light of recent research that finds a decrease in mental well-being and an increase in mental health problems from early to mid-adolescence (Deighton, Yoon, & Garland, 2020). Therefore, if there is a lot of changing in protective factors that link to changes in well-being and a known dip in

well-being over the subsequent years, this could be an important period to focus on the identification of risk and early intervention using qualitative methods, as per the studies in this thesis.

#### **7.4.2 Considering *the stressor load* of individual adolescent beneficiaries in intervention design**

Notably, whilst there is much interest in well-being programmes, authors have suggested that further research on promoting well-being is required before such programmes are widely implemented (Stallard, 2011). In this context of a mixed evidence base, understanding the nuances factors linked to mental well-being is important. From the evidence presented here, there is considerable heterogeneity in both the reported stressors and the factors that promote mental well-being, which suggests the creation of interventions to reduce the negative effects of stressors and promote mental well-being need to account for heterogeneity in specific social contexts and individual stressor load.

For school-based programmes, adolescents may arrive at school with a range of contextual family stressors that they have to manage and cope with independently, unless the school and surrounding welfare agencies are aware of the adolescent's home setting and have a response in place (Bywaters et al., 2015). Intervention designers need to engage with what stressors are most difficult to manage from an adolescent's perspective, taking a broad view of many domains of school, friends, home, and self, including stressors at the levels of the individual adolescent such as managing worries or emotional states. Potentially, there are long-term cost savings from making sure interventions are attuned to the need and *stressor load* of the targeted adolescent. Providing one intervention that does not address the multiple stressors or failing to elicit which stressors an individual adolescent may feel *least* able to cope with risks interventions being ineffective and unnoticed by the beneficiary with long term sequelae.

The focus on perception of support (and by extension the perception of interventions) is relevant to the prevention of psychopathology and preventative

interventions (Yeager, Dahl, & Dweck, 2018). Studies find that how interventions are presented to adolescents can influence their success (Yeager et al., 2018). Interrupting trajectories for adolescents with a high *stressor load* would require not only the provision of support or interventions but, importantly, would require that their *perception (and appraisal)* that either the support was helpful or suited their specific needs, or that adolescents felt more able to seek support or draw on their own coping resources in relation to perceived stressors (or a perceived reduction in the stressor itself). Thus, the aim of an intervention would not only be to increase the amount and quality of support in relation to stressors of adolescents in this group, but also to decrease their perceived ambivalence about the support that is provided. One participant discussed the role of many types of support in his life as ‘a double-edge sword’. The aim of interventions ought to enable adolescents to have a positive experience of support structures in order to increase the likelihood of positively contributing to their mental well-being. This could either occur through identification of support that is suited to the adolescent’s specific needs, or through processes of cognitive reappraisal to encourage adolescents to reframe support that is being provided (Shapero et al., 2019).

### **7.4.3 Implications for support provision for adolescents with a high stressor load**

The different relationships between support and stressors reported within three ideal types has implications for practitioners and clinicians seeking to provide support to adolescents that may be at risk of poor mental well-being and the risk of psychopathology. For adolescents that have had the experience of a lack of or uncertain support towards stressors, these adolescents may need considered interactions with staff to reassure them that it is possible to receive support that will help them to alleviate their stressors. For adolescents that have a high stressor load and limited support and coping strategies, it is important that service providers and adults around the adolescent understand their unique profile of stressors and what protective factors currently exist. For example, if a young person has behaviour difficulties and all their support at school is provided in relation to their behaviour when, in fact, they are facing family poverty and instability at home, it is important that the school has an awareness of the broader range of factors that an adolescent may be “carrying” in addition to the behavioural difficulties.

Provision of support for adolescents that are more autonomous is complex. Adolescents that professed to prefer to solve their problems independently and reported character traits such as maturity and independence may have different support needs than those that prefer to draw on support from school, parents and other sources and may be more accustomed to reaching out to others for support, such as community-based organisations or organisations external to school. These adolescents still require consideration because (based on their reports) they may comprise a subset of adolescents less likely to approach service-providers, but it is likely that not all problems and difficulties an adolescent experiences can be managed independently. Therefore, support for these adolescents needs to be tailored to build on existing supports (that may be self-generated). For example, support may be best if it builds on their own coping strategies or reduces a stressor, rather than providing support that is not mediated by parents or school.

Some questions remain for adolescents that reported a range of effective protective factors. For adolescents allocated as 'Multiple Sources of Support', it is important to remark that whilst these adolescents reported a range of protective factors in place for mental well-being, it is unknown how they might respond if one of their major supportive factors was removed or if they experienced a severe stressor at a later date. Does a wide range of support render an adolescent better protected against future stressors? Whilst we might assume this to be the case, it is not a certainty. Within this category there were a few examples of adolescents that reported few or non-existent stressors. Further research is required to understand how adolescents with no prior experience of stressors may cope with future stressors as compared to those that *may* have been *inoculated* (through overcoming previous exposure). More research is needed to understand the role of stressors in contributing to inoculation against further stressors. The patterns that emerged from the typology provide a general reminder that adolescents have very different support needs.

## **7.5 Strengths of a qualitative approach**

In the first study on reported stressors, attention to adolescents' individual descriptions of stressors revealed that some adolescents described a chain of stressors leading to outcomes. In some cases, adolescents identified a factor as causal. Morrow

& Smith (2012) suggest that qualitative research is advantageous for the study of sequences, and Erickson (1986) has stated that one of the benefits is to be able to identify perceived causal linkages. Thus, taking a qualitative approach to study the reported mechanisms that were visible in some adolescents' reports of effects of stressors on mental well-being and risk of psychopathology was highly appropriate.

Another strength of qualitative methods as applied to the study of stressors and protective factors is that they elicit what academic constructs, such as protective factors, mean to adolescents and tap into their lived experience of recollected protective factors (Lindseth & Norberg, 2004). For example, instead of using the construct of protective factors, adolescents' perceptions of support were more appropriate as this reflected the words that they used and understood themselves. Adolescent conceptions of stressors and protective factors are important as they may diverge from adult preconceptions. Researchers may have assumptions about what is protective for adolescents that may influence their inquiry or follow patterns of research because such variables have been researched in the past, not because they are bottom-up from naturalistic settings. When considering protective factors described by adolescents from semi-structured interviews versus those studied within the literature, it is understood that adolescents view the world differently and have a different set of experiences than adults (Kirk, 2007; Morrow & Richards, 1996). Qualitative research has a track record of being able to bridge this gap through documenting subjective perspectives that may either disrupt and in some ways reinforce the findings of the established literature (See Lavie-Ajayi & Joffe, 2009). An example of disjuncture in qualitative research can be found in Joffe's study of social representation of AIDS, where Joffe examined lay understandings of AIDS held by Zambian adolescents, as contrasted to scientific understandings of AIDS (Joffe, 1998).

The breadth of the interview schedule in Studies 3 and 4 enabled a broad range of risk and protective factors to be gleaned from the dataset. Factors included time with pets to a mother's new boyfriend to playing with stress balls. However, some narrowing of the potential range of stressors and protective factors occurred through the design of the semi-structured interview schedule; for example, within the studies we asked specifically about school, home life and friends (Stapley et al., 2019). The interview schedule did not include questions about broader political, environmental or economic events such as climate change, parental employment, Brexit or safety within the

neighbourhood, yet some of these topics have been discussed by adolescents in the Good Childhood Report, following being asked directly about them (The Children's Society, 2019). However, in some cases in the QLS, stressors in these societal domains, such as witnessing a terrorist attack, were described by a small subset of adolescents. The benefit here is that such stressors were entirely identified by adolescents.

Ideal-type analysis has been successfully applied in psychotherapy research (Wachholz & Stuhr, 1999; Werbart, et al., 2011), but it is less common in studies of patterns of resilience and risk and protective factors. Ideal-type analysis enabled attention to individuals' use of language, as well as how several protective factors may work together. Examining changes in case reconstructions over time enabled the illustration at the case level of a decline or increase in mental well-being. Ideal-type analysis has been described in longitudinal qualitative research as 'sensitive' enough to capture changes in individuals' descriptions (Werbart et al., 2011, p. 110). Ideal-type analysis is credited with having a level of reliability that permits generalisation (Wachholz & Stuhr, 1999). In terms of the findings from the ideal types studies, this suggests that there could be applicability to other groups, but this would require further testing. In the first study, thematic analysis was applied, which yielded clear themes of stressors as well as data regarding their prevalence, but the focus on the individual biography of each participant was not retained. In contrast, ideal-type analysis enabled a focus on the adolescent's narrative, the biographical detail of each participant, while also allowing for inquiry into similarities and differences between participants' narratives.

A number of research benefits derive from the study of longitudinal data (Caspi et al., 2014; Thomson, 2007). Longitudinal data is particularly suited to studying changes in protective factors and psychopathology as patterns can be observed that may be missed in the snapshots provided by cross-sectional designs (Caspi et al., 2014). A longitudinal approach to qualitative research involves cross-sectional analysis across the data set and, in the final study, examining the changes in adolescent reports of protective factors over time (Thomson & Holland, 2003). Being able to draw on this longitudinal data has been well suited to the study of qualitatively reported stressors, risk, and protective factors for a number of reasons. Studying reported risk and protective factors over time as per the final two qualitative studies as part of the

longitudinal study was beneficial in that a familiarity with individual cases could be developed, as well as increasing the “intensity and the density” of the data (Thomson, 2007). In my experience, this allowed for further insight into the ways that protective factors in relation to risk and mental well-being had a level of chronicity.

Repeated interviews with the same participants have been described to lead to increased understanding of individual participants, and this was my personal experience as the QRT interviewed the same participants (where possible) at Time 2 (Thomson & Holland, 2003). Studying adolescent narratives over time was important with the topic of severe and/or chronic stressors because some adolescents reported some severe stressors such as marital conflict between parents or maltreatment by a parent (or caregiver) across consecutive years. It became clear that some stressors were not isolated incidents or limited to a brief period in a participants’ life, but ongoing stressors that changed over time. Capturing these chronic stressors in the final study was important due to the deleterious nature of these stressors on mental well-being and risk of psychopathology, particularly when operating in combination with other stressors in an adolescent’s life.

Another benefit of taking a qualitative approach towards the study of risk and protective factors reported by adolescents was that it became possible to understand risk and protective factors and their qualities through an adolescent’s subjective “filter” (Fonagy, Gergely, & Jurist, 2018). A qualitative approach enabled attention to adolescents’ lived experience of a topic under study and the meaning ascribed to risk and protective factors (Denzin & Lincoln, 2008; Lindseth & Norberg, 2004). Thus, rather than focusing on isolated variables, it was possible to understand experiences and how variables intersect and may be highly individual for different participants.

Arguably, taking a qualitative approach towards protective factors is important in order to increase understanding of mental well-being to apply to interventions, and to promote mental well-being and reduce the risk of psychopathology. Within research on adolescent mental well-being there are many studies of risk behaviours (Rich & Ginsburg, 1999; Rodham, Brewer, Mistral, & Stallard, 2006). However, there are fewer qualitative studies of risk and protective factors in the English context. Rich & Ginsburg (1999) advocated that interventions to promote adolescent well-being are more likely to

be successful if they are grounded in adolescents' lived experiences with an awareness of their social context. More than twenty years ago, Rich & Ginsburg (1999) argued that, "Designing an intervention for a behavior that adults have determined to be negative without understanding the adolescent life context in which that behavior developed is predictive of failure" (p. 376). From my studies, it was clear how *variable* stressors were, as well as the extent that protective factors, both in terms of help-seeking, coping and preferences around what types of support was helpful were between individual adolescents. Adolescents discussed both interventions that were effective and types of support that were not effective and there was considerable variation in these reports. There is scope to understand what adolescents perceive to increase their wellbeing, as well as protective factors that decrease the negative effect of a stressor or reduce feeling sad or anxious. Thus, qualitative reports of effects of protective factors in relation to outcomes, can potentially illuminate the overlap and nuances between mental wellbeing and mental health.

## 7.6 Limitations of a qualitative approach

Despite the important role of qualitative research in studying stressors and protective factors in relation to mental well-being and the risk of psychopathology in adolescents (and the pertinence to the thesis central question), there were a number of limitations with reliance on an entirely qualitative approach. First, the findings from the qualitative studies were based only on adolescent reports. It is therefore difficult to know whether the same reports would be found again if interviewed by a different person at a different time, and thus there is limited (but some) generalisability in qualitative research (Morse and Field, 1995; Shenton, 2004).

A range of factors influence the data gained from a qualitative interview, including mood of the participant (and potentially the researcher) on the day, micro events in a young person's life (such as missing the bus or forgetting homework), being in a school setting, and desirability bias of the interviewee wanting to do well within the interview context (Krumpal, 2013; Nederhof, 1985). Social desirability bias, the desire to discuss desirable information and emphasise socially accepted or valued responses, is widely understood to be a challenge within qualitative research (Krumpal, 2013; Nederhof, 1985). Social desirability bias can include instances of *self-deception*: when participants

describe truths about themselves that they believe to be true (but are not), and *other-deception*: where participants give an impression that is not true in order to represent themselves in a positive light (Nederhof, 1985). Scholars have brought attention to the fact that the responses participants provide is influenced by context (Delmar, 2010). The fact that in the QLS the interviews were conducted at school may have influenced the type of responses (in schools participants are oft required to give the correct answers to successfully complete their schoolwork) versus if interviews were conducted at an adolescent's home or youth centre (which is less connected to processes of education). Thus, the context in which data is collected is highly influential on what knowledge is produced and this has implications for the extent that it could be transferred to other contexts (Delmar, 2010).

Recall and memory can influence research quality. Scholars have brought attention to the fact that, like questionnaire data, interview data is *retrospective* and children and adolescents, in particular, may not accurately remember events, and this may therefore undermine the validity of the data (Docherty & Sandelowski, 1999; Kraemer, Lowe, & Kupfer, 2005; Mahon, Glendinning, Clarke, & Craig, 1996). Other scholars suggest that, in fact, children are able to recall events fairly accurately from a young age (Docherty & Sandelowski, 1999). Another limitation is that different researchers may focus on different topics in the context of the interview, yielding a level of heterogeneity across the dataset. For example, one interviewer may be more sensitive to family dynamics and relationships, another may be more aware of adolescents' digital worlds, and another to their experience of school (Thomson & Holland, 2003). Despite following an interview schedule, the established rapport may influence the overall flow of an interview. As stated, what an adolescent chooses to share with the researcher and the rapport with the interviewer can also influence the data collected in the interview setting (Prior, 2018). Rapport has been variously defined but is generally understood to entail that the researcher builds empathy and a connection with the research participant, and rapport varies between combinations of researchers and research participants (Prior, 2018).

Further, data must be approached with caution in that it cannot show information about an adolescent's actions. Differences may exist between the ways that participants portray themselves in an interview versus their own behaviours in daily life. For

instance, if an adolescent portrays themselves to be mature, independent, and actively solving their own problems, this does not discount the possibility that they receive substantial support from parents and school that they chose not to report in a particular interview. Thus, a reliance on qualitative reports from interview data is fairly limited in that the researcher is constrained from further insight into an adolescent's complete experience of protective factors beyond the interview. Elsewhere, it has been written that adolescents might not feel able to share what they really think or feel with an adult researcher or therapist and that there is a power divide between adult researcher and adolescent participant (Kirk, 2007; Morrow & Richards, 1996). Løvgren et al. (2020) suggest that it may be difficult for an adolescent to share negative views or experiences because it may risk "assigning to themselves or the therapist a position they regard as unattractive or even immoral" (p. 12). When asked about help-seeking behaviour and support, Løvgren et al. (2020) suggest that adolescents may be more likely to portray themselves as "help-seekers" as they may want to represent themselves as undertaking the behaviours that appear "empowered" and "competent" (Løvgren et al., 2020).

It is important to maintain a level of discernment towards adolescents' accounts from a single point in time and not assume the accuracy of accounts based on one or two data collection points alone. Scholars have suggested that it is important to hold in mind the *positionality* of the adolescent and the researcher. Positionality is a central concept from social positioning theory (Hall et al., 2005; Holmes, 2014). Rather than anticipating patterns of behaviour derived from demographic characteristics such as gender, age or ethnicity, positioning theory argues that individuals shift and change through social exchange (Løvgren et al., 2020; Pérez-Manjarrez, 2019). When considering the lived experience of research participants, positionality encourages the researcher to be reflective on their own social position as a researcher and how this influences the research process (Adeagbo, 2020). On reflection, because I am a White adult female researcher, there could be aspects of stressors and protective factors that an adolescent that belongs to a minority ethnic group may be less inclined to share with me, as is true with other factors such as age, gender, and level of education.

Some researchers have proposed that in order to reduce the risk of bias in data collection, it might be easier for participants to relate to interviewers that are more similar to them in terms of aspects of social identities. Some studies, for example, have

ensured that male interviewers interview male participants, have even matched the ethnicity of the interviewer with that of the participants, or ensured that in the coding process a variety of coders with ethnic backgrounds are involved. For example, Ungar et al.'s (2018) study of adolescents' experiences of therapeutic relationships involved coders with Caucasian, African Canadian and Japanese Canadian backgrounds to broaden the diversity of perspectives involved in data analysis (Ungar et al., 2018). Whilst there were participants of many different ethnic backgrounds in both qualitative samples (HeadStart Phase 2 and 3) and the qualitative research team brought some ethnic diversity as well, our team was all female, White and White mixed. In spite of these barriers, all participants in the sample discussed stressors and protective factors, with some providing more detail than others. However, it is perhaps worth considering the possibility that additional risk and protective factors may have been divulged had there been a closer matching of participants in terms of gender, age, and ethnic background.

### **7.6.1 Limitations of ideal-type analysis**

Reliance on adolescents reports was a shortcoming of the chosen approach. Whilst the purpose was to focus on adolescent reports of stressors and protective factors, there was no means by which to triangulate reports with other sources of data such as parent reports and teacher reports of protective factors. Triangulation is widely understood to contribute to the rigour and trustworthiness of studies (Barbour, 2001; Shenton, 2004) and has been carried out in other ideal types studies (O'Keeffe, Martin, Target, & Midgley, 2019). Ethical permission was not obtained to garner data on this particular topic but could suggest avenues for future studies.

The allocation of participants to the three ideal types, though tested with a young person, was not tested with participants themselves. Member checks were not possible as the study used data from the QLS and ethical permission was not in place to have further contact with participants regarding this particular study. It is the case that the study would benefit from respondent validation, where respondents check the findings or check their own allocation to types (Barbour, 2001; Tobin & Begley, 2004). Within the literature, questions have been raised about whether respondent validation is needed for qualitative studies (Birt, Scott, Cavers, Campbell, & Walter, 2016; Richards & Morse,

2007) Some scholars suggest that it is not required in all qualitative studies or needs to be conducted in a more sophisticated way than checking findings with participants (Birt, Scott, Cavers, Campbell, & Walter, 2016; Richards & Morse, 2007). In this case, some reported stressors (e.g., parents under financial stress or interparental conflict) were quite sensitive. Furthermore, in some cases, adolescents give highly mixed reports of a protective factor. The designation in the study by myself and other researchers may differ from a participant's assessment of a protective factor. For example, if an adolescent reports maltreatment but does not identify it as a difficulty. Due to the nature of the sensitivities of the stressors under study, some stressors may be too sensitive to seek respondent validation from the young person. In summary, the designations of type and numbers of participants within the types are not truth statements, they are data collected at one time and subject to interpretation. However, a general characterisation of aggregate protective factors (e.g., USS, SIFS, MSS) based on reports gained in interview can be obtained that provide an overall profile of protection and risk.

Another possible criticism of the ideal types analysis is that it accentuates one particular participant (that is selected as an optimal case) for all the other participants with that ideal type category. Therefore, there is a possibility that the chosen ideal type may tell us information about that particular individual rather than something about the wider group. For example, the optimal case for the 'Self-Initiated Forms of Support' was less common in that he had experienced some professional success out of school at a young age. However, given that, theoretically speaking, ideal types are hypothetical "tools" (Marcelino, 2014) to compare other cases, then it does not matter if the optimal case has some unique characteristics as they remain a helpful contrast. Other participants are compared with the ideal type, even if the characteristics of the optimal case are quite distinctive. Scholars have offered a reminder that ideal types are tools for advancing theory within the broader project of understanding (*verstehen*) social processes (Grønning, 2017). Thus, if the aim is to understand the processes underlying well-being, then examination of a particularly distinctive optimal case, in terms of their reported protective factors, remains useful.

As a method of gathering data on protective factors, it is vital to note that different readings of the reports of risk and protective factors for each participant's transcript can lead to different interpretations of the selection of a risk or a protective factor from the

data. Equally, there were minor differences in the use of the typology to classify the cases as ideal types (which can be compensated to a certain extent by reaching agreement between the assignment to types by other researchers and my own). Some cases were particularly difficult to classify. Therefore, reports of risk and protective factors are not an objective measure and, as qualitative data, statements can be interpreted differently (Ratner, 2002).

Consideration of what an adolescent might share with an external adult interviewer has relevance for adolescents assigned to the 'Multiple Sources of Support' ideal type as well. It is possible that, in the interview setting, adolescents may paint a picture of being able to access support and portray school and home as places of support in order to appear that they are "normal" or "competent", drawing again on points made by Løvgren et al., (2020), and avoid alarm.

A minority of cases did not provide enough information from their interview to cohesively form a profile of stressors and protective factors and then assign them to an ideal type. For instance, some participants described very sparingly difficult stressors (such as separation from a parent and temporarily living with relatives) but with very little information about perceived effects on mental wellbeing. Other cases were very difficult to assign to one ideal type or another. For example, participants that reported risk factors and many self-initiated strategies occupied a grey area between USS and SIFS and were only assigned through careful discussion with other researchers.

## **7.7 Conclusion**

To conclude, the current thesis addressed the question: how can qualitative investigations into adolescent experiences of stressors, risk-factors, and protective factors further our understanding of mental well-being and the prevention of psychopathology?

The contribution to the wider field of adolescent mental health has comprised a range of findings. This thesis has documented the lived experience of stressors in three qualitative studies, one of which explicitly focused on the meaning and prevalence of

stressors as experienced by adolescents in receipt of preventative interventions. The first qualitative study of stressors found that adolescents described both internal and external stressors. These internal and external stressors were reported to interact and link to poor outcomes, such as worries about difficulties at home affecting behaviour at school and leading to disciplinary consequences at home. These chains of stressors were reported to lead to some negative outcomes including some symptoms of psychopathology.

Following exploration of perceived stressors, the thesis went on to investigate protective factors, from both the existing research base and from adolescents' lived experience. The thesis adopted a broad view of protective factors that included both factors that were perceived to reduce the negative effects of stressors, as well as factors perceived to increase mental well-being. From this approach, a wide range of factors were found to affect mental well-being, both from the research base of empirical studies, as well as from the diverse array of factors provided by adolescents own lived experience of protective factors. Through investigation of the current literature, the thesis went on to contribute greater clarity to the study of protective factors by updating Masten & Powell's (2003) framework with current literature on protective factors in relation to the outcome of mental well-being and the risk of psychopathology.

The studies in this thesis included an ideal types analysis of protective factors in relation to mental well-being and psychopathology risk based on qualitative data from adolescent reports. Ideal type analysis provided a method to group patterns of protective factors through the subjective reports of adolescents in the HeadStart program. The final study demonstrated how the ideal types typology could be used as a device to study changes in patterns of reported protective factors over time. The typology represents a new emphasis towards the study of protective factors that focuses in detail on the factors that adolescents *perceive* to be important and effective in the reduction and management of perceived stressors and promotion of wellbeing. This implies a shift in language away from (but not discarding) designating adolescents as "high-risk" or "at risk" but emphasising the lived experience of the protective factors (how many and how effective) in relation to a reduction or management of perceived 'stressor load' that varies individually.

The patterns identified by the typology have raised questions about adolescents that continued to report stressors and did not report improvements in their protective factors over time and are likely to be most at-risk of poor outcomes. The patterns found raise some interesting questions. During the period of adolescence, should interventions aim to increase autonomy (such as independent problem solving) in adolescents to increase mental well-being? Or should interventions aim to ensure that all adolescents have a wide range of support? Given the key role of parental support to mental well-being, should interventions aim to improve adolescent-parent relationships or parenting when it is reported to be less prominent for particular adolescents (González-Carrasco et al., 2019; Oberle et al., 2011)? Further, is being autonomous or being well supported a better predictor of overcoming future stressors or changes in protective factors? Studied over time, the typology has the potential to identify those who may report the least perceived support and the highest stressor load. It can equally be used to trace changes in perceptions of protective factors and a deterioration in protective factors that could correlate with a reduction in mental well-being. Further, it can situate the experience of an intervention, such as HeadStart support, within a wide array of other protective factors (parental, friend, teacher, EC, support from other professionals). Such an approach can give a sense of scale of how the adolescent appraises that support within their wider range of perceived protective factors.

Theoretically, the typology could be used in risk identification for adolescents that report a range of stressors that do not have or that are not receiving or engaging with externally provided support. The typology is in early development and, as such, would require application in conjunction with other methods. For example, triangulation with teacher or parental reports of stressors and protective factors would be beneficial. One of the conclusions of the combined studies within the thesis is that those adolescents with the *least* perceived support over two timepoints may be at substantial risk of poor mental well-being or risk of psychopathology. Within the thesis, there are some instances where particular adolescents appear to lack adequate support in relation to a range of stressors. Some initial evidence of this has been elucidated through interview data on reported stressors and difficulties coping with them and a lack of support.

In summary, as an approach to the study of protective factors for the purpose of the promotion of mental well-being and the prevention of psychopathology, qualitative

research has, in some ways, been under-utilised compared to other methods within psychology and evidence based adolescent mental health. This is in spite of the fact that it offers many benefits, including illustrating the specificity of lived experience, highlighting linkages between stressors across domains and protective factors, illuminating mechanisms and capturing perceived changes in both stressors, protective factors and processes reported over time (Copeland-Linder et al., 2010; Ungar, 2003) and illustrating which factors adolescents attribute to contribute to positive and negative mental well-being and mental health outcomes (and which factors they omit). This thesis has provided evidence drawing directly from adolescents' subjective accounts and experiences of stressors and protective factors, in relation to both increasing mental well-being and reducing the risk of psychopathology, to close that gap.

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## Appendices

# Appendices

## Appendix A: HeadStart Phase 2: Information Sheet for Service-Users and Parents/Guardians

Information Sheet for service-users of HeadStart & parents/guardians

**You will be given a copy of this information sheet.**

Title of Project: **HeadStart evaluation: Service-user interviews/focus group**

This study has been approved by the UCL Research Ethics Committee (Project ID Number): 1530/006

### **Researcher details:**

Name                      Dr Jaqueline Hayes

Contact Details        If you have any questions, please email us on [headstartevaluation@annafreud.org](mailto:headstartevaluation@annafreud.org) or ring us on 0207 443 2221.

### **What is the research about?**

This research is an evaluation of a programme called HeadStart which is happening in 12 areas across England. The aim of HeadStart is to provide support to children and young people to improve their general well-being and for those coping with difficult circumstances. This research aims to find out more about the services that HeadStart partnerships are offering to young people. It aims to find out what new things have been tried, what has helped and what has been less effective, in order to learn for the future about how to improve on services that help to increase resilience.

### **Who are we speaking to?**

We are speaking to young people who have used the services, staff that have organised the services, and staff in schools and the community that also have been involved. We are asking different groups of people so that we can build up a good picture of what these services have been like, who they

have helped, and how they can be improved in the future. We would like to invite you to participate in this research project because you recently used a HeadStart service.

### **What does this involve?**

Taking part in this research means agreeing to be interviewed. In some cases, this is in a small group with other young people called a 'focus group', but most of the time, this will be an interview with just one young person at a time and a researcher. The researcher will ask a few questions about the services that you have received and will ask for your views and opinions about these.

The conversation can last for as long as you want to talk up to a maximum of 1 hour: the interviews will usually be between 30 to 45 minutes long. They will take place in a private room at a service you have used.

A focus group is usually a little bit longer, but a maximum of 1 hour and a half.

The interviewer will show you what questions they are going to ask you at the beginning of the interview (or focus group) so that you will know what to expect.

The interview/focus group will be audio-recorded so that we can write down what you said afterwards. The written version of the interview is known as a 'transcript'.

### **What are the benefits of taking part?**

Taking part in this research may help to build our knowledge about what helps people to become more resilient and so help to plan services. This may benefit other young people in the future. Some people find that making this contribution can be rewarding, and interesting. If you would like to see the final report for the research, you can leave your contact details and we will send this to you at the end of the project (in 2016).

### **What are the risks of taking part?**

There are few risks to taking part. Occasionally, someone may feel upset about something they are talking about. The researchers think it is very important that you are comfortable in the interview and that you only discuss only what you feel able to talk about. The researchers prefer you to tell them if there is anything you don't want to talk about and they will definitely not pressure you to do so.

If, after the interview, you feel upset and want to talk to someone further, the researchers will have given you a list of people in your area that you can speak with.

### **Will information about me be kept confidential?**

Your interview will be strictly confidential. The only time we might need to break this rule is if you tell us something that makes us think that you, or someone else, is in danger. In that case, we will have to tell someone who can stop that danger from happening.

Audio-recordings will be kept in a protected computer file and only be accessed by researchers to this study. When the recordings are typed up as transcripts, any details that can identify you as an individual will be taken out. This means that your name will be changed, as well as the names of others you mention. You will be asked to pick a different name for yourself at the end of your interview that we will use on transcripts.

We will keep audio recordings up until the end of the study (August 2016), when they will be deleted.

### **What happens if I change my mind?**

You can change your mind about participating in this research, at any time. You do not have to tell us a reason for this. If you do wish to leave the study, your interview and transcript will be deleted, and not used in any reports. Once we have written the final reports (in March 2016), it will not be possible to withdraw your contributions, so it is best to tell us as soon as possible if you do change your mind.

You can also stop the interview at any point – just tell the researcher interviewing you that you no longer wish to take part.

Leaving the study at any stage will not affect how anyone treats you and will not affect the services you receive or the help others will give you. It will not disadvantage you in any way.

### **What happens next?**

Please discuss the information above with others or ask us if there is anything that is not clear or if you would like more information. You can keep this information sheet to look at whenever you need to.

If you decide you would like to take part, you can tell your parent/guardian and give your consent (on a written form). Your parent or guardian must also give consent in order for the interview to go ahead. Then, you can return the form to us and we will arrange a time, at your convenience, to interview you.

**All data will be collected and stored in accordance with the Data Protection Act 1998.**

Informed Consent Form for parents/carers

**Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.**

Title of Project: **HeadStart evaluation: Service-user interviews/focus groups**

This study has been approved by the UCL Research Ethics Committee (Project ID Number): **1530/006**

Before you agree to your child/young person taking part, the person organising the research must explain the project to you.

If you have any questions coming from the Information Sheet, or any other questions about the research study, please ask the researcher before you to decide whether or not you give consent for the child/young person you are responsible for to join in. You will be given a copy of this Consent Form to keep and look at whenever you want to.

### **Participant's Statement**

I

- have read the notes written above and the Information Sheet and understand what the study involves.
- understand that if I or my child/young person decides at any time that we no longer wish for them to take part in this project, I can tell the researchers and leave the study straight away. I understand that I do not have to give a reason for this and that the researchers won't expect me or my child to. I

understand that withdrawing from the study will not affect any services we receive from HeadStart or anywhere else.

- understand that the interview/focus group will be audio recorded and I agree to this audio recording.
- consent to the information my child gives being used as part of this research study.
- understand that what my child says will be treated as strictly confidential and handled in line with the Data Protection Act 1998.
- understand that information my child gives may be used in reports along with the responses of other participants to the study
- agree that the research project named above has been explained enough to me and I agree for my child to take part in this study.

Signed

Date:

## Appendix B: Field Guide for Staff



**Field Guide for Qualitative Data Collection - Evaluation Phase**

**HeadStart National Pilot Evaluation**

**27 August, 2015**

## **Field Guide for Qualitative Data Collection - Evaluation Phase**

### **Purpose of the Field Guide**

This field guide is for use in the qualitative evaluation phase of the national pilot evaluation that commences September to December 2015. The guide covers the following:

1. Interview requirements to inform liaison with hosts
2. Do's and Don'ts for interviewing
3. Underlying goals for the interview schedule
4. Interview schedule for children
5. Interview schedule for parents
6. Guidance for interviewing children
7. Guidance for interviewing parents
8. Safeguarding information
9. Collecting materials on the intervention

### **1. Interview Requirements**

There is an additional document that provides information for partnerships/field visit hosts that must be provided to hosts in advance of your visit so that they can prepare accordingly. However, the information is also provided here for your reference.

#### **Interview length:**

Time required for interviews with children 30-45 minutes.

Time required for interviews with parents 45 mins-1 hour.

#### **Location:**

We will work with you to understand the most appropriate place to interview service users. We can do home visits if required. Obviously a place where a young person feels comfortable would be important. We are looking for a quiet location where there are no other people present to enable confidentiality.

#### **Consent:**

Mia will go through the recruitment procedure with each site. Please refer to the recruitment procedures document and check with Mia if you are unsure of what you need to do in advance of your site visit.

Interviews with children under the age of 16 require parental consent. Children under the age of 16 also need to give “assent at the time of the interview”. There is a form for this that we will provide.

Interviews with parents also require consent.

All participants need to complete two copies of the consent/assent forms – one for them to keep and one for us to keep.

For visits that are yet to be scheduled we will provide partnership hosts with expression of interest forms so that children and young people can volunteer to be part of the study. For trips that are already scheduled we will rely on the host to choose who we should interview.

#### **Presence of others:**

In previous fieldwork visits, we had the challenge of unexpected additional people attending the interview. We need to clarify with the hosts that there will not be anyone else attending that has not been pre-agreed. It is fine if the young person requests for someone else to be there but we want to avoid partnerships and service providers also in the room where possible so that interviewees feel able to speak openly and honestly.

There must be two members of the research team present at any home visit, but only one will be the interviewer.

#### **Selection of interview subjects:**

The primary purpose of this research is to interview children. We are providing the interview schedule for parents for sites where the partnership has chosen an intervention for in-depth study that targets parents, rather than, or as well as, children as the service user/beneficiary.

In the selection of subjects to interview, it is important that the service users have not recently begun the intervention but have been involved in the intervention for some time (at least 4 weeks - if a weekly intervention). In cases where individuals have just begun the intervention, it is better

to interview individuals from the previous cohort of service users. Before scheduling the interviews, please make sure with the key contact for the visit the amount of time that service users have been undergoing the intervention. If you have any doubts, after discussion with the key contact, please see Mia to clarify with the partnership/key contact.

### **Naming the intervention to children and parents:**

Not all children and parents will know either the intervention or HeadStart by name. For instance, in the case of Cornwall, they might not know “Thrive” but they may know that a school counsellor has been working with them. It’s important to find out from the field visit host what name the children or parents will most understand- whether it’s the name of the intervention or in some rare cases, just the name of an individual or a session with a named individual. Then use this name throughout the interview schedules.

## **2. Dos and Don’ts**

### Do’s

- Ask questions that build on what participants are saying - e.g., “tell me more about...”
- Follow up and be interested/curious in the things that the interviewees raise as this is the information that we are yet to discover.
- Use different words to ask questions in a more child-friendly way.
- If you see a blank face, re-phrase the question.
- Describe the intervention that you are referring to throughout the interview in ways that the interviewee will recognise.

### Don’ts

- Don’t panic if what an interviewee says doesn’t fit with the interview schedule – be prepared for the unexpected as we cannot predict what interviewees will say!
- Don’t worry if a young person/parent says that nothing has changed, explore the lack of change with them (for example if a young person says that they are unhappy, find out why and what they find difficult or enjoy in their life; what do they think could be helpful for them).
- Don’t worry if a young person/parent becomes emotional and reassure them and check if they want to continue.
- Don’t hurry to the next question if they are emotional.

## **3. Underlying goals of the interview schedules for both YP and parents:**

Remember that the interview schedules are guides to help facilitate your conversations with the young people/parents about their experiences. You do not need to ask all of the prompts in each section (unless it feels appropriate with a particular interviewee to do so), rather the prompts are there to guide you about the areas of interest that we wish to find out about and to help you phrase questions to ask them.

The following are the overall goals of the interview schedules, which it is important to have in mind when conducting the interviews:

1. To establish whether the intervention has played a role in changes for the YP/parent, if any, and what else has played a role in changes, if any, in well-being.
2. To find out, from the young people's/parent's perspective, what they did during the intervention and what they thought of it (positives and negatives)
3. To find out what they would like to change about the intervention, if anything
4. To find out how they understand resilience
5. To understand their own perspective on what issues they face, how they deal with issues and whether the intervention has helped them deal with these issues.

#### **Deviating from the interview schedule:**

If you find that you are deviating from the interview schedule this is not a problem, however it's important that you cover all of the underlying goals (outlined above). Below is a key line of inquiry to help you to structure your questions.

1. Start with introductory questions (make sure to mention the intervention)
2. Ask about the young person's/parent's experiences of the intervention. Ask about how the young person/parent is feeling now (how is life now) compared to before they started the intervention (looking for changes, if any, and factors that have led to changes). If they haven't described the intervention as a factor (and you've heard about the other factors already that have led to changes), then refer to the intervention and ask if that's been a factor.
  - 2b. Ask for examples.

#### **4. Young Person Semi-Structured Interview Schedule**

**Introduction:** “My name is X and I’m trying to find out about intervention X, how it works and how you found it. Thanks for doing this interview with me. I have a few questions that I’d like to ask you. If you don’t want to answer a question or it’s unclear just tell me and we can skip it or I can explain it a little bit. If you have any questions for me you are welcome to ask me at the end. Everything that we talk about today is private or confidential unless I’m worried that any harm is going to come to you or to anyone else, in which case I would need to speak to my supervisor, whose name is Jess, and [name of site safeguarding officer], but I would tell you if I was worried in this way first. You are welcome to stop the interview at any time”

**Introductory questions:**

- First of all, how did you get involved in intervention X?
- How long ago was that?
- How many sessions did you go to?

Prompts:

- o Most sessions? A few sessions? One session?
- o Did you go to the last session?

**Questions about the young person’s experiences of the intervention:**

- Can you tell me about what happened during intervention X?

Prompts:

- o What did you do? Did you do different things in different sessions?
  - o Who did you meet?
  - o What happened at the beginning of the intervention? What happened after that?  
How did the intervention end?
  - o How did you feel at the end of the intervention?
  - o Did you learn any new things as a result of the intervention? (e.g., about yourself) **If so, what?**
- What did you like about the intervention? What didn’t you like about the intervention?
  - What were the most helpful things about the intervention for you?
  - Was there anything that you would have liked to have been different about the intervention?  
**If so, what?**

Prompts:

- Was there anything that could have made it more helpful for you? **If so**, what?
- Is there anything that could make it more helpful for other young people? **If so**, what?

### Questions about the young person's outcomes:

- What kinds of problems are young people facing where you live?
- How were things in your life before you started intervention X?
- Compared to before you started intervention X, how have you been feeling?

#### Prompts:

- How have things been at home with your family?
- How have things been at school?
- How have things been with your friends?
- What has improved/got better? Has anything got worse?

*[ask for concrete examples, e.g. How would I know that you were feeling 'happy'? What sorts of things do you do when you're feeling 'happy'?]*

*[check whether the feelings/behaviours that they describe now are different to before the intervention, e.g. Is that different to how you were feeling before?]*

- In thinking about the changes that you just mentioned, what do you think led to those changes?

#### Prompts:

- What/who has been helpful (or unhelpful)?
- What/who has made you feel better?
- What do you do when you have difficulties in your life?
- **NB If the young person doesn't mention the intervention, check out whether they feel that the intervention is linked to any of the changes that they've spoken about, e.g.,** Was your experience of the intervention linked to these changes that you've talked about? **If so**, how? What has the intervention changed in your life (if anything)?
- **NB If the young person doesn't feel that anything has changed, explore this, e.g.** Did you expect to feel any differently as a result of the intervention? Even though you don't really feel any differently now, was there anything that was helpful about the intervention for you? Was there anything that could have made the intervention more helpful for you? Has there been anything that's been unhelpful for you?

*[ask for concrete examples, e.g. What was helpful/unhelpful about that?]*

- To finish off with, I want to talk to you about something called 'resilience'. Resilience can mean lots of different things to different people. Some people think of resilience in terms of being able to recover from being ill. Other people might think of resilience as being able to deal with difficult things in life, like bouncing back after a difficult time. In thinking about these things that we've just talked about, what does resilience mean to you?
- Could you tell me about a time when you have shown resilience? Could you tell me what happened? What did you do? Were other people involved?

Prompts:

- o Could you tell me about a time when you saw another person show resilience? Could you tell me what happened? What did they do? Were other people involved?
- In what ways do you think that the intervention has helped you and/or your family to become more resilient?
- Were any other people involved in helping you to become resilient?

Prompts:

- o Family members?
- o Others?
- o What did they do?
- Finally, what would I need to know to grow up well where you grew up?

**Concluding statements:** "The answers that you give me will go towards some research about programs across the country that are supporting young people's well-being. Your answers will be anonymous, which means that no one will know who said it."

## **5. Parent Semi-Structured Interview Schedule**

**Introduction:** "My name is X and I'm trying to find out about intervention X, how it works and how you found it, and any changes that you have experienced in your life and well-being since you started it. Thanks for doing this interview with me. I have a few questions that I'd like to ask you. If you don't want to answer a question or it's unclear just tell me and we can skip it or I can explain it further. If you have any questions for me you are welcome to ask me at the end. Everything that we talk about today is confidential unless I'm worried that any harm is going to come to you or to anyone else, in which case I would need to speak to my supervisor, whose name is Jess, and [name of site safeguarding officer], but I would tell you if I was worried in this way first. You are welcome to stop the interview at any time"

### **Introductory questions:**

- First of all, how did you get involved in intervention X?
- How long ago was that?
- How many sessions did you go to?
- Is anyone else from your family involved in intervention X?
- 

### **Questions about the parent's experiences of the intervention:**

- Can you tell me about what happened during intervention X?

#### Prompts:

- What did you do?
- Who did you meet?
- What happened at the beginning of the intervention? What happened after that? How did the intervention end?
- How did you feel at the end of the intervention?
- Did you learn any new skills or knowledge? **If so**, what?
- How much time did you need to put into the intervention?
- Were there any aspects of the intervention that surprised you? **If so**, what?
- What did you like about the intervention? What didn't you like about the intervention?
- What were the most helpful things about the intervention for you?

#### Prompts:

- What do you feel that you have gained by participating in the intervention?
- Do you feel that you have gained from the intervention the things that you were expecting to gain? **If so**, what?
- Is there anything that you do differently in your life or in your relationships now that you have participated in this intervention? **If so**, what?
- Was there anything that you would have liked to have been different about the intervention? **If so**, what?

#### Prompts:

- Was there anything that could have made it more helpful for you? **If so**, what?
- Is there anything that could make it more helpful for other parents? **If so**, what?

### **Questions about the parent's outcomes:**

- Compared to before you started intervention X, how have things been? For you personally? In your family?

Prompts:

- Has anything changed for you, in your life or in the way that you're feeling? **If so**, how?
- What has improved/got better? Has anything got worse?

*[ask for concrete examples]*

*[check whether the feelings/behaviours that they describe now are different to before the intervention, e.g. Is that different to how you were feeling before?]*

- In thinking about the changes that you just mentioned, what do you think led to those changes?

Prompts:

- What/who has been helpful (or unhelpful)?
- What do you do when you have difficulties in your life?
- **NB If the parent doesn't mention the intervention, check out whether they feel that the intervention is linked to any of the changes that they've spoken about, e.g.**, Was your experience of the intervention linked to any of these changes that you've described? **If so**, how? What has the intervention changed in your life (if anything)?
- **NB If the parent doesn't feel that anything has changed, explore this, e.g.** Did you expect to feel any differently as a result of the intervention? Even though you don't really feel any differently now, was there anything that was helpful about the intervention for you? Was there anything that could have made the intervention more helpful for you? Has there been anything that's been unhelpful for you?

*[ask for concrete examples, e.g. What was helpful/unhelpful about that?]*

- To finish off with, I want to talk to you about something called 'resilience'. Resilience can mean lots of different things to different people. Some people think of resilience in terms of the capacity to recover. Other people might think of resilience as the capacity to cope with challenges in life. In thinking about these things that we've just talked about, what does resilience mean to you?
- Could you tell me about a time when you have shown resilience? Could you tell me what happened? What did you do? Were other people involved?

Prompts:

- Could you tell me about a time when you saw another person show resilience?  
Could you tell me what happened? What did they do? Were other people involved?
- In what ways do you think that the intervention has helped you and/or your family to become more resilient?
- Were any other people involved in helping you to become resilient?

Prompts:

- Family members?
- Others?
- What did they do?

**Concluding statements:** “The answers that you give me will go towards some national research by the Anna Freud Centre about programs across 12 areas in England that are supporting young people’s and families’ well-being. When we write about our findings for this research, your answers will be anonymous. If you would like a copy of your interview transcript, please let us know.”

### **1. Advice for Interviews with Children/Young People (CYP)**

- The preference would be for CYP to be interviewed without their parent present just in case this inhibits them from speaking about some topics, but we can be flexible about this according to the interviewees’ needs - if the CYP would like their parent to be present during their interview then of course that’s fine.
- Parental consent and CYP assent needs to be taken for children under the age of 16.
- If the CYP is becoming upset or stressed by any questions, make it clear to them that they can stop the interview at any point, or skip a question. Make it really clear that you won’t mind this and that it won’t have any bad consequences for them if they want to stop the interview.
- Outlining what confidentiality means and the limits to confidentiality is important at the start of the interview. This means that if the CYP says anything to you at any point that makes you feel that they (or someone else) may be at risk of harm, then they need to know that this will be taken seriously and that you will need to talk to someone else (i.e., Jess Deighton – your supervisor, and the site safeguarding officer) about it.
- It is important to cover the areas in the interview schedule, but remember, it is only a structure to get people talking about their experiences, and the aim is for a flowing conversation about their experiences. It’s really important to follow up and be interested in the things that the CYP raise as this is the information that we are yet to discover.
- There may be silences where people are thinking. Give them space to think, and do not immediately fill silences. You could check in with them and say something like, ‘I’m not sure if the question feels a bit hard or whether you are having a think about it’. If they are really struggling to understand the question, explain it to them in a different way (have a look at the prompts).

- Bring paper and coloured pens or pencils to each interview as asking a CYP to draw something that they don't know how to describe can make a real difference. It can also be a good icebreaker, for instance, if you both draw together and discuss your drawings with each other.
- If a CYP is shy or nervous during the interview and/or is struggling to answer the questions, then you can always take a break from trying to interview them and just chat to them about the things that they like to do or what their plans are for after the interview. You can then come back to the interview when the CYP is potentially a bit more relaxed.

## **7. Advice for Interviews with Parents**

- It is really important to ensure that you take a neutral, non-judgmental stance when conducting interviews.
- If the parent is becoming upset or stressed by any questions, make it clear to them that they can stop the interview at any point, or skip a question.
- Outlining what confidentiality means and the limits to confidentiality is important at the start of the interview. This means that if the parent says anything to you at any point that makes you feel that they (or someone else) may be at risk of harm, then they need to know that this will be taken seriously and that you will need to talk to someone else (i.e. Jess Deighton – your supervisor, and the site safeguarding officer) about it.
- It is important to cover the areas in the interview schedule, but remember, it is only a structure to get people talking about their experiences, and the aim is for a flowing conversation about their experiences. It's really important to follow up and be interested in the things that the parents raise as this is the information that we are yet to discover.
- There may be silences where people are thinking. Give them space to think, and do not immediately fill silences. If they are really struggling to understand the question, explain it to them in a different way (have a look at the prompts).

## **8. Safeguarding Information**

### **Our safety as interviewers:**

- Two researchers must be present at each home visit, but only one will be the interviewer.
- Emily must be aware of the date/time/location of each of your interviews for each site. Emily (or Mia or Jess, in Emily's absence) will phone you at the end of your visit to the site (before you leave the site) to check in with you about how your interviews went and to discuss any safeguarding concerns that may have arisen from your interviews.

### **Participant safety:**

- Before starting your interviews, you must know the name and contact details of the site safeguarding officer. Essentially, should any safeguarding issues arise during the

interviews, we would report them to the site safeguarding officer and they would take them forward, but we would also report them to Jess (as our line manager) to document them here.

- Discuss confidentiality and the limits to confidentiality with participants at the start of their interviews, as per the interview schedule. If you need to break confidentiality because you are concerned about an interviewee's, or anyone else's, safety/well-being then let the interviewee know at the end of their interview that you are going to speak to your supervisor and your safeguarding contact at the site about the things that they are saying that are worrying you, in order to make sure that it doesn't just get forgotten. If you do this, then the site safeguarding officer needs to let the young person know specifically what will happen next (i.e., what action they will take) as they may be anxious that all sorts of things are going to happen, such as telling their parents etc.
- The types of issues arising in interviews with young people that need to be flagged as something that is worrying you with the interviewee, and then discussed with Jess and the site safeguarding contact are:
  - o Binge or persistent drinking
  - o Sex with adults
  - o Violence at home
  - o Major absence of parenting or adult care
  - o Drug use
  - o Self-harm
  - o Suicidality (including thoughts, plans, attempts)
  - o Abuse
- Generally, err on the side of caution – i.e., it is better to report a potential safeguarding issue (something that makes you concerned about the interviewee's, or anyone else's, safety), even if you're not sure that it is a safeguarding issue. Safeguarding issues should be reported to the safeguarding contact at the site, as well as Jess (or Mia, Emily, or Jac, if you cannot get hold of Jess). Let the safeguarding contact at the site know that you will also be reporting the safeguarding issue to Jess, Mia, Emily, or Jac. It is the site safeguarding officer's responsibility to decide whether or not to take action following the safeguarding issue that you have raised. However, should the site safeguarding officer decide not to take any action on a safeguarding issue and we disagree with this decision, this should be reported by Jess to the Anna Freud Centre Clinical Governance Group.
- This following point only applies in very rare or extreme circumstances (such as terror of going home, a plan to make an immediate suicide attempt, explicit injuries): If you are concerned about the interviewee being at immediate risk then stop the interview and talk to the interviewee about your concerns and speak to your supervisor/the site safeguarding contact in the middle of the interview. You could say something like this: 'What you've told me is really worrying and I want to give you the best possible advice so I'm going to ring my line manager and discuss this with her'.

**Contact details:** (Deleted)

## **9. Collecting Materials About the Intervention**

As the research will in form an in-depth case study for each intervention it is necessary to obtain as much information as possible about the intervention. Possible information sources may include:

Previous evaluation results of the intervention

- Case Studies
- Marketing Materials (such as brochures and pamphlets)
- Plans and Guides
- Training materials for practitioners or those delivering the intervention
- Any additional materials that are given to children or parents

It's important to gather as much information as possible about the intervention, so you may gather materials that are not on this list.

### **Final Things to Remember**

- You cannot begin an interview with a child unless you have a signed copy of the parental consent form in your hand and a completed assent form. Equally, you cannot begin an interview with a parent without a completed consent form.
- Please bring spare consent and assent forms to the interview. We have set up processes to obtain consent and assent but in the event that this has not been gained, please bring "back-up" consent and assent forms to obtain permission on the day.
- Please bring a notebook in case you have any technical difficulties with recording equipment.

## Appendix C: Table of Headstart Interventions Studied in Headstart Phase 2

HeadStart interventions selected by Local Authority partnership with brief description, type (targeted or universal) and age group (in school year group with age).

Local Authority	Intervention	Type	Age group
Blackpool	Equine and Art therapy: Sessions of horse care and horse riding followed by sessions of art therapy.	Targeted	Year 8 (12-13)
Birmingham	PATHS: A curriculum- based intervention in schools.	Universal	Year 8 (12-13)
Cornwall	Thrive and Community Facilitators. Individualised support at home and in the community for young people identified as at risk of mental health issues.	Targeted	Year 6 –11 (10-16)
Cumbria	Mates in Mind: A peer to peer emotional resilience training programme in schools.	Universal	Year 9 (13-14)
Hull	Young Peoples Peer Mentoring Project. Peer mentoring for young people at risk of mental health issues.	Targeted	Year 8-10 (12-15)
Kent	Family Focus an intervention providing support for adolescents and their families identified at risk, targets YP with family risk such as domestic violence.	Targeted	Year 8 (12-13)
Knowsley	Stop, Gap, Go. A mindfulness programme for students, parents and teachers taught in schools.	Targeted	Year 6- 8 (10-13)
Lewisham	The BelEve Transition Program. A school-based peer mentoring programme working on young people-led issues.	Targeted	Year 7 & 9 (11-12 & 13-14)
Newham	Supported volunteering, a programme providing volunteering opportunities in the community and group work for young people identified as at risk of mental disorders.	Targeted	Year 7, 8 & 9 (11-14)
Middlesbrough	One-to-one counselling and emotional support provided in schools for adolescents at risk of mental disorder.	Targeted	Year 7-10 (11-15)

Local Authority	Intervention	Type	Age group
Southampton	LINX: Group work and curriculum for young people experiencing domestic abuse who are exhibiting risk-taking or violent behaviour.	Targeted	Year 6-10 (10-15)
Wolverhampton	Getting Ahead Days Digital Experience days including resilience curriculum.	Universal	Year 6 & 8 (10-11 & 12-13)

## Appendix D: Search Terms for the Scoping Review

Table of the generic search formula for the study: What Types of Protective Factors Have Been Found to Increase Adolescent Wellbeing and Reduce the Risk of Psychopathology in Current Research.

Participant: Adolescent	Protective Factor	Outcome: Well-Being
Adolescent	Protective factor	Health
Youth	Asset	Quality of Life
Student	Resource	Life satisfaction
Pupil	Resilience factor	Happiness
Child	Strength	Mental health
Young Adult	Asset	Outcomes
Adolescence	Resilience	Psychopathology
Teen*	Protective factor	Adjustment
Teenager	`Variable`	Mental well-being
Young person	Protective resources	Emotional well-being
Young people	Promotive factor	Subjective wellbeing
Girls		Psychological wellbeing
Boys		Well-being
Males		
Females		
Preteen		

## Appendix E Studies Identified in the Scoping Review

*Table 0-1 Tabulation of the complete list of studies included in the review, with authors and year of publication, title, type of study and study aim*

Author and year	Title	Type of study	Study aim
Abubakar et al., (2013)	Attachment and psychological well-being among adolescents with and without disabilities in Kenya: The mediating role of identity formation	Quantitative	To evaluate the relationship between attachment and identity development, and their influence on psychological well-being in adolescents with and without disabilities in Kenya.
Afzal, Atta, & Malik (2016)	Role of positive psychological capital in prediction of emotions and subjective wellbeing among adolescents	Quantitative	To investigate the role of positive psychological capital (PsyCap) in the prediction of positive and negative emotions and subjective wellbeing (SWB) among school adolescents.

Author and year	Title	Type of study	Study aim
Almroth, László, Kosidou, & Galanti (2018)	Association between adolescents' academic aspirations and expectations and mental health: a one-year follow up	Quantitative	To study the relationship between academic aspiration and mental health.
Al-Yagon (2011)	Adolescents' subtypes of attachment security with fathers and mothers and self-perceptions of socioemotional adjustment	Quantitative	To examine adolescents' secure attachment with both versus one parent, for deeper understanding of adolescents' perceptions of their socioemotional adjustment.
Anderson-Butcher et al., (2010)	Adolescent weblog use: Risky or protective?	Qualitative	To describe the content of 100 weblog users' communications through a risk and resilience framework.
Bali & Sharma, (2017)	Resilience in relation to social support among adolescents	Quantitative	To investigate the relationship between resilience and social support among government and private school adolescent.

Author and year	Title	Type of study	Study aim
Balluerka, Gorostiaga, Alonso-Arbiol, & Aritzeta, (2016)	Peer attachment and class emotional intelligence as predictors of adolescents' psychological well-being: A multilevel approach	Quantitative	To analyse whether gender, age, peer attachment, and class-level emotional intelligence could predict adolescents' psychological well-being by applying a multilevel approach.
Banyard, Hamby, Grych (2016)	Using values narratives to promote youth well-being in schools: An exploratory quantitative evaluation of the Laws of Life Essay	Quantitative	To examine differences between those who did and did not complete a values narrative about a guiding principle in their own life.
Best et al., (2014)	Online communication, social media, and adolescent wellbeing: A systematic narrative review	Review	To systematically review and synthesise current empirical research on this topic, identifying both the beneficial and harmful effects of online communication and social media technology.
Bluth, et al., (2017)	Age and gender differences in the associations of self-compassion and emotional well-being in a large adolescent sample	Quantitative	To examine whether adolescents' self-compassion differed by age and gender, and secondly, whether its associations with emotional well-being (perceived stress, life satisfaction, distress intolerance, depressive symptoms, and anxiety) also differed by age and gender.

Author and year	Title	Type of study	Study aim
Bluth & Eisenlohr-Moul (2017)	Response to a mindful self-compassion intervention in teens: A within-person association of mindfulness, self-compassion, and emotional well-being outcomes	Quantitative	To investigate the role of a mindful self-compassion program would decrease stress, depressive symptoms, and anxiety and increase resilience, gratitude, and curiosity/exploration, and to ascertain if mindfulness and self-compassion co-varied with these outcomes over time.
Bowker & Etkin, (2016)	Evaluating the psychological concomitants of other-sex crush experiences during early adolescence	Quantitative	To evaluate the psychological concomitants of other-sex crush experiences (having and being viewed by others as a crush).
Brière et al., (2018)	Prospective associations between sport participation and psychological adjustment in adolescents	Quantitative	To examine whether sport participation is associated with reduced psychological difficulties in adolescents and whether associations differ by sport and personal characteristics.
Briggs et al., (2011)	Assessing and promoting spiritual wellness as a protective factor in secondary schools	Review	To review the literature linking spiritual wellness and thriving in the adolescent population.

Author and year	Title	Type of study	Study aim
Brownlee et al., (2013)	A systematic review of strengths and resilience outcome literature relevant to children and adolescents	Review	To conduct a systematic review of strengths and resilience outcome literature relevant to children and adolescents.
Bryden et al., (2015)	Coping as a mediator between negative life events and eudaimonic well-being in female adolescents	Quantitative	To explore relationships among negative events, coping, and eudaimonic well-being for female teenagers.
Buist, Deković, & Prinzie (2013)	Sibling relationship quality and psychopathology of children and adolescents: A meta-analysis	Review	To investigate the link between child and adolescent sibling relationship quality (warmth, conflict, and differential treatment) and internalising and externalising problems.
Calmeiro, Camacho, & de Matos (2018a)	Life satisfaction in adolescents: the role of individual and social health assets	Quantitative	To explore the relationship between adolescents' life satisfaction and individual and social health assets.

Author and year	Title	Type of study	Study aim
Çelik & Çetin (2015)	The role of proximal and distal resilience factors and locus of control in understanding hope, self-esteem and academic achievement among Turkish pre-adolescents	Quantitative	To assess the relationship between resilience, hope, self-esteem, locus of control and academic achievement.
Cheie & Miu (2016)	Functional and dysfunctional beliefs in relation to adolescent health-related quality of life	Quantitative	To investigate the roles of functional and dysfunctional beliefs in adolescent Health Related Quality Of Life, while also taking into account age- and gender-related differences.
Coholic (2011)	Exploring the feasibility and benefits of arts-based mindfulness-based practices with young people in need: Aiming to improve aspects of self-awareness and resilience	Qualitative	To describe an innovative research-based group program that teaches young people in need mindfulness-based methods using arts-based method.
Collibee, et al., (2014)	The moderating role of friendship quality on associations between autonomy and adolescent adjustment	Quantitative	To examine interactions between adolescent friendship quality and observed autonomy among ninth-grade students (42 female).

Author and year	Title	Type of study	Study aim
Correia & Dalbert (2009)	Belief in a just world, justice concerns, and well-being at Portuguese schools	Quantitative	To hypothesise that belief in a just world should serve as a resource helping to maintain positive well-being and to assimilate experienced injustice.
Crescentini, et al., (2018)	Temperament and character effects on late adolescents' well-being and emotional-behavioural difficulties	Quantitative	To investigate the question of personality's relation to well-being and psychosocial adjustment in adolescence.
Dailey (2006)	Confirmation from family members: Parent and sibling contributions to adolescent psychosocial adjustment	Quantitative	Two studies examined the relationship between confirmation (i.e., validation, acceptance) by family members and adolescent psychosocial adjustment (i.e., self-esteem, strength of self-concept, and autonomy).
Davey, Eaker, & Walters (2003)	Resilience processes in adolescents: Personality profiles, self-worth, and coping.	Quantitative	To examine the potential for different associations of two correlates of resilience (self-worth and coping) with a third (personality dimensions).

Author and year	Title	Type of study	Study aim
David, Predatu, & Cardoso (2018)	A pilot study of the RETHINK online video game applied for coaching emotional understanding in children and adolescents in therapeutic video game environment: The feeling better resources game	Quantitative	To Investigate the Feeling Better mini video game, part of the Rethink therapeutic online platform as a resource activity, as a useful tool in coaching the distinction between functional and dysfunctional emotions in children and adolescents in the therapeutic video game environment.
Donchi & Moore, (2004)	It's a boy thing: the role of the internet in young people's psychological wellbeing	Quantitative	To assess the relationship between psychological wellbeing and Internet use among adolescents, focussing not only on time spent on the Internet, but also on the relative strength/importance of both face-to-face and Internet friendship networks.
Dray et al., (2017)	Systematic review of universal resilience-focused interventions targeting child and adolescent mental health in the school setting	Review	To examine the effect of universal, school-based, resilience-focused interventions on mental health problems in children and adolescents.
DuBois et al., (2002)	Getting by with a little help from self and others: Self-esteem and social support as resources during early adolescence	Quantitative	To investigate the influences of social support and self-esteem on adjustment in early adolescence in a two-year longitudinal study.

Author and year	Title	Type of study	Study aim
Eames, et al., (2016)	The Team of Life: A narrative approach to building resilience in UK school children	Mixed Methods	To report findings from pilot work evaluating feasibility and outcomes for the programme within a UK secondary school setting.
Everri, Mancini & Fruggeri (2015)	Family functioning, parental monitoring and adolescent familiar responsibility in middle and late adolescence	Quantitative	To examine the relationship among family functioning, parental monitoring, and family responsibility in Italian adolescents in two age ranges 14-15 and 18-19 years in the first and last two years of secondary school.
Feinberg & Hetherington (2001)	Differential parenting as a within-family variable	Quantitative	To investigate whether differential parental negativity or warmth is linked to adolescent adjustment apart from the effect of the level of parenting toward each child separately.
Feng & Astell-Burt, (2017)	The relationship between neighbourhood green space and child mental wellbeing depends upon whom you ask: Multilevel evidence from 3083 children aged 12-13 years	Quantitative	To investigate whether similar associations between child mental wellbeing (as measured using the total difficulties score and the internalising and externalising subscales) and neighbourhood green space quantity and quality.

Author and year	Title	Type of study	Study aim
Flouri, et al., (2010)	Adverse life events, area socio-economic disadvantage, and adolescent psychopathology: The role of closeness to grandparents in moderating the effect of contextual stress	Quantitative	To investigate whether closeness to grandparents moderates the association between contextual stress and adolescent psychopathology and prosocial behaviour, measured with the strengths and difficulties questionnaire (SDQ).
Froh, et al., (2009)	Gratitude and subjective well-being in early adolescence: Examining gender differences	Quantitative	To examine gender differences in gratitude and wellbeing in early adolescents.
Furness, et al., (2017)	Maximising potential: The psychological effects of the youth development programme Project K	Quantitative	To investigate changes in self- efficacy, resilience, connectedness, and wellbeing in students participating in Project K.
Gerber et al., (2013)	Adolescents with high mental toughness adapt better to perceived stress: A longitudinal study with Swiss vocational students	Quantitative	To test the association between higher mental toughness and increased resilience towards stress.

Author and year	Title	Type of study	Study aim
Gomez-Baya, et al., (2018)	Responses to positive affect, life satisfaction and self-esteem: A cross-lagged panel analysis during middle adolescence	Quantitative	To examine the longitudinal associations between responses to positive affect (emotion-focused positive rumination, self-focused positive rumination, and dampening) and psychological adjustment (self-esteem and life satisfaction) during middle adolescence.
Greve & Thomsen, (2013)	Developmental conditions of adaptive self-stabilization in adolescence: An exploratory study	Quantitative	To examine the developmental conditions for self-regulation, as part of the larger construct of adaptation.
Griciūtė (2016)	Optimal level of participation in sport activities according to gender and age can be associated with higher resilience: Study of Lithuanian adolescents	Quantitative	Resilience differences between sedentary adolescents and adolescents were classified as sport activity categories in gender and age groups.
Guse & Vermaak (2011)	Hope, psychosocial well-being and socioeconomic status among a group of South African adolescents	Quantitative	To explore levels of hope and psychosocial well-being among South African adolescents from different socioeconomic contexts.

Author and year	Title	Type of study	Study aim
Heaven & Ciarrochi, (2007)	Personality and religious values among adolescents: A three-wave longitudinal analysis	Quantitative	To assess the relationships between endorsement of religious values, some of the major personality dimensions, and social and emotional well-being amongst teenagers.
Huynh, et al., (2013)	Exposure to public natural space as a protective factor for emotional well-being among young people in Canada	Quantitative	To examine the relationship between exposure to public natural space and positive emotional well-being among young adolescent Canadians.
Iannotti, et al., (2009)	Patterns of adolescent physical activity, screen-based media use, and positive and negative health indicators in the U.S. and Canada	Quantitative	To examine how adolescent physical activity (PA) and screen-based media use (SBM) relate to physical and social health indicators, and cross-national differences in these relationships.
Jayman, et al., (2018)	Improving socio-emotional health for pupils in early secondary education with Pyramid: A school-based, early intervention model	Quantitative	To examine the effectiveness with pupils in early secondary education; service users' perceptions and experiences were investigated to increase understanding of Pyramid's impact, thus supporting enhanced practice

Author and year	Title	Type of study	Study aim
Johnson, et al., (2007)	Youth civic engagement in China: results from a program promoting environmental activism	Mixed Method	To investigate perceptions of program impact on the personal and social development of Chinese youth.
Kaur & Amin (2017)	Psychological capital and stress among school students	Quantitative	To explore gender differences in the psychological capital and stress among school students.
Keskin & Çam (2010)	Adolescents' strengths and difficulties: Approach to attachment styles	Quantitative	To investigate the relationship between adolescent difficulties and attachment style.
Keyfitz, et al., (2013)	The role of positive schemas in child psychopathology and resilience	Quantitative	To examine a new questionnaire and its relationship to depression, anxiety, and resilience.

Author and year	Title	Type of study	Study aim
Khalsa, et al., (2012)	Evaluation of the mental health benefits of yoga in a secondary school: a preliminary randomized controlled trial	Quantitative	To evaluate potential mental health benefits of yoga for adolescents in secondary school.
Lambert et al., (2014)	Looking on the bright side: An assessment of factors associated with adolescents' happiness.	Quantitative	To determine possible factors which may be associated with happiness among New Zealand adolescents.
Laursen & Birmingham (2003)	Caring relationships as a protective factor for at-risk youth: An ethnographic study	Ethnographic	To understand the role of caring relationships as a protective factor for at-risk youth.
Lester & Cross (2015)	The relationship between school climate and mental and emotional wellbeing over the transition from primary to secondary school	Quantitative	To examine the relationship between students' mental and emotional wellbeing and factors pertaining to school climate, focussing on the domains of safety, social relationships, and school connectedness, during the last year of their primary schooling (age 11–12 years) and their first 2 years of secondary school.

Author and year	Title	Type of study	Study aim
Leventhal et al., (2015)	Building psychosocial assets and wellbeing among adolescent girls: A randomized controlled trial	Quantitative	To conduct a randomised control trial of Girls First Resilience Curriculum at 57 government schools in India.
Leveresen, Danielsen, Birkeland, & Samdal (2012)	Basic psychological need satisfaction in leisure activities and adolescents' life satisfaction	Quantitative	To examine the relationship between adolescents' satisfaction of the psychological needs for competence, relatedness, and autonomy in their participation in leisure activities and their perceived life satisfaction.
Levin & Currie (2010)	Family structure, mother-child communication, father-child communication, and adolescent life satisfaction: A cross-sectional multilevel analysis	Quantitative	To investigate the association between mother-child and father-child communication and children's life satisfaction, and the moderating effect of communication with stepparents.
Levin, Dallago, & Currie (2012)	The association between adolescent life satisfaction, family structure, family affluence and gender differences in parent-child communication	Quantitative	To examine young people's life satisfaction in the context of the family environment, using data from the 2006 HBSC: WHO-collaborative Study in Scotland.

Author and year	Title	Type of study	Study aim
Loton & Waters, (2017)	The mediating effect of self-efficacy in the connections between strength-based parenting, happiness and psychological distress in teens	Quantitative	To investigate the mediating effect of self-efficacy in the connection between strength-based parenting, happiness and psychological distress in adolescents.
Mazur et al., (2016)	Behavioural factors enhancing mental health - preliminary results of the study on its association with physical activity in 15- to 16-year-olds	Quantitative	To investigate the role of physical activity influences in the variability of selected indices of mental health.
McCoy & Bowen, (2015)	Hope in the social environment: Factors affecting future aspirations and school self-efficacy for youth in urban environments	Quantitative	To identify some potential pathways through which parental relationships and neighbourhood environments may impact perceptions of future success and aspirations and self-efficacy in school settings for adolescents in urban environments.
Meltzer, Dogra, Vostanis, & Ford, (2011)	Religiosity and the mental health of adolescents in Great Britain	Quantitative	To investigate the religiosity correlates of childhood psychopathology-strength of belief, importance of being able to practice one's religion, and worship frequency.

Author and year	Title	Type of study	Study aim
Moksnes, Løhre, & Espnes (2013)	The association between sense of coherence and life satisfaction in adolescents	Quantitative	To investigate possible gender and age differences on life satisfaction as well as the association between sense of coherence (SOC) and life satisfaction.
Moreira, Gouveia, & Canavarro, (2018)	Is mindful parenting associated with adolescents' well-being in early and middle/late adolescence? The mediating role of adolescents' attachment representations, self-compassion and mindfulness	Quantitative	To examined if mindful parenting was associated with increased adolescents' wellbeing.
Moreno, et al., (2016)	Characterization of vulnerable and resilient Spanish adolescents in their developmental contexts	Quantitative	Used the adversity level associated with family functioning and the positive adaptation level, as measured by means of a global health score, to distinguish four groups within a representative sample of Spanish adolescents aged 13-16 years.
Morgan & Haglund (2011)	Corrigendum to 'Social capital does matter for adolescent health: Evidence from the English HBSC study'.	Quantitative	To measure and assess the relative importance of a range of social indicators representing the different domains of social capital on the health, wellbeing and health-related behaviours of young people.

Author and year	Title	Type of study	Study aim
Mykota & Muhajarine (2005)	Community resilience impact on child and youth health outcomes: A neighbourhood case study	Qualitative	To investigate community resilience from the perspectives of well-defined, geographically bounded neighbourhoods and in relation to factors within them that may mediate, either positively or negatively, child and youth health outcomes.
Nidich, et al., (2011)	Academic achievement and transcendental meditation: a study with at-risk urban middle school students	Quantitative	To determine the feasibility of implementing a meditation program with at-risk urban adolescents.
Oberle et al., (2011)	Life satisfaction in early adolescence: personal, neighborhood, school, family, and peer influences	Quantitative	To examine the relationship of early adolescents' satisfaction with life to trait optimism and assets representing the social contexts in which early adolescents spend most of their time.
Ohannessian (2009)	Media use and adolescent psychological adjustment: An examination of gender differences	Quantitative	To examine media use and psychological adjustment (as indicated by depression and anxiety symptomatology) in adolescents aged 14-16 years old.

Author and year	Title	Type of study	Study aim
O'Reilly et al., (2018)	Review of mental health promotion interventions in schools	Review	To review evidence-based research of mental health promotion interventions in schools and examined the reported effectiveness to identify those interventions that can support policy.
Pate, Maras, Whitney, & Bradshaw (2017)	Exploring psychosocial mechanisms and interactions: links between adolescent emotional distress, school connectedness, and educational achievement	Quantitative	To examine the association between adolescent emotional distress, school connectedness, and educational achievement by exploring potential mechanistic and interactive roles of perceived school connectedness on the emotion–education association.
Prabhu & Shekhar, (2017)	Resilience and perceived social support among school-going adolescents in Mangaluru	Quantitative	To investigate the relationship between resilience and social support among government and private school adolescent
Quinn & Oldmeadow (2013)	Is the igeneration a 'we' generation?: Social networking use and belonging in 9–13-year-olds	Quantitative	To examine the relationship between social networking use and feelings of belonging among children aged 9-13 years.

Author and year	Title	Type of study	Study aim
Randolph & Johnson (2008)	School-based mentoring programs: A review of the research	review	To examine outcome evaluations of eight school-based mentoring programs to compare the organizing frameworks, evaluate whether and how best practices were integrated into program service. structures, determine evaluation methods, and assess participant outcomes.
Redmond et al., (2009)	Long-term protective factor outcomes of evidence-based interventions implemented by community teams through a community-university partnership	Quantitative	To examine protective parent and youth skills outcomes of evidence-based preventive interventions selected from a menu and delivered by community teams supported by a community-university partnership model called PROSPER.
Riekie, Aldridge, & Afari (2017)	The role of the school climate in high school students' mental health and identity formation: A South Australian study	Quantitative	To understand the role of school climate on adolescent mental health and identity formation.
Rodríguez-Fernández, Ramos-Díaz, Madariaga, Arrivillaga, & Galende (2016)	Steps in the construction and verification of an explanatory model of psychosocial adjustment	Quantitative	Tested an explanatory model of psychosocial adjustment during adolescence, with psychosocial adjustment during this stage being understood as a combination of school adjustment (or school engagement) and subjective wellbeing.

Author and year	Title	Type of study	Study aim
Ruvalcaba et al., (2017)	Extracurricular activities and group belonging as a protective factor in adolescence	Quantitative	To investigate the relationship between belonging to different types of social groups and the positive and negative mental health indicators of Mexican adolescents.
Sagatun, et al., (2007)	The association between weekly hours of physical activity and mental health: a three-year follow-up study of 15- to 16-year-old students in the city of Oslo, Norway	Quantitative	To investigate the association between weekly hours of physical activity at age 15-16 and mental health three years later.
Salguero, et al., (2012)	Perceived emotional intelligence as predictor of psychological adjustment in adolescents: A 1-year prospective study	Quantitative	To analyse the predictive validity of perceived emotional intelligence over psychological adjustment at two timepoints.
Sánchez-López et al. (2009)	Physical activity and quality of life in schoolchildren aged 11-13 years of Cuenca, Spain	Quantitative	To examine the differences in quality of life (QoL) between active and sedentary schoolchildren and analysed these differences by gender and weight status.

Author and year	Title	Type of study	Study aim
Shean, Cohen, & de Jong (2015)	Developing well-being in Australian youth: Contingencies of self-esteem	Qualitative	To identify what adolescents perceived as protective factors that enhanced their well-being and resilience.
Stewart & Suldo (2011)	Relationships between social support sources and early adolescents' mental health: The moderating effect of student achievement level	Quantitative	To examine how perceived social support from parents, classmates, and teachers jointly and uniquely predicted psychopathology (i.e., internalizing, and externalizing symptoms) and wellness (i.e., life satisfaction).
Suldo & Huebner (2004)	Does life satisfaction moderate the effects of stressful life events on psychopathological behaviour during adolescence?	Quantitative	To test the prediction that adolescents' judgments of life satisfaction moderate the influence of stressful life events on the subsequent development of psychopathological behaviour
Temel & Atalay (2018)	The relationship between perceived maternal parenting and psychological distress: Mediator role of self-compassion	Quantitative	To investigate the mediator role of self-compassion in the relationship between perceived maternal parenting and psychological distress among adolescents.

Author and year	Title	Type of study	Study aim
Tennant, et al., (2007)	A systematic review of reviews of interventions to promote mental health and prevent mental health problems in children and young people	Review	Aimed to summarise the findings of published systematic reviews evaluating interventions to promote mental health and prevent mental health problems.
Tiêt & Huizinga (2002)	Dimensions of the construct of resilience and adaptation among inner-city youth	Quantitative	To review the conceptualization of resilience and empirically examines the dimensionality of a construct of resilience and adaptation by using structural equation modelling techniques.
Tiet, Huizinga, & Byrnes (2010)	Predictors of resilience among inner city youths	Quantitative	To identify predictors of resilience through longitudinal interrelations among predictors, and bi-directional relationships between resilience and life context factors.
Toner, Haslam, Robinson, & Williams (2012)	Character strengths and wellbeing in adolescence: Structure and correlates of the Values in Action Inventory of Strengths for Children	Quantitative	To examine the dimensions underlying the values in action character strengths defined by Peterson and Seligman (2004) to test their association with wellbeing.

Author and year	Title	Type of study	Study aim
Tunariu et al., (2017)	The iNEAR programme: An existential positive psychology intervention for resilience and emotional wellbeing	Quantitative	To evaluate the effectiveness of a new psychological intervention, the iNEAR, which is a resilience and wellbeing programme consisting of a classroom-based set of activities designed to facilitate the formation of positive identities through the acquisition of skills for growth and personal flourishing.
Tusaie, Puskar, & Sereika (2007)	A predictive and moderating model of psychosocial resilience in adolescents	Quantitative	To identify point prevalence of psychosocial resilience (PR) and to test moderating and predictive relationships among optimism, chronological age, gender, perceived family and friend support, number of bad life events, and PR in rural adolescents.
Ungar & Teram, (2000)	Drifting toward mental health: High-risk adolescents and the process of empowerment	Qualitative	To examine the link between the process of empowerment and mental health.
Ussher, Owen, Cook, & Whincup (2007)	The relationship between physical activity, sedentary behaviour and psychological wellbeing among adolescents	Quantitative	To investigate the relationship between adolescents' self-reported physical activity level, sedentary behaviour and psychological wellbeing; while controlling for a broad range of sociodemographic, health and developmental factors.

Author and year	Title	Type of study	Study aim
Van Dyke & Elias, (2007)	How forgiveness, purpose, and religiosity are related to the mental health and well-being of youth: A review of the literature	Review	To review the literature addressing certain personal qualities in the promotion of youth resilience.
Vella, et al., (2017)	Bidirectional associations between sport involvement and mental health in adolescence	Quantitative	To investigate the potential bidirectional relationships between sport participation and mental health during early adolescence.
Viejo, Ortega-Ruiz, & Sánchez (2015)	Adolescent love and well-being: The role of dating relationships for psychological adjustment	Quantitative	To measure the link between romantic relationship experience and personal adjustment, taking into account effects of age and sex, and to analyse the effect of adolescent dating relationship quality on personal adjustment.
Viholainen, et al., (2014)	Adolescents' school-related self-concept mediates motor skills and psychosocial well-being	Quantitative	To investigate whether the self-concepts (SCs) of school-related physical education (SCPE), reading (SCR), and mathematics (SCM) mediate the relationship between MSs and PSWB in adolescence.

Author and year	Title	Type of study	Study aim
von Rueden et al., (2006)	Socioeconomic determinants of health-related quality of life in childhood and adolescence: results from a European study	Quantitative	To investigate the impact of two different socioeconomic status (SES) measures on child and adolescent self-reported health related quality of life (HRQoL).
Waite, Shanahan, Calkins, Keane, & O'Brien, (2011)	Life events, sibling warmth, and youths' adjustment	Quantitative	To test whether sibling warmth moderated the association between each of family-wide, youths' personal, and siblings' personal life events and both depressive symptoms and risk-taking behaviours.
Waters (2011)	A review of school-based positive psychology interventions.	Review	To review school-based interventions that have been designed to foster student wellbeing and academic performance by following a positive psychology approach that seeks to cultivate positive emotions, resilience, and positive character strengths.
Weber, et al., (2013)	Relationships among higher-order strengths factors, subjective well-being, and general self-efficacy-The case of Israeli adolescents	Quantitative	To investigate relationships among five higher-order strengths factors, subjective well-being, and general self-efficacy in participants that live under challenging conditions.

Author and year	Title	Type of study	Study aim
Wille, et al., (2008)	Risk and protective factors for children's and adolescents' mental health: results of the BELLA study	Quantitative	To report the frequencies and distributions of potential risk and protective factors and analyses their effects on children's mental health.
Wong et al., 2009	A comparative study on resilience level between WHO health promoting schools and other schools among a Chinese population	Quantitative	To compare the resilience scores between schools within the healthy school award (HSA) scheme (HPS group) and those not (non-HPS group).
Zhang, Zhao, Ju, & Ma (2015)	Paternal involvement as protective resource of adolescents' resilience: roles of male gender-role stereotype and gender	Quantitative	To investigate the association between father involvement and adolescents' resilience and the roles of male gender-role stereotype and male gender-role identity were examined.
Ziv & Kiasi (2016)	Facebook's contribution to well-being among adolescent and young adults as a function of mental resilience	Quantitative	To study the relationship between Facebook use and psychological well-being, with mental resilience expected to moderate the relationship.

## Appendix F: Table of Definitions of Protective Factors Found in Studies

*Definitions of protective factors provided by individual studies as part of the Scoping Review. Where no definition is provided within the published paper, the measures for the specific protective factor are provided, with sample items.*

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Abubakar et al., (2013)	Attachment and psychological well-being among adolescents with and without disabilities in Kenya: The mediating role of identity formation	Parent attachment	"Inventory of parent and peer attachment (IPPA) A short 36-item version of the IPPA (Nada Raja, McGee & Stanton, 1992) was administered. The measure evaluates the perceived quality of maternal, paternal and peer attachment security, using 12 items for each of the subscales." (p. 851)

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
		Peer attachment	"Inventory of parent and peer attachment (IPPA) A short 36-item version of the IPPA (Nada Raja, McGee & Stanton, 1992) was administered. The measure evaluates the perceived quality of maternal, paternal and peer attachment security, using 12 items for each of the subscales." (p. 851)
Afzal, Atta, & Malik, (2016)	Role of positive psychological capital in prediction of emotions and subjective wellbeing among adolescents	Psychological capital	Psychological capital refers to "an individual's positive psychological state of involvement that is characterized by: (1) having confidence (efficacy) (2) making a positive attribution (optimism) of achievement in the present moment and in the future; (3) deterministic toward goals and, when needed, generating other pathways to goals (hope) in order to achieve them; and (4)... (resilience) to attain success (Luthans, Youssef, & Avolio, 2007)." (2016, p.72).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
		Hope	"Hope is one of the subscales of the PsyCap measure" (p.75).
		Optimism	"Optimism is one of the subscales of the PsyCap measure" (p.75).
Almroth, László, Kosidou, & Galanti, (2018)	Association between adolescents' academic aspirations and expectations and mental health: a one-year follow up.	High individual academic aspirations	Future aspirations and goals were measured at baseline using the 'Future aspirations and Goals' (FG) five-item subscale of the Student Engagement Instrument (SEI)... The five items of the FG subscale measure aspirations and perceived importance for continued education, the value put on education and hopefulness about the future (p. 505).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Al-Yagon (2011)	Adolescents' subtypes of attachment security with fathers and mothers and self-perceptions of socioemotional adjustment.	Secure attachment with both parents	"In line with previous valid outcomes for the Attachment Security Style scale (Kerns et al., 1996) in early adolescents (Lieberman et al., 1999), its 15-item Hebrew adaptation (Granot & Maysless, 2001) was utilized here to assess adolescents' perceptions of attachment security with each parent. After reading a dual statement like "Some adolescents find it easy to trust their mom/dad BUT other kids are not sure if they can trust their mom/dad," adolescents chose which statement was more characteristic of them." (p. 293).
Anderson-Butcher et al., (2010)	Adolescent weblog use: risky or protective?	Weblogging	"Weblogs, or personal websites updated in time-based fashions, are common media used for expressing thoughts and networking socially online." (p. 63).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Balluerka, Gorostiaga, Alonso-Arbiol, & Aritzeta, (2016)	Peer attachment and class emotional intelligence as predictors of adolescents' psychological well-being: A multilevel approach	Class level emotional intelligence	Class EI was "defined as "The perception of the students about the way in which their class pays attention to and values the feelings of classmates, is clear rather than confused about the emotions felt in the class and uses positive thinking to repair negative moods in the class." (Balluerka, Aritzeta, Gorostiaga, Gartzia, & Soroa, 2013, p. 112)." (p. 2).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Banyard, Hamby, & Grych (2016)	Using values narratives to promote youth well-being in schools: An exploratory quantitative evaluation of the Laws of Life Essay.	Values Narratives (Engagement with the writing exercise)	High school students each year are invited or required by their schools to write an essay about one of their "laws of life," defined as a value or idea that guides how they see themselves or how they live their lives. They complete these essays during late middle school or high school, and winning essays are judged and chosen locally and regionally." (p. 4).
		Peer attachment	"Peer attachment was assessed via the Inventory of the Parent and Peer Attachment (IPPA; Armsden & Greenberg, 1987) in its Basque version (Alonso-Arbiol, Balluerka, et al., 2014). This inventory measures adolescents' attachment security towards significant other figures (mother, father, and peers), implying specifically the emotional aspects that help create or foster bonds with such figures, as opposed to other dimensions of friendship quality in the case of peers....An example of an item would be: "I can count on my friends when I need to get something off my chest."" (p. 4).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Baroun, (2006)	Relations among religiosity, health, happiness, and anxiety for Kuwaiti adolescents.	Religious motivation in boys	"The Intrinsic Religious Motivation scale (Hoge, 1972) consists of 10 statements, e.g., My faith involves all life and In my life I experience the presence of the Divine, answered on a 5-point intensity scale." (p. 719)
		Strength of religiosity	"Strength of religious belief, physical health, mental health, happiness, and life satisfaction were measured to clarify inner dynamics of religiosity among these Kuwaiti adolescents, e.g., What is your level of religiosity, How is your mental health, and Do you feel happy in general? (Abdel-Khalek, 2002, 2006)." (p.719).
		Physical health	As above
		Religious belief	As above

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Bluth, Campo, Futch, & Gaylord, (2017)	Age and gender differences in the associations of self-compassion and emotional well-being in a large adolescent sample.	Self-compassion	Defined as "non-judgmentally connecting with one's own suffering and failure as an inherent aspect of being human and taking an active role in self-soothing when experiencing emotional challenges (Neff 2003)." (p. 841).
Bluth & Eisenlohr-Moul, (2017)	Response to a mindful self-compassion intervention in teens: A within-person association of mindfulness, self-compassion, and emotional well-being outcomes	Making Friends with Yourself: A Mindful Self-Compassion Program for Teens	"8-week mindful self-compassion programme" (p. 116).
		Mindfulness	"Mindfulness, described as the practice of bringing attention and awareness to one's momentary experience with a sense of acceptance and non-judgment (Kabat-Zinn, 1994)" (p. 109).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
		Self-compassion	"Treating oneself kindly when faced with challenges" (p. 115).
Bowker & Etkin (2016)	Evaluating the psychological concomitants of other-sex crush experiences during early adolescence.	High crush status a protective factor at high levels of anxious withdrawal.	"Both having and being viewed as an other-sex (member of the opposite sex) crush" (p. 846).
Brière et al., (2018)	Prospective associations between sport participation and psychological adjustment in adolescents.	Sport participation	"Participants were asked, 'Do you regularly take part in an organized sport?' with the following answer choices: no, I don't participate in any sport; yes, once a week; yes, twice a week; yes, three times a week; yes, four or more times a week. " (p. 576).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Bryden, Field, & Francis, (2015)	Coping as a mediator between negative life events and eudaimonic well-being in female adolescents	Primary and secondary control coping	The Responses to Stress Questionnaire (RSQ; Connor-Smith, et al. 2000) is a 57-item measure that assesses how adolescents respond to stress within a particular domain. The RSQ measures stress responses across five dimensions: primary control coping; secondary control coping; disengagement coping; involuntary engagement; and involuntary disengagement (Connor-Smith et al. 2000)" (Byrden et al., 2015, p. 3726).
Buist, Deković, & Prinzie, (2013)	Sibling relationship quality and psychopathology of children and adolescents: A meta-analysis.	More sibling warmth was linked to less internalizing and externalizing problems.	Sibling warm defined as level of warmth and, conflict between siblings and differential treatment from parents (p. 97)

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Calmeiro, Camacho, & de Matos (2018)	Life satisfaction in adolescents: The role of individual and social health assets	School connectedness	School connectedness represents the extent to which students feel accepted, respected, included, and supported in school (Gerard & Booth, 2015; Murphey et al., 2004). (2018, p. 4).
		Family support	"Family support was assessed by the average of 4 items, including "My family tries to help me" and "I can talk to my family about my problems"." (p.3).
		Social competence	"Social competence is vital for the achievement of specific social and interpersonal goals and involves the use of interpersonal skills such as interpreting social cues, conflict resolution or making social decisions (Catalano et al., 2004)." (p. 2).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
		Academic achievement	For academic achievement: "The participants were asked to provide their last year's grade point average (GPA) for the academic achievement scores." p328
		Self-regulation	"Self-regulation represents the adolescents' ability to monitor their activities, evaluate their performance, motivate themselves and maintain their resilience while experiencing school and social disappointments (Zimmerman, 2002)" (p. 2).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Çelik, & Çetin (2015)	The role of proximal and distal resilience factors and locus of control in understanding hope, self-esteem and academic achievement among Turkish pre-adolescents	Personal factors: locus of control, self-liking, hope, academic achievement	"Self-esteem was measured by using the Rosenberg Self-Esteem Scale (Rosenberg 1965). Hope was measured using Children's Hope Scale (Snyder et al. 1997). Academic achievement The participants were asked to provide their last year's grade point average (GPA) for the academic achievement scores." (p. 328)

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
		School	<p>"Resilience was measured using California Healthy Kids Survey (Constantine et al. 1999; Constantine and Benard 2001). The survey's resilience and youth development module (RYDM) was based on the assumption that youth who experienced high levels of environmental assets would develop certain resilience traits. The scale consisted of ...The individual characteristics consisted of Communication and cooperation, Problem solving, Self-efficacy, Goals and aspirations, Empathy and Self-awareness. The protective environment characteristics involved Caring relationships with adults, High expectations from adults and Opportunities for meaningful participation in 4 different environments as family, school, community and peers." (p. 328).</p>
		Family resilience	As per measure above

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
		Community	"The community represented an adult from outside of school or home who was supportive of the child." (p. 338).
Cheie & Miu (2016)	Functional and dysfunctional beliefs in relation to adolescent health-related quality of life.	Functional beliefs	"Core beliefs, either functional or dysfunctional, represent general, strongly held views about ourselves, others, and the world, influencing the way we react in different circumstances (Ellis, 1994)" (p. 174) .
Coholic (2011)	Exploring the feasibility and benefits of arts-based mindfulness-based practices with young people in need: Aiming to improve aspects of self-awareness and resilience.	Fun	"This theme of "fun" encompassed and linked together the major categories including both group content and processes. For example, the aspects of the group program that the children enjoyed and that were fun were grouped into three major categories: arts- based activities and games, which included mindfulness-based exercises, learning things about themselves and ideas about life, sharing and expressing ideas, learning to use imagination, and being encouraged to engage in a variety of activities; eating snacks—the children appreciated the food that

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Collibee, LeTard, & Wargo Aikins (2014)	The moderating role of friendship quality on associations between autonomy and adolescent adjustment.	Friendship quality (for adolescents with low levels of autonomy and relatedness or high levels of undermining autonomy."	was provided at break-time; and making friends." (p. 310).  The Friendship Quality Questionnaire (FQQ; Parker & Asher, 1993) included 40 items describing youth perceptions of the quality of their best friendship. Subscales represent validation, intimacy, conflict, conflict resolution, help and guidance, and companionship within the relationship, with higher scores reflecting higher friendship quality." (p. 256).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Correia & Dalbert, (2009)	"Belief in a just world, justice concerns, and well-being at Portuguese schools":	Personal belief in a just world	The Belief in a Just World scale consists of six items (sample item, "I think basically the world is a just place". Personal BJW was measured with the seven items of Personal Belief in a Just World Scale (Dalbert, 1999; sample item: "I am usually treated fairly")." (2009, p. 424)
		Self-efficacy	"Self-efficacy was measured with the seven items of the School Related Self-efficacy Scale (Jerusalem & Satow, 1999; sample item "If I should solve a difficult task at the blackboard, I believe that I can manage it")." (2009, p. 424)

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
		Self esteem	"We measured self-esteem with Rosenberg's (1965) 10-item Self-Esteem Scale (sample item: "On the whole I am satisfied with myself" (p. 424).
		Trust	"General trust was measured using the Revised Philosophies of Human Nature Scale (Wrightsman, 1991) with ten items ( sample item: "The typical person is sincerely concerned about the problems of others")." (p. 427).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Crescentini, Garzitto, Paschetto, Brambilla, & Fabbro (2018)	Temperament and character effects on late adolescents' well-being and emotional-behavioural difficulties	Character maturity specifically self-directedness	The maturity of the self, i.e., the character, is defined at three levels: at the intrapersonal level with Self-Directedness (SD; purposeful, responsible and reliable vs purposeless, blaming and unreliable), at the interpersonal level with Cooperativeness (Co; helpful, empathic and ethical vs unhelpful, critical and opportunistic), and at the transpersonal level with Self-Transcendence (ST; holistic and united with the universe vs self-centered and unimaginative)." (p. 2).
		Self-transcendence	Self-Transcendence; holistic and united with the universe vs self-centered and unimaginative." (p. 2).
		Cooperative	"Cooperative; helpful, empathic and ethical vs unhelpful, critical and opportunistic." (p. 2).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Dailey (2009)	Confirmation from family members: Parent and sibling contributions to adolescent psychosocial adjustment.	Confirmation by parents	"Confirmation (validation and acceptance) specifically addresses how messages from others impacts individuals' sense of self (Buber, 1965; Laing, 1961; Watzlawick et al., 1967)" (p. 292).
		Confirmation from family members	"Confirmation specifically addresses how messages from others impacts individuals' sense of self (Buber, 1965; Laing, 1961; Watzlawick et al., 1967)" (p. 292).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Davey, Eaker, & Walters (2003)	Resilience processes in adolescents: Personality profiles, self-worth, and coping.	Combination of extraverted, agreeable, and open to new experiences	<p>"Personality was measured using the Inventory of Children's Differences (Havill &amp; Halverson, 1996). This measure contains 64 items designed to measure five aspects of personality in preteens and in adolescents. This personality assessment was used to develop profiles that might be considered protective factors; that is, they predispose an individual to greater potential for resilience." (p. 353).</p>
David, Predatu, & Cardoso, (2018)	A pilot study of the RETHINK online video game applied for coaching emotional understanding in children and adolescents in therapeutic video game environment: The feeling better resources game.	Video game intervention teaching distinction between functional and dysfunctional emotions	<p>"According to the binary model of distress (David, Montgomery, Macavei, &amp; Bovbjerg, 2005), stemming from the Rational-Emotive Behavior Therapy/ Coaching (Ellis, 1962) theory, there are functional and dysfunctional negative emotions, the latter ones being maladaptive. More specifically, functional negative emotions (e.g., sadness, worry, annoyance) are triggered by rational beliefs and lead to adaptive behaviors (e.g., problem solving), while dysfunctional emotions (e.g., depression, anxiety, anger) are triggered by irrational beliefs and lead to maladaptive behavioral responses (e.g., avoidance; David, Lynn, &amp; Ellis, 2009; David &amp; Szentagotai, 2006)." (pp. 58-59)</p>

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Donchi & Moore (2004)	It's a boy thing: the role of the internet in young people's psychological wellbeing.	Females with more online friends	"Respondents' use of the Internet and face-to-face relations for communicating with friends was measured using the 12-item Social Network Scale (Moody, 2001). The scale consists of two 6-item subscales: Internet social network importance (e.g., 'I converse more easily with people when I am on the Net') and face-to-face social network importance (e.g., 'I like to have a lot of friends whom I see regularly')" (p. 80).
		Males with more face-to-face friendships	"The UCLA Loneliness Scale was used to measure loneliness conceptualised as a global, unidimensional construct (Version 3; Russell, 1996). The 20-item scale has 10 descriptive feelings of loneliness and 10 descriptive feelings of satisfaction with social relationships." (p. 81).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
DuBois et al., (2002)	Getting by with a little help from self and others: Self-esteem and social support as resources during early adolescence	Social support	"Ratings of social support from youth were obtained using a modified version of the Perceived Social Support Scale (Procidano & Heller, 1983). The modified measure (DuBois, Felner, Sherman & Bull, 1994) consists of 30 items and yields separate scores for levels of perceived social support received from family, peers, and school personnel, respectively." (p. 825)
		Self esteem	"The Self-Esteem Questionnaire (SEQ; DuBois et al., 1996), a self-report measure for older children and young adolescents, was used to obtain youth ratings of self-esteem. The measure yields scale scores for self-evaluations pertaining to each of five separate domains: peer relations, school, family, physical appearance, and sports/athletics, as well as global self-esteem." (p. 826)

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Eames, Shippen, Sharp, & Eames, Shippen, & Sharp, (2016)	The Team of Life: A narrative approach to building resilience in UK school children.	Team of Life	"The narrative process in the Team of Life first invites young people to think about who is in their 'team of life', by creating 'team-sheets' representing significant people in their lives, e.g., Goalkeeper: Who is your goalkeeper? Who helps to 'keep' what is precious to you safe? 6 Who help to guard your goals? Defender: Who else assists you in protecting your dreams, in protecting what is precious to you? Striker: Who assists you and encourages you in trying to score goals?" (p. 5-6).
Everri, Mancini, & Fruggeri, Everri, Mancini, & Fruggeri, (2015)	Family Functioning, Parental Monitoring and Adolescent Familiar Responsibility in Middle and Late Adolescence	Parental monitoring	"Adolescents' perception of parental monitoring was assessed with the Parental Monitoring Questionnaire (Kerr et al. 2010; Stattin and Kerr 2000), validated in Italy by Miranda et al. (2012). The four dimensions were: (a) parental knowledge (of the adolescent) (b) youth disclosure (c) parental control... and (d) parental solicitation... of information" (p. 3061)
		Parental monitoring	As above

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Feinberg & Hetherington (2001)	Differential parenting as a within-family variable.	Differential parenting	"Differential parenting assessed by a signed difference score of parenting toward Child 1 minus parenting to Child 2." (p. 30).
Feng & Astell-Burt, (2017)	The relationship between neighbourhood green space and child mental wellbeing depends upon whom you ask: multilevel evidence from 3083 children aged 12-13 years.	Neighbourhood green space quality	"Green space quality was reported by the spokes-parent through responding to the following statement: <i>"there are good parks, playgrounds and play spaces in this neighbourhood"</i> (2017, p. 3). Responses to the statement were on level of agreement.
Flouri, Buchanan, Tan, Griggs, & Attar-Schwartz (2010)	Adverse life events, area socio-economic disadvantage, and adolescent psychopathology: The role of closeness to grandparents in moderating the effect of contextual stress.	Closeness to grandparents	"Closeness to grandparents was measured with Elder and King's (2000) scale of grandparent–grandchildren relationship quality. Children indicated... the extent to which they felt appreciated, loved or cared for by their grandparent, the extent to which the grandparent helped them in significant ways, the extent to which they perceived happiness in their relationship with their grandparent, and the extent to which they were close compared to other grandchildren to the grandparent. Children completed the scale for each living grandparent (p. 404)

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Froh, Yurkewicz, & Kashdan, (2009)	Gratitude and subjective well-being in early adolescence: Examining gender differences	Gratitude	"The Gratitude Adjective Checklist (GAC; McCullough et al., 2002) was used to assess gratitude. It is the sum of three adjectives: grateful, thankful, and appreciative. A Likert scale from 1 (not at all) to 5 (extremely) followed each item. Students were asked to rate the amount they experienced each feeling "since yesterday" (2009, p. 637).
Furness, Williams, Veale, & Gardner, (2017)	Maximising potential: The psychological effects of the youth development programme Project K.	Intervention Project K	"Each Project K programme runs over 14 months and has three components: a three-week residential wilderness adventure, a non-residential 10-day community challenge, and a 12-month mentoring partnership (Moore, 2005); these components are described in more detail below. Project K aims to improve social, psychological, and physical wellbeing in 13- to 15-year-old students identified as having low self-efficacy, but who do not demonstrate high risk behaviours such as significant mental health or behavioural problems. Includes..."wilderness adventure, community challenge, mentoring, self-efficacy, resilience and connectedness" (p. 14).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Gerber et al.,( 2013)	Adolescents with high mental toughness adapt better to perceived stress: A longitudinal study with Swiss vocational students.	Higher mental toughness	"Participants completed the 18-item short form of the MTQ48 (Clough, Earle, & Sewell, 2002), which measures total mental toughness. Previous studies showed high correlations between the short and long forms of the MTQ (Clough et al., 2002). The MTQ instruments generally have high test–retest reliability, high internal consistency, and are moderately associated with other psychological constructs such as optimism and self-efficacy" (Clough et al., 2002; Kaiseler, Polman, & Nicholls, 2009). (p. 809).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Gomez-Baya, Mendoza, Gaspar & Gomes (2018)	Responses to positive affect, life satisfaction and self-esteem: A cross-lagged panel analysis during middle adolescence	Positive rumination	This factor was measured through the "Responses to the Positive Affect Questionnaire Feldman et al. (2008). The study added items "to assess emotion-focused positive rumination (i.e., "Savor this moment"), and items 2, 4, 7 and 8 to assess dampening (i.e., "Think 'I don't deserve this', "Think about things that have not gone well for you," "Think about how hard it is to concentrate" and "Think 'people will think I'm bragging' "). (p. 465).
		More frequent self-attribution of positive affective states	As above

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Thomsen & Greve, (2013)	Developmental conditions of adaptive self-stabilization in adolescence: An exploratory study.	Parental variables	"Parental flexibility of goal adjustment. Parental accommodative tendencies were assessed by the original version of the Flexible Goal Adjustment Scale (Brandtstadter & Renner, 1990). In order to measure the adaptive fit within the dyadic parent-child relationship, we created a measure for the mutual co-adjustment between parents and adolescents by combining two scales obtained from the adolescent participants and (one of) their parents, respectively." (p. 124).
		Cognitive resources	"Cognitive abilities. Three measures were used to assess selected cognitive abilities: Imaginativeness, Reframing and Capacity for Abstract thought." (p. 123).
Griciūtė, (2016)	Optimal level of participation in sport activities according to gender and age can be associated with higher resilience: Study of Lithuanian adolescents.	Participation in sport activities	"Participation in sport activities (PSA) was measured with the Consistent Five Categories Schema (CFCS). Warren et al. (2010), in their review of physical activity assessment methodologies...named the following three fundamental dimensions of physical activity: intensity, frequency and duration that are incorporated to calculate energy expenditure (EE) associated with physical activity" (p. 128).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Guse & Vermaak, (2011)	Hope, psychosocial well-being and socioeconomic status among a group of South African adolescents.	Hope	"The Children's' Hope Scale (CHS) (Snyder et al., 1997). The CHS measures an individual's level of hope. It is based on Snyder's hope theory (that there are different routes to an overall goal) (Snyder, 2005; Snyder et al., 1997) and was developed for use with youth aged 7 to 16 years." (p. 528).
Heaven & Ciarrochi, (2007)	Personality and religious values among adolescents: A three-wave longitudinal analysis	Religious values in females	"We assessed intrinsic religious values by asking participants to indicate the extent to which they adhere to three guiding principles in their life: 'Being saved from your sins and at peace with God'; 'Being at one with God or the universe' and 'Following your religious faith 'Being at one with God or the universe' and 'Following your religious faith" (p. 686).
		Religious values in males	As above

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Huynh, Craig, Janssen, & Pickett (2013)	Exposure to public natural space as a protective factor for emotional well-being among young people in Canada.	Family affluence	"The current analysis used the Family Affluence Scale (FAS) to represent student SES. This scale combines four items of equal weight: number of vehicles owned in family, having a bedroom to oneself, number of family vacations in the past year, and number of computers owned" (p. 4)
		Perceived neighbourhood safety	"Perceived neighborhood safety may be influenced by physical neighborhood features and may play a role in the neighborhood context of health. This variable was based on student responses using a Likert scale to the statement "it is safe for younger children to play outside during the day" (p. 4)

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
		Lower levels of perceived rundown houses in neighborhoods	Two questions describing neighborhood aesthetics were obtained from the HBSC Administrator Questionnaire. Each school administrator was asked to what extent there were "garbage, litter, or broken glass in the street or road, on sidewalks, or in yards" and "vacant/shabby houses and buildings" in their school's neighbourhood" (p. 4)
Iannotti, Kogan, Janssen, & Boyce (2009)	Patterns of adolescent physical activity, screen-based media use, and positive and negative health indicators in the U.S. and Canada.	Physical activity	"Physical activity. Students were provided with a definition of PA and examples of moderate-to-vigorous PA. PA was then assessed with two questions asking about the number of days the respondent engaged in at least 60 minutes of PA over the last week and in a typical week. A mean of the responses to these two questions was used as the measure of PA" (2009, p. 494).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Jayman, Michelle, Ohl & Fox, Pauline and Hughes (2018)	Improving socio-emotional health for pupils in early secondary education with Pyramid: A school-based, early intervention model	The Pyramid club (an intervention)	"The Pyramid Club, 10-week intervention, is typically delivered as an after-school club for small groups (10–12 children), facilitated by three or four, trained leaders; the 90-min weekly sessions follow a manualized programme (with accompanying resource pack)." (p. 2).
Johnson, Johnson-Pynn, & Pynn (2007)	Youth civic engagement in China: results from a program promoting environmental activism	Roots and Shoots intervention	"R & S is an environmental and humanitarian program for youth formed by Jane Goodall. R&S champions hands-on activities and community service in the context of real-world experiences to foster learning, personal growth, and to strengthen youth's developmental potential. Members identify needs, formulate action plans, and negotiate and communicate with project beneficiaries, stakeholders, and one another." (p. 360).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Kaur & Amin (2017)	Psychological capital and stress among school students	Psychological capital	<p>"Psychological capital is defined as an individual's positive psychological state of development and is characterized by: having confidence (self-efficacy) to take on and put in the necessary effort to succeed at challenging tasks; making a positive attribution (optimism) about succeeding now and in the future; persevering toward goals and, when necessary, redirecting paths to goals (hope) in order to succeed; and when beset by problems and adversity, sustaining and bouncing back and even beyond (resilience) to attain success (Luthans et al., 2007). Positive psychological capital is who you are (optimism, resilience, self-efficacy &amp; hope) (Luthans et al., 2004)." (p. 495).</p>
Keskin & Çam, (2010)	Adolescents' strengths and difficulties: Approach to attachment styles.	Secure attachment style	"Attachment style was measured through the Relationship Scale Questionnaire" (p. 433)

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Keyfitz, Lumley, Hennig, & Dozois, (2013)	The role of positive schemas in child psychopathology and resilience.	Positive schemas	<p>"Positive Schema Questionnaire (PSQ) This 36-item, 6-point Likert-type self-report questionnaire is a measure of positive core schema themes in youth. Participants rated how much they agree with statements such as "I look at the bright side of things," and "I believe in myself." Schema domains assessed included: (a) worthiness (b) self-efficacy (c) optimism (d) success (e) trust, and (f) social connectedness." (2013, p. 100).</p>
Khalsa, Hickey-Schultz, Cohen, Steiner, & Cope (2012)	Evaluation of the mental health benefits of yoga in a secondary school: a preliminary randomized controlled trial	Yoga	<p>"Participants in the yoga intervention attended two to three yoga sessions per week during the 11- week program during which either 23, 25, 31, or 32 sessions were held (depending upon the class). Yoga sessions were 30 min (three classes) or 40 min (one class) long and were held either two times (two classes) or three times (two classes) per week. (<a href="http://www.yogaed.com">http://www.yogaed.com</a>). This secular program includes simple yoga postures, breathing exercises, visualization, and games with an emphasis on fun and relaxation and minimizing risk without unduly complex or physically athletic or demanding techniques." (p. 82)</p>

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Briggs, Akos, Czyszczon, & Eldridge, (2011)	Assessing and promoting spiritual wellness as a protective factor in secondary schools	Spiritual wellness	"Components of spiritual wellness can include meaning and purpose in life, inner resources, transcendence, and positive interconnectedness" (Howden, 1992; Westgate, 1996)." (p. 175).
Lambert et al., (2014)	Looking on the bright side: An assessment of factors associated with adolescents' happiness.	Family connection	"This scale comprised nine items: 'How often do you and your family have fun together?'; 'How do your family members get along?' ; 'How do you view your relationships with your family?' 'How much of the time do you feel close to your mum?'; 'How much of the time is your mum warm and loving towards you?'; 'Do you get to spend enough time with her?'; 'How much of the time do you feel close to your dad?'; 'How much of the time is your dad warm and loving towards you?' and 'Do you get to spend enough time with him?'" (p. 104)

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
		Friend/peer connection	<p>"Friend/peer connection – This scale comprised nine items: 'How many friends do you have? How good are you at making and keeping friends?' 'Do you have a group of friends that you hang-out with?' 'Do you have a friend or friends that you can talk to about anything?' ; 'Do you have a friend that you feel close to?' ; 'Do you have fun with your friends?'; 'Do your friends like doing the same things as you do?'; 'Do your friends help you and look out for you?' and 'Do your friends leave you out of things?'" (p. 104)</p>
		School Connection	<p>"School connection – This scale comprised eight items: 'How do you feel about school?'; 'Do you feel like you are part of your school?'; 'Do you belong to any school sports teams?'; 'Do you belong to any clubs or teams other than sports teams at school?'; 'Do you do activities to help others at school?'" (p. 104)</p>

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
		Regular exercise	"In the past 7 days, how many times have you done any exercise or activity that makes you sweat or breathe hard, or gets your heart rate up?" (p. 104)
		Meals with family	Measured through the question: "In the past 7 days, how many times did all, or most, of your family living in your house eat a meal together?" (p. 104)
Laursen & Birmingham, (2003)	Caring relationships as a protective factor for at-risk youth: An ethnographic study	Caring relationships	"The participants underscored repeatedly the fact that having a caring adult who was not only available to them but also accepting, supportive, understanding, and interested made all the difference." (p. 243). The following seven characteristics emerged from the analysis of perceptions of caring adults: trust, attention, empathy, availability, affirmation, respect, and virtue.' (p. 244).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
León-Del-Barco, Fajardo-Bullón, Mendo-Lázaro, Rasskin-Gutman, & Iglesias-Gallego (2018)	Impact of the Familiar Environment in 11- to 14-Year-Old Minors' Mental Health	Absence of maternal rejection	"Affection Scale children version. The first factor called Affection-Communication evaluates the perception that children have of the affection, interest, and communication that their parents (Father-Mother) express towards them: "It comforts me when I am sad", "It accepts me as I am", "He is affectionate to me". (p. 4)
		Absence of paternal rejection	
Lester & Cross, (2015)	The relationship between school climate and mental and emotional wellbeing over the transition from primary to secondary school.	Peer support for adolescents aged age 11–12 years	"The peer support at school scale (adapted from the 24-item Perceptions of Peer Social Support Scale; (Ladd, Kochenderfer, & Coleman, 1996) comprised eleven items." Examples include "How often would students: choose you on their team; tell you you're good at things; explain something if you didn't understand; invite you to do things with them?"(p. 5).
		Feeling safe at school	"Safety at school was a single item adapted from the Peer Relations Questionnaire (Rigby & Slee, 1998) and measured on a three-point scale for each time point with a higher value reflecting greater feelings of safety at school." (p. 5).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
		Connectedness to School	<p>"The connectedness to school scale comprised four items adapted from the Resnick et al. (1997) six item School Connectedness Scale (I feel close to people at school; I feel like I am part of this school; I am happy to be at school; the teachers treat students fairly) measured on a five-point scale." (p.5).</p>
Leventhal et al., (2015)	<p>Building psychosocial assets and wellbeing among adolescent girls: A randomized controlled trial.</p>	Girls first resilience curriculum	<p>"Initial sessions integrate methods from positive psychology, social-emotional learning, and life skills. Girls identify their character strengths (Peterson &amp; Seligman, 2004) and use these to identify and plan to reach goals. Girls then learn coping skills, building on their character strengths, and drawing from other positive psychology skills, such as finding benefits in difficult situations ("benefit finding"; Tennen &amp; Affleck, 2002); and emotional intelligence skills such as identifying and managing difficult emotions (Goleman, 2006). In the final sessions, girls work together to design and carry out projects to increase peace in their own or others' lives. They are asked to exercise character strengths, emotional intelligence, and interpersonal skills, and to use these in a way that is meaningful to them." (p. 286).</p>

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Leveresen, Danielsen, Birkeland, & Samdal, (2012)	Basic psychological need satisfaction in leisure activities and adolescents' life satisfaction	Psychological need satisfaction, and especially the need for competence and relatedness in leisure	"To assess perceived need satisfaction in participation in leisure activities, a subset was adapted from the Basic Need Satisfaction at Work Scale (Deci et al. 2001; Ilardi et al. 1993). Three subscales were used: competence, relatedness, and autonomy. There were three items for competence (e.g., "I learn interesting new things in the activities I do in my leisure time"), three items for relatedness (e.g., "The people I spend time with in my leisure time activities I consider to be my friends"), and three items for autonomy (e.g., "I feel free to express my ideas and opinions in my leisure time activities")." (p. 1591).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Levin & Currie (2010)	Family structure, mother-child communication, father-child communication, and adolescent life satisfaction: A cross-sectional multilevel analysis	Mother-child and father-child communication	"Young people were asked "How easy is it for you to talk to the following persons about things that really bother you?" A checklist which included father, mother, stepfather (or mother's boyfriend) and stepmother (or father's girlfriend) was then presented with response options very easy, easy, difficult, very difficult and don't have or don't see this person. This variable has been piloted for use with adolescents in several countries across Europe and North America (Currie et al., 2008c) (p. 155).
		Relationship with mother was particularly important, especially among girls	Measured as above.

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
		Traditional two parent family	"Schoolchildren were asked about the family structure in their only or main home, where they lived most of the time and were given a checklist of people from which they ticked who lived there. This included mother, father, stepmother, and stepfather. Respondents were re-coded as living with both parents, a stepfamily, single mother, single father or other." (p. 155).
Levin, Dallago, & Currie (2012)	The association between adolescent life satisfaction, family structure, family affluence and gender differences in parent-child communication.	Parent-child communication	"Young people were asked 'How easy is it for you to talk to the following persons about things that really bother you?' Responses for mother, father, stepmother (or father's partner), and stepfather (or mother's partner) (residence unspecified)." were obtained. This measure has been piloted internationally for use within the HBSC study (Currie et al. 2008c). Parent-child communication was then coded as '(all) parents easy to talk to', '(at least) one parent difficult to talk to and (at least) one parent easy to talk to', '(all) parents difficult to talk to.'" (p. 292).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
		Family structure (for boys and girls aged 13 and 15 years old).	<p>"Children were given a checklist of people from which they ticked those living in their main or only home. This included mother, father, stepmother (or father's partner), stepfather (or mother's partner), siblings, grandparents, and adults other than their parents such as foster parents or care homes. Respondents were recoded as living with both parents, stepfamily, single parent or other." (p. 291)</p>
		Easy Communication (for girls only)	See above
Loton & Waters (2017)	The mediating effect of self-efficacy in the connections between strength-based parenting, happiness, and psychological distress in teens.	Strength based parenting	<p>Strength-based parenting is defined as "a style of parenting that seeks to deliberately identify and cultivate positive states, positive processes and positive qualities in one's children" (Waters, 2015a)" Following Govindji and Linley's (2007) two factor model of strengths, students completed a scale that assessed the degree to which their parents know their strengths [SBP-Knowledge; three items; e.g., My parent/carer(s) knows the things I am good at] and the degree to which they feel their parents encourage them to use their strengths (p.6).</p>

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
(Mazur et al., 2016)	Behavioural factors enhancing mental health - preliminary results of the study on its association with physical activity in 15- to 16-year-olds.	Protective effect of physical activity appeared to be stronger in small towns and villages	<p data-bbox="1503 523 2004 627">"Self-efficacy is a general sense of one's competence and ability to fulfil goals in life (Schwarzer and Jerusalem, 1995; Zimmerman, 2000)." (p.6)</p> <p data-bbox="1473 786 2033 978">"Physical activity was defined as "any activity that increases your heart rate and makes you get out of breath some of the time". MVPA indicator (Moderate-to-Vigorous Physical Activity) was assessed by asking: "On how many days in the past week were you physically active for 60 minutes or more". (p. 317).</p>

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Ohannessian (2009)	Media use and adolescent psychological adjustment: an examination of gender differences	Boys who spent relatively more time playing video games and watching television	"Adolescent Media Use. They were asked to indicate how much time they spent doing each activity listed "on an average/typical day." The activities included watching television, talking on the phone, text messaging, e-mailing/IMing, playing video games (PlayStation, Nintendo, Game Boy, Xbox, etc.) or computer games, and "surfing the Web." (p. 587).
McCoy & Bowen, (2015)	Hope in the social environment: factors affecting future aspirations and school self-efficacy for youth in urban environments	Parental support	"The parent construct comprised five items reflecting the respondent's relationship with his/her parents: (1) like—can get parents to do things they like, (2) help—can get help from parents, (3) bad— can talk with parents about bad things, (4) self—can be self with parents, and (5) home better—can make things better at home with parents." (p. 134).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Meltzer, Dogra, Vostanis, & Ford, (2011)	Religiosity and the mental health of adolescents in Great Britain.	Religiosity	"As no single question can comprehensively describe a person's religious life several dimensions of religiosity were covered in the questionnaire apart from religious denomination: (a) strength of religious belief on an 11-point scale from weakly held to strongly held, (b) the importance of practicing one's religion on an 11-point scale from not necessary to essential and (c) frequency of attendance at religious services or prayer meetings." (p. 705)
		Safe neighbourhood	"The neighborhood construct comprised three items focused on youth level of comfort in their own neighborhoods: (1) home—can be safe within a few blocks from home, (2) friends—can do things safely with friends in neighborhood, and (3) alone—feel safe alone in neighborhood." (p. 134).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Moksnes, Løhre, & Espnes (2013)	The association between sense of coherence and life satisfaction in adolescents.	Sense of coherence	"To measure sense of coherence (SOC), a Norwegian 13-item short version of the originally 29-item Orientation to Life Questionnaire based on Antonovsky's conceptualization of SOC was used [16]. Examples of some items are: "Do you have the feeling that you don't really care about what goes on around you?" and "Has it happened that people whom you counted on disappointed you?" (2013, p. 1335).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Moreira, Gouveia, & Canavarro (2018)	Is mindful parenting associated with adolescents' well-being in early and middle/late adolescence? The mediating role of adolescents' attachment representations, self-compassion and mindfulness.	Mindful parenting	<p>"The Portuguese version of the Interpersonal Mindfulness in Parenting Scale (IM-P; Duncan 2007; Moreira and Canavarro 2017) was used to assess mindful parenting. The Portuguese scale contains 29 items scored on a 5-point Likert scale...: (1) Listening with Full Attention (e.g., "I pay close attention to my child when we are spending time together"), (2) Compassion for the Child (e.g., "I try to be understanding and patient with my child when he/she is having a hard time"), (3) Non-Judgmental Acceptance of Parental Functioning (e.g., "When I do something as a parent that I regret, I try to give myself a break"), (4) Self-Regulation in Parenting (e.g., "In difficult situations with my child, I pause without immediately reacting"), and (5) Emotional Awareness of the Child (e.g., "I can tell what my child is feeling even if he/she does not say anything")" (p. 1775).</p>

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Moreno, García-Moya, Rivera, & Ramos, (2016)	Characterization of vulnerable and resilient Spanish adolescents in their developmental contexts.	Sense of coherence	"This construct has to do with a person's ability to interpret their social environments as predictable and ordered, their confidence that any life demand can be successfully dealt with as well as a motivational-emotional component that helps one to see difficult situations as challenges and facilitates an active engagement in problem-solving (Antonovsky, 1987)." (p. 15).
		Body image	"It was assessed with an item created for the HBSC study. Specifically, they are asked "do you think your body is...?" and the response options on a 5-point Likert scale ranged from 1, <i>much too fat</i> , to 5, <i>much too thin</i> ." (p. 9).
		Perceived academic achievement	Participants were asked: "in your opinion, what does your teacher think about your school performance compared to your classmates?" (p. 8).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
		Teacher support	"It was assessed by means of the following three items: "I feel that my teachers accept me as I am," "I feel that my teachers care about me as a person," and "I feel a lot of trust in my teacher;". Items were answered on a 5-point Likert scale. (Torsheim et al., 2000).. " (p. 8).
		Curiosity	"The curiosity and exploration construct reflects openness and interest in learning, good management of the uncertainty associated with new or unknown situations (Kashdan et al., 2009)". (p. 16).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
		Moderate to vigorous physical activity (MVPA)	"Adolescents were asked about their level of Moderate to Vigorous Physical Activity (MVPA), as indicated by the number of days in which they felt physically active during a total of at least 60 min a day over the last 7 days. The response options ranged from 0 to 7 days and.. the extent they got out of breath" (p. 16).
Morgan & Haglund, (2011)	"Social capital does matter for adolescent health: Evidence from the English HBSC study": Corrigendum.	Social networking	"Social networking in the neighbourhood was derived from the number of days per week (never; less than once a week; 1–2 days; 3 or more days a week) young people reported being involved in: youth clubs; sports clubs; church/choir; drama/dance group; cadets/adventure Scouts guides and similar clubs; other club or organization." (p. 366)

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
		Autonomy and control	"Autonomy and control in the neighbourhood: scoring and summing the responses to four questions relating to whether young people felt they were able to make suggestions or put forward ideas about parent/teacher associations; school associations; religious organizations and other community groups." (p. 365).
		Neighbourhood involvement	"Neighbourhood sense of belonging was created in the same way as for indicators of belonging". Statements included: "you can trust people around here; I can ask for help from friends and neighbours; and most people around here would try to take advantage of you if they got the chance." (p. 365)
		School sense of belonging	"School sense of belonging used responses to three statements; the students in my class enjoy being together; I feel I belong at this school and I feel safe at this school." (p. 365)

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Oberle, Schonert-Reichl, & Zumbo (2011)	Life satisfaction in early adolescence: personal, neighborhood, school, family, and peer influences	Optimism	We assessed early adolescents' optimism with the Optimism subscale from the Resiliency Inventory (RI; Noam and Goldstein 1998; Song 2003). The scale consists of nine items assessing respondents' positive perspective on the world and the future in general (sample item: "More good things than bad things will happen to me") (p. 894).
		Family sense of belonging	"Family sense of belonging was derived from responses to four items asking the respondents about the amount and types of activities they did together with their family; going for a walk; sitting and talking about things; visiting friends and relatives; and going places." (p. 365).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
		School connectedness	<p>Sense of school connectedness was assessed via the 14-item Sense of School as a Community Scale developed by the Developmental Studies Center to assess school connectedness in 3rd to 6th graders (DSC 1994). Students were asked how much they agreed with statements such as “When I am having a problem, some other student will help me,” “Students in this school really care about each other,” and “I feel I can talk to the teachers in this school about things that are bothering me.” (p.893).</p>
		Parental support	<p>“Early adolescents’ perceived support by their primary caretakers was assessed with the Parental Support subscale of the California Healthy Kids Survey (WestEd 2005). Early adolescents were asked to rate statements concerning their parent/caregiver at home, for example “In my home, there is a parent/ caregiver or another adult who talks with me about my problems,” “In my home, there is a parent/caregiver or another adult who believes that I will be a success,” and “In my home, there is a parent/caregiver or another adult who always wants me to do my best.” (p. 893)</p>

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
		Neighbourhood support	"We used the Neighborhood Support subscale of the California Healthy Kids Survey (WestEd 2005) to assess the existence of non-related supportive adults that early adolescents perceived in their community/neighborhood." (p. 892)
		Positive peer relationships	"We assessed early adolescents' positive peer relationships using the Relationships with Peers subscale from the Resiliency Inventory (RI; Noam and Goldstein 1998; Song 2003). The subscale comprises seven items assessing respondents' relationships with friends (sample items: "I make friends easily," "I have a friend I can trust," "I have fun with my friends"). (p. 893).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Pate, Maras, Whitney, & Bradshaw, (2017)	Exploring psychosocial mechanisms and interactions: Links between adolescent emotional distress, school connectedness, and educational achievement	School connectedness	"Specifically, three items pertained to measures of social belongingness derived from Bollen and Hoyle (1990). Respondents were asked how much they agreed or disagreed to the following items: "You feel close to people at school," "You feel like you are a part of your school," and "You are happy to be at your school." Another three items pertained to students' perceptions of their teachers including: "Teachers at your school treat students fairly," "Since school started this year, have you had trouble getting along with your teachers," and "How much do you feel that your teacher cares about you?" (p. 33)
Prabhu & Shekhar (2017)	Resilience in relation to social support among adolescents	Social support	"Social support is a multidimensional concept that includes the skill recognition dimension of resilience to stress irrespective of support actually received like informative and emotional and the gender and school sources of the support like family and friends." (p. 604)

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Quinn & Oldmeadow, (2013)	Is the iGeneration a 'We' generation?: Social networking use and belonging in 9- to 13-year-olds	Social networking in boys	"Those who used SNSs were asked six questions regarding their SNS use (e.g., 'How often do you use a social networking site to contact your friends in your group?'. Three of these questions were adapted from Valkenburg and Peter's (2007) study" (p. 138).
Mykota & Muhajarine, (2005)	Community resilience impact on child and youth health outcomes: a neighbourhood case study	Protective structural characteristics	Protective structural characteristics include safety as it relates to traffic and vehicular safety specifically and neighbourhood safety more generally. Although neighbourhood safety embodies social and interpersonal processes, such as neighbourhood watch, block parents, and policing, the physical presence of these resources or services in the neighbourhood is what distinguishes these factors as structural neighbourhood characteristics." (2005, p. 10)

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Redmond et al., (2009)	Long-term protective factor outcomes of evidence-based interventions implemented by community teams through a community-university partnership	Family-focused intervention The Strengthening Families Program: For parents and youth 10–14	Family-Focused Intervention. "The Strengthening Families Program: For Parents and Youth 10–14 (SFP: 10–14), implemented by each of the 14 intervention communities, is based upon empirically supported family risk and protective factor models (DeMarsh and Kumpfer 1986; Kumpfer et al. 1996; Molgaard et al. 2000). The long-range goal of the SFP: 10–14 is to reduce youth substance use and other problem behaviors. Intermediate goals include the enhancement of parental skills in nurturing, limit-setting, and communication, as well as youth prosocial and peer resistance skills." (p. 518)
		Project ALERT	"Project ALERT is an 11-session program based on the social influence model of prevention and integrates three theories of behavior change: the health belief model, which focuses on cognitive factors that motivate health behavior (Rosenstock et al. 1988); the social learning model, which emphasizes social norms and significant others as key determinants of behavior." (p. 519)

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Riekie, Aldridge, & Afari, (2017)	The role of the school climate in high school students' mental health and identity formation: A South Australian study.	School connectedness	Students perceive that students at the school they are part of a community, measured through items such as when I come to school I feel welcome" (p. 97)
Rodríguez-Fernández, Ramos-Díaz, Madariaga, Arrivillaga, & Galende, (2016)	Steps in the construction and verification of an explanatory model of psychosocial adjustment.	Social support, Teacher support, family support, peer support, self-concept, resilience	"Family and peer support were measured using the Support from Family and Friends questionnaire (AFA; Landero & González, 2008)." (p. 23).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
		Self-concept	<p>"Self-concept was assessed using the Multidimensional Self-Concept Questionnaire (AUDIM; Fernández-Zabala, Goñi, Rodríguez-Fernández, &amp; Goñi, in press), which consists of 33 items spread over 11 dimensions pertaining to the four domains of self-concept (physical, personal, social, and academic). (p. 23)."</p>
		Resilience	<p>"The CD-RISC Scale was used to analyze resilience (Connor &amp; Davidson, 2003). It comprises 25 items and although it is a five-dimensional scale (personal competence, trust in one's intuition tolerance of adversity, positive acceptance of change, control and spirituality), following the example set by other authors." (p. 23).</p>
(Ruvalcaba et al., 2017)	<p>Extracurricular activities and group belonging as a protective factor in adolescence</p>	Belonging to a sport group	Not defined

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
		Belonging to scout group	"The World Organization of the Scout Movement (WOSM) has promoted the service to both country and community, through leadership, outdoors living, and the creation of social support." (p. 47)
		Belonging to an artistic group	"Aguilar, Bedau, and Anthony (2009) considered that artistic environments based on the community are proper for meeting the needs of young people regarding emotional intelligence, given that arts offer structures, dynamics, and systems that allow the adolescent to express their emotions and develop positive relations." (p. 47)

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Sagatun, Sjøgaard, Bjertness, Selmer, & Heyerdahl (2007)	The association between weekly hours of physical activity and mental health: a three-year follow-up study of 15- to 16-year-old students in the city of Oslo, Norway.	Sports participation in boys aged 15-16 (not in girls)	"Physical activity was measured by a question on weekly hours of physical activity outside of school, defined as exertion 'to an extent that made you sweat and/or out of breath'." (p. 1).
Sánchez-López et al., (2009)	Physical activity and quality of life in schoolchildren aged 11-13 years of Cuenca, Spain.	Increased physical activity	"Items 13 (In the past 4 weeks, how often did you play active games or sports?) and 28 (In the past 4 weeks, how often did you run hard to play or do sports?) were used to determine the frequency and intensity of physical activity and were not included with the summary measurements used to calculate the resilience dimension." (p. 808).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Shean, Cohen, & de Jong (2015)	Developing well-being in Australian youth: Contingencies of self-esteem.	Self-worth	"Self-worth was generated through five sources: unconditional relationships, boundaries, self-efficacy, existence, and purpose." (p. 179).
Stewart & Suldo, (2011)	Relationships between social support sources and early adolescents' mental health: The moderating effect of student achievement level.	Classmate support	"Social support is an expansive construct that describes the physical and emotional comfort given to individuals by their family, friends, and other significant people in their lives (Israel & Schurman, 1990)." (p. 1017).  The Child and Adolescent Social Support Scale (CASSS; Malecki, Demaray, & Elliot, 2000) is a 60-item self-report scale that measures participants' perceived support from parents, teachers, classmates, close friends, and school. Each subscale consists of 12 items and measures four types of social support (i.e., emotional, instrumental, appraisal, and informational). (p. 1020).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
		Parent support	As per The Child and Adolescent Social Support Scale (CASSS; Malecki, Demaray, & Elliot, 2000) above (p. 1020).
		Academic achievement	"Two different types of achievement variables (i.e., standardized assessments in reading and math, and year-to-date grade-point average [GPA]) were combined into a composite variable of academic achievement." (p. 1021)
Temel & Atalay (2018)	The relationship between perceived maternal parenting and psychological distress: Mediator role of self-compassion	Self-compassion	"Self-compassion (SC) is defined as one's ability to face any type of suffering or failures with a kind, caring and non-judgmental manner by neither ignoring nor exaggerating them." (2018, p. 2).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Tiet, Huizinga, & Byrnes, (2010)	Predictors of resilience among inner city youths	Bonding with teachers at school	"Bonding to teachers was composed of two items: (1) how many of their teachers the youths liked, and (2) how much the youths would want to be like the teacher they liked most." (p. 364).
		Extracurricular activities	"Involvement in Extracurricular Activities Youths reported on 8 items concerning their involvement in different types of extramural activities in schools and community activities during the school year and in the past summer, including athletic activities, service clubs, hobby clubs, or student government." (p. 365)
		Lower levels of parental discord	"Conflict Tactics Scale (CTS; Archer 1999). The CTS solicits information about arguments and physical violence between parents over the past year. Fourteen items were asked regarding instances when the respondent was the victim, and then the same 14 were asked for when the respondent was the perpetrator" (p. 365).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
		Fewer adverse life events	"Adverse life events were assessed by a five-item measure that has been shown to have good validity (Thornberry and Krohn 2003). Youths reported whether they had a bad grade on a test, a fight or argument with close friends, a change of school, failed a grade, and had broken up with boy/girlfriend during the past year." (p. 365).
		Less association with deviant peers	Measured through gang involvement. "Gang involvement was measured by two self-reported items on involvement in a delinquent gang during the school year and in the summer. A score of 2 indicated involvement during the school year and summer, a score of 1 indicated involvement in either the school year or summer, and a score of 0 indicated no gang involvement." (p. 364).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Tiêt & Huizinga (2002)	Dimensions of the construct of resilience and adaptation among inner-city youth	Low level of anti-social behaviour/prosocial behaviour	Measured via the following measures: "Delinquency. The delinquency measure, adopted from the National Youth Survey (Elliot, Huizinga, & Ageton, 1985), was a measure of youth report on the frequency of involvement in 39 kinds of delinquent acts during the past year. The use of delinquency as a measure of resilience led to the interest in general delinquency, and a delinquency measure that combined the frequency of involvement across all delinquent behavior was constructed. Drug use. Drug use was measured with 19 items including tobacco, alcohol, marijuana, other illicit drug use, and licit drug use without a prescription. The measure of drug use as an indicator of resilience leads to the interest of a general measure of drug use and therefore was constructed by totalling the number of times a respondent used each drug" (p. 265).
Toner, Haslam, Robinson, & Williams, (2012)	Character strengths and wellbeing in adolescence: Structure and correlates of the Values in Action Inventory of Strengths for Children.	Temperance	Temperance (forgiveness modesty, prudence, and self-control (2012, p. 637).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Toner, et al., 2012		Vitality	Incorporates: "Humour and playfulness, leadership, bravery and courage, perspective, zest, enthusiasm and energy, and social intelligence." (p. 637).
Toner, et al., 2012		Transcendence	"Transcendence defined as "appreciation of beauty, gratitude, hope, humour, spirituality." (p. 637).
Toner, et al., 2012		Hope	"One strength to emerge as a strong and reliable predictor on both measures of life satisfaction and happiness was hope (fully defined as "hope, optimism and future-mindedness")." (p. 641).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Toner, et al., 2012		Caution	An aspect of "temperance" (p. 640).
Toner, et al., 2012		Zest	As aspect of "courage" (p. 640).
Tunariu, Tribe, Frings, & Albery (2017)	The iNEAR programme: An existential positive psychology intervention for resilience and emotional wellbeing.	INEAR programme	"The iNEAR programme constitutes a set of seven self-contained 1-hour lessons that can be usefully housed by a larger positive-education curriculum. Each lesson is centred on a specific theme and intended outcome, realized through one or multiple activities. Each activity is intended to generate existential-type-moments-of-insight in the classroom." (p. 365).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Tusaie et al., (2007)	A predictive and moderating model of psychosocial resilience in adolescents	Optimism	Optimism was measured by the Life Orientation Test-Revised (LOT-R; Scheir, Carver, & Bridges, 1994)." (p. 56)
		Family Support	"Perceived social support was measured by the Perceived Social Support Scale (PSS; Procidano & Hellers; 1983). It is a 40-item, self-report list to measure perceived social support." (p. 56)

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Salguero, Palomera, & Fernández-Berrocal, (2012)	Perceived emotional intelligence as predictor of psychological adjustment in adolescents: A 1-year prospective study.	Perceived emotional intelligence	"The TMMS (Salovey et al. 1995) was used to assess PEI. The scale has three factors that provide three subscale scores: Attention to feelings (monitoring feelings and emotions, e.g., "I pay a lot of attention to how I feel"), emotional clarity (the ability to discriminate feelings and emotions, e.g., "I am usually very clear about my feelings"), and emotional repair (the ability to regulate unpleasant moods or maintain pleasant ones, e.g., "No matter how badly I feel, I try to think about pleasant things")." (p. 25).
Suldo & Huebner, (2004)	Does life satisfaction moderate the effects of stressful life events on psychopathological behavior during adolescence?	Life satisfaction	"Global life satisfaction has been defined as individuals' cognitive evaluations of the positivity of their lives as a whole, based on their own standards (Shin & Johnson, 1978)" (Suldo & Huebner, 2004, p. 94).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Ungar & Teram (2000)	Drifting toward mental health: High-risk adolescents and the process of empowerment.	Control	"The theme of control was common to all students definition of mental health" (2000, p. 238).
		Acceptable identity	Acquiring and maintaining an acceptable identity that is congruent with one's sense of self (2000, p. 239).
Ussher, Owen, Cook, & Whincup (2007)	The relationship between physical activity, sedentary behaviour and psychological wellbeing among adolescents	High levels of physical activity	<p>"Children reported their physical activity/sedentary behaviours and the children's parents also reported the child's activity (p. 852) Physical activity questions:</p> <p>(i) 'Which one of the following statements describes you best? All or most of my free time is spent doing things which involve little physical effort (e.g. Doing homework, talking to friends, and watching TV)" (p. 855).</p>

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Vella, Swann, Allen, Schweickle, & Magee, (2017)	Bidirectional associations between sport involvement and mental health in adolescence	Time involved in sport	"The average weekly time spent in team and individual sports was calculated from six parental reported items. First, two items assessed regular participation in either team or individual sports. For team sports, parents were asked, "In the last week, has (your) child participated in team sport (e.g., football, cricket, or netball)?" For individual sports, parents were asked, "In the last week, has (your) child regularly participated in individual sport (e.g., tennis, karate, or gymnastics)?" Sport participation was further specified as a regular activity undertaken outside school hours". (p. 689).
Van Dyke & Elias, (2007)	How forgiveness, purpose, and religiosity are related to the mental health and well-being of youth: A review of the literature.	Religiosity	Religiosity was measured using the Brief Multidimensional Measure of Religiousness/Spirituality (Fetzer Institute & National Institute on Aging Working Group, 1999)." (p. 410).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Viejo, Ortega-Ruiz, & Sánchez (2015)	Adolescent love and well-being: The role of dating relationships for psychological adjustment.	Quality dating relationship	"Two instruments were used to measure positive and negative quality sales. First, the Network Relationship Inventory (NRI: Furman and Buhrmester 1985, 1992): romantic relationship and measured with 5 points Likert Scale reported four scales: intimacy, communication, expectative about the future and conflicts measures." The second involved "peer transgressive behaviours" measures related to "imbalance of power" (p. 1224).
Viholainen, Aro, Purtsi, Tolvanen, & Cantell, (2014)	Adolescents' school-related self-concept mediates motor skills and psychosocial well-being	Good motor skills	"Motor skills were assessed by "a self-report adolescent version of the well-known Developmental Coordination Disorder Questionnaire (DCDQ; Wilson, Kaplan, Crawford, Campbell, & Dewey, 2000)" (p. 271).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
von Rueden, Gosch, Rajmil, Bisegger, & Ravens-Sieberer, (2006)	Socioeconomic determinants of health-related quality of life in childhood and adolescence: results from a European study	(Increased) Family wealth	"The information supplied by children and adolescents about the familial SES was assessed using the family affluence scale (FAS). The aim of implementing this index was to facilitate children and adolescents in their description of familial SES indicators reflecting the family's wealth. These indicators include family car ownership, whether children and adolescents have their own bedroom, the number of holidays with the parents per year, as well as family computer ownership." (p. 131).
Wille, Bettge, Ravens-Sieberer, & group, (2008)	Risk and protective factors for children's and adolescents' mental health: results of the BELLA study	Personal resources	"Personal resources describe features of the child's or adolescent's personality such as high self-efficacy or pronounced optimism. High self-efficacy is conceptualised as a stable trait of personality and describes the firm belief in personal competence to manage stressful situations efficiently" (p. 134).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
		Family climate	"Family climate was measured by administering a modified version of the Family Climate Scale. It contains nine items (e.g., in our family everybody cares about each other's worries' or Owe often go to the cinema, visit sport events or go on excursions')." (p. 137).
		Social resources	"Social support was measured by means of the German translation of the Social Support Scale [16]. Items not applicable for children and adolescents were eliminated and the wording was modified slightly. It contains eight items enquiring into the level of support received by the respondent, e.g., being listened to, being shown affection or being given information." (p. 137)

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Waite, Shanahan, Calkins, Keane, & O'Brien (2011)	Life events, sibling warmth, and youths' adjustment	Sibling warmth	"Sibling warmth was measured through an adaptation of a scale from Blyth, Hill, and Thiel (1982). Specifically, eight items (e.g., "How much do you go to your brother/sister for advice/support?"; "How important is your brother/sister to you?") assessed youths' perceptions of emotional intimacy." (2011, p. 906)
Weber, Ruch, Littman-Ovadia, Lavy, Gai, 2013	Relationships among higher-order strengths factors, subjective well-being, and general self-efficacy: The case of Israeli adolescents.	Transcendence	Transcendence is defined as "religiousness, hope, love" (2013, p. 326).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Wong et al., (2009)	A comparative study on resilience level between WHO health promoting schools and other schools among a Chinese population	WHO Health Promoting School	"The HPS approach covers key areas including school-based programmes improving students' psychological health, but there have been few studies evaluating the resilience performance of these schools. This study compared the resilience scores between schools within the healthy school award (HSA) scheme (HPS group) and those not (non-HPS group)." (p. 149).

Author(s) and publication year	Study title	Protective factor studied	Definition of protective factor provided by the study
Zhang, Zhao, Ju, & Ma, (2015)	Paternal involvement as protective resource of adolescents' resilience: roles of male gender-role stereotype and gender	Paternal involvement	"Children's perception of paternal involvement was assessed using the adapted version of Perris' Egna Minne av Barndomsnaupporstran (EMBU). The adapted version of EMBU consisted of six subscales...that gave indication of the degree to which fathers were punitive, overprotective, rejecting, overinvolved, emotional or ignoring the subject." (p. 1957).
Ziv & Kiasi, (2016)	Facebook's contribution to well-being among adolescent and young adults as a function of mental resilience	Facebook use	"The final index included seven items designed to capture various aspects of Facebook use, including frequency ("How many times a day do you usually visit Facebook?"), duration (in hours), extent (number of groups), type of content published ("What kinds of information have you revealed in your Facebook profile?"), and depth of engagement ("How often do you update your status or post content on Facebook?"; "How many photos have you uploaded to your Facebook account?"). The other 25 items comprised statements addressing the importance of Facebook in participants' lives" (p. 532).

## **Appendix G: HeadStart Phase 3 Information Sheet for Schools**

### **Information for schools**

#### **What is HeadStart?**

HeadStart is a 5-year programme trialling a broad range of initiatives for improving resilience and emotional wellbeing in 10- to 16-year-olds. Funded by Big Lottery, HeadStart is being rolled out in school and community settings in six area-based partnerships across England, of which [name of partnership] is one. Ongoing support and evaluation for the programme is being provided by a Learning Team headed by the Anna Freud National Centre for Children and Families in collaboration with Manchester University, the London School of Economics (LSE), Common Room, and the Child Outcomes Research Consortium (CORC).

#### **How is HeadStart being evaluated?**

One way in which the Learning Team is evaluating HeadStart is through interviews (max. 60 minutes in length) with 10-15 young people in 1-2 schools in each of the six areas. With the young people's assent and parental consent, the young people will be interviewed five times in total – first in Year 7, then in Year 8, Year 9, Year 10, and finally in Year 11. The young people will receive a £10 Love2Shop voucher per interview as a thank you for taking part.

#### **Why are we interviewing young people?**

All young people experience difficult times at one point or another. This study is a really exciting and one-of-a-kind opportunity for us to learn valuable information about young people's perspectives on coping with difficult times, the support that they may receive in relation to their emotional wellbeing, their perceptions of what constitutes helpful and unhelpful support, the impact of such support, and how this may change over time.

#### **How can you help?**

We would like to ask for your help in:

- ❖ Introducing the study to the relevant young people
- ❖ Sending information sheets and consent forms to parents about the study
- ❖ Collecting signed consent forms from parents
- ❖ Arranging an annual 3-day period for us to visit your school to conduct our interviews with the young people

As your school is such an important part of this learning/research, we will be feeding back to you each year about the emerging findings from the research across all six of the HeadStart

areas. We would also like to offer you a £50 voucher as a thank you for helping us with this part of the evaluation of HeadStart.

## Appendix H: Expression of Interest (EOI) Form for Young People

### Expression of Interest Form

#### Who are we?

We are a team of researchers working at the Anna Freud National Centre for Children and Families and University College London.

#### What is this research study about?

This research is looking at a programme called HeadStart, which is happening in 6 areas across England. HeadStart aims to support young people to improve their wellbeing and help them to cope with difficult situations. We would like to find out about the different things that have been tried by schools and other services in these 6 areas to help young people.

#### Why have I been given this form?

You and other young people have recently used Turn 2 Us (a HeadStart service). We would like to interview young people about their experiences of using HeadStart services, such as what they found helpful and how they feel now, and about their understanding and experiences of coping in difficult times.

**We may not be able to interview everyone, but if you would possibly like to be a part of this research study, or would like to find out more about it, please fill out this form and return it to a member of staff at your school:**

**Your name:** .....

(Your school would also need to speak to your parent/guardian about whether they would be happy for you to take part)

\_\_\_\_\_

\_\_\_\_\_

## Appendix I: Information Sheet for Parents/Carers



### Information Sheet for Parents/Carers

Title of project: **HeadStart Qualitative Evaluation**

This study has been approved by the UCL Research Ethics Committee (Project ID Number): **7963/002**

#### **What is the research about?**

This research is looking at a programme called HeadStart, which is happening in six areas across England. The aim of HeadStart is to provide support to young people to improve their wellbeing and help them to cope with difficult situations that they may be facing now or that they may face in the future. This part of the research aims to find out more about the services that are being offered to young people in these six areas to do this. It aims to find out what has helped and what has been less helpful, in order to learn for the future about how to improve services that aim to increase young people's wellbeing.

#### **Who are we speaking to?**

We are speaking to young people who may have received or may in future receive support or services from HeadStart, and staff who have organised the services. We are asking different groups of people so that we can build up a good picture over time of what these services have been like, who they have helped, and how they can be improved in the future. We would like to invite your child to take part in this research project because they may have recently used a HeadStart service.

#### **What does this involve?**

Taking part in this project means agreeing for your child to be interviewed once a year for up to five years (the final time would be when your child is in Year 9). Your child will receive a £10 Love2Shop voucher after each interview as a thank you from the research team for taking part. With your child's permission, we will re-contact your child each year to arrange their interview. This will be an interview with just your child and a researcher. The researcher will ask your child some questions about their understanding of coping in difficult times, and about the support or services that your child may have received. The researcher will ask about your child's views, opinions and experiences. The conversation can last for as long as your child wants to talk (up to a maximum of 1 hour), but will usually last for 30 to 45 minutes. Your child's interview can take place in a private room at your child's school, at your house, or in a local community building – wherever is more convenient for you and your child. The researcher will talk to your child about the questions that they are going to ask your child at the beginning of the interview so that your child will know what to expect. The interview will be audio-recorded so that we can write down what your child said afterwards, so that we don't forget. The written version of the interview is called a 'transcript'.

#### **What are the benefits of taking part?**

Your child taking part in this project may help us to understand more about what helps to increase young people's wellbeing and so may help to improve services for young people. This may benefit other young people in the future. Some people find that taking part in research like this can be a rewarding and interesting experience.

## Appendix J: Information Sheet for Young People about Participating in the Qualitative Longitudinal Study



### Information Sheet for Young People

Title of project: **HeadStart Qualitative Evaluation**

This study has been approved by the UCL Research Ethics Committee (Project ID Number): **7963/002**

#### **What is the research about?**

This research is looking at a programme called HeadStart, which is happening in six areas across England. The aim of HeadStart is to give support to young people to improve their wellbeing and help them to cope with difficult situations that they might face now or in the future. This part of the research aims to find out more about the support being offered to young people in these six areas. It aims to find out what has helped and what has been less helpful, in order to learn for the future about how to improve support that aims to increase young people's wellbeing.

#### **Who are we speaking to?**

We are speaking to young people who may have had support from HeadStart (or who may receive support in the future), and staff who deliver this support. We are asking different groups of people so that we can build up a good picture over time of what this support has been like, who it has helped, and how it can be improved in the future. We would like to invite you to take part in this research project because your school has suggested that you and other young people in your school may have some experience of HeadStart support now or in the future.

#### **What does this involve?**

Taking part in this project means agreeing to be interviewed once a year for up to five years (the final time would be when you are in Year 9). You will receive a £10 Love2Shop voucher after each interview as a thank you from the research team for taking part. With your permission, we will re-contact you each year to arrange your interview. This will be an interview with just you and a researcher. The researcher will ask you a few questions about your understanding of coping in difficult times, and about the services or support that you may have received. The researcher will ask about your views, opinions, and experiences. The conversation can last for as long as you want to talk (up to a maximum of one hour), but will usually last for 30 to 45 minutes. Your interview can take place in a private room at your school, at your house, or in a local community building. The researcher will talk to you about the questions that they are going to ask you at the beginning of the interview so that you will know what to expect. The interview will be audio-recorded so that we can write down what you said afterwards, so that we don't forget. The written version of the interview is called a 'transcript'.

#### **What are the benefits of taking part?**

You taking part in this project may help us to understand more about what helps to increase young people's wellbeing and so may help to improve services for young people. This may benefit other young people in the future. Some people find that taking part in research like this can be a positive and interesting experience. If you would like to see what we find from this research, you can tell the researcher that you meet with and we will send this to you at the end of the project (in 2023).

**What are the risks of taking part?**

There are few risks to taking part. Occasionally, someone may feel upset about something that they are talking about. The researchers think that it is very important that you are comfortable in the interview and that you only talk about what you want to. If there is anything that you don't want to talk about then just let the researcher know and they will definitely not pressure you to do so. If, after the interview, you feel upset and want to talk to someone further, the researcher will have given you a list of people in your local area that you can speak with.

**Will information about me be kept confidential?**

Your interview will be kept strictly confidential or private. The only time that we might need to break this rule is if you tell us something that makes us think that you, or someone else, is in danger. In that case, we will have to tell someone who can stop that danger from happening. Audio recordings will be kept in a password-protected computer folder and will only be accessed by researchers involved with this project. When the recordings are typed up as transcripts, any details that can identify you as an individual will be taken out. This means that your name will be changed, as well as the names of others or places that you may mention. We may write up some of the things that you say in reports, which will be read by people outside of this research, but other people won't be able to recognise that it's you in the reports. We will keep audio recordings up until the end of the project (May 2023), when they will be deleted.

**What happens if I change my mind?**

You can change your mind about taking part in this research, at any time. You do not have to tell us a reason for this. If you do wish to leave the study, your interview audio recordings and transcripts will be deleted. Once we have written the reports of the findings (four to six months after the interviews), it will not be possible to withdraw your contributions (although any information that would identify you as an individual would not be included), so it is best to tell us as soon as possible if you do change your mind. You can also stop the interview at any point – just tell the researcher interviewing you that you no longer wish to take part. Leaving the study at any stage will not affect how anyone treats you and will not affect the services that you may receive. It will not disadvantage you in any way.

**What happens next?**

Please discuss the information above with others or ask us if there is anything that is not clear or if you would like more information. You can keep this information sheet to look at whenever you need to. If you decide that you would like to take part, you can tell your parent/guardian and give your assent (on a written form). Your parent/guardian must also give their consent (on a written form) in order for the interview to go ahead. Then you and your parent/guardian can return the forms to us and we will arrange a time, at your convenience, to interview you.

**All data will be collected and stored in accordance with prevailing data protection legislation.**

Researcher contact details:

Name: **Dr Emily Stapley**

Contact details: **If you have any questions, please email us at**  
[REDACTED]

## HeadStart Qualitative Evaluation Privacy Notice

### What are the researchers allowed to do with information about you?

To process information, or data, about you as part of the HeadStart research project, we (the researchers) must have a legal basis (or a reason that is justified by the law) to do so. This note explains the legal basis and the rights that you have in relation to information about you that we may collect and use. These rights are as set out in the [General Data Protection Regulation](#) (GDPR), which became law from May 2018. The GDPR is designed to protect and support the personal data rights for everyone in the UK.

HeadStart is working in your school. It is a new service, so we are running a research project to understand how it may help schools and young people. As part of the HeadStart research project, we (the researchers) will collect and process the following types of information about you and other young people who may have had support from HeadStart (or who may receive support in future):

- Your interview audio recordings and interview transcripts
- Your name, age, gender and ethnicity

Legally, we are able to process (use) this information, on a general processing and special category data basis, because it is part of a study carried out in the public interest (Article 6(1)(e) and Article 9(2)(j) of the GDPR and Schedule 1 of the Data Protection Act 2018). There is a public interest and value in learning more about how best to support young people's mental health.

We will never use this information to single you out, or to tell your teachers or parents things that they don't already know. The only time that we might need to break this rule is if you tell us something that makes us think that you, or someone else, is in danger. In that case, we will have to tell someone who can stop that danger from happening.

**However, you can still tell us what to do, or what not to do, with your information (i.e. you have rights!),** among other things, you can:

- Ask us to tell you more about who is handling your information, who it is being shared with, and what they are doing with it
- Ask us to stop using, and delete, the information that we have collected about you. If you don't want us to use your information or if you would like to ask us for more information, please tell your teacher or parent/guardian, or let us know directly using the contact details below

For more details about your rights, please also have a look at this website: <https://ico.org.uk/your-data-matters/>, and the [UCL privacy notice](#).

The organisation who are in charge of making sure that we use your information properly is called The National Lottery Community Fund (Apex House, 3 Embassy Drive, Birmingham, B15 1TR). They have asked the researchers at the Anna Freud National Centre for Children and Families, in collaboration with the University of Manchester, to collect and use your information from this project for them.

We will not move or share information that identifies you outside the European Economic Area (EEA) and we will make sure that it is held securely at all times at the Anna Freud National Centre for Children and Families. We use an external company (The Transcription Centre, The Colmore Building, 20 Colmore Circus Queensway, Birmingham, B4 6AT UK; <https://www.transcriptioncentre.co.uk/>) to transcribe interview data and we have an agreement in place with them, which ensures that this organisation also keeps your interviews secure and strictly confidential.

We will keep information that allows us to know who you are for a seven-year period while the research project is taking place. Access to the data is restricted. At the end of the research project, we will destroy any information that allows us to know who you are, but we may still use the information (anonymised interview transcripts) that does not link back to your personal details for research for another 20 years, after which it will be permanently disposed of.

Your rights related to data processing have been set out in this notice and will be respected. For further information, please see <https://ico.org.uk/for-the-public/is-my-information-being-handled-correctly/>.

If you have any concerns or questions about our research, the data processing, and/or your involvement in the project, please contact:

Dr Emily Stapley  
[emily.stapley@annafreud.org](mailto:emily.stapley@annafreud.org)  
020 7433 2980  
Anna Freud National Centre for Children and Families  
Kantor Centre of Excellence  
4-8 Rodney Street  
London N1 9JH

For data rights requests, please contact:  
Data Protection Officer: Susan Henry ([headstart@annafreud.org](mailto:headstart@annafreud.org))

## Appendix K: Letter to Parents in Response to Updated Laws Regarding How Information Can Be Handled Following GDPR Legislation Occurring in May 2018



Dear Parent/Guardian,

HeadStart is working in partnership with your child's school and a number of other schools across England. The aim of HeadStart is to provide support to young people to improve their wellbeing and to help them to cope with difficult situations that they may be facing now or that they may face in the future. Last year, as you may remember, we interviewed your child (with your consent) and other young people in your child's year group who may have received or who may in future receive support or services from HeadStart. As per the consent that you gave, we will also interview your child again this year, and then once per year for the next two years.

During their interview, which will take place at your child's school, one of our researchers will ask your child some questions about their understanding of coping in difficult times, and about any support or services that your child may have received. The researcher will ask about your child's views, opinions, and experiences. The conversation can last for as long as your child wants to talk (up to a maximum of one hour) but will usually last for 30 to 45 minutes. Your child will receive a £10 Love2Shop voucher after each interview as a thank you from the research team for taking part. This research project aims to gain a better understanding of young people's wellbeing, what helps, and what is less helpful, to learn for the future about how to improve services that aim to increase young people's wellbeing.

We are writing to you now to inform you about our updated processes because the laws about how information can be handled changed in May 2018. You have already read our study information sheet provided with this letter, but the new notice on page 3 of the information sheet updates you on the steps to comply with this that we take as part of this research, including how we collect, analyse, make sense of, and present information. It also tells you about your rights (and those of your child) in relation to this, including your right to remove your child from this research project. If you have any queries, please contact us at [emily.stapley@annafreud.org](mailto:emily.stapley@annafreud.org).

Best wishes,

Dr Emily Stapley

Evidence Based Practice Unit (EBPU), Anna Freud National Centre for Children and Families, Jordan House, 47 Brunswick Place, London, N1 6EB

## Appendix L: Information Sheet for Staff Regarding Conducting Interviews for the Qualitative Longitudinal Study at their School



### Information Sheet for Staff

Title of project: **HeadStart Qualitative Evaluation**

This study has been approved by the UCL Research Ethics Committee (Project ID Number): **7963/002**

#### **What is the research about?**

This research aims to find out more about the services that HeadStart partnerships are offering to young people. It aims to find out about what new things have been tried, what has helped young people, and what has been less effective, in order to learn for the future about how to plan services that help to increase wellbeing and resilience.

#### **Who are we speaking to?**

We are speaking to young people who have used the services, staff who have organised the services, and staff in schools and the community who have also been involved. We are enquiring from different angles so that we can build up a good picture of what these services have been like, who they have helped, and how they can be improved in the future. We would like to invite you to participate in this research project because you were recently involved in the delivery of a HeadStart service.

#### **What does this involve?**

Taking part in this research means agreeing to be interviewed. This will be an interview with you as an interviewee and a researcher. The researcher will ask a few questions about the services that you have been involved with and will ask for your views and opinions about these. The conversation will last for as long as you want to talk (up to a maximum of 1 hour), but will usually last for 30 to 45 minutes. The interview will take place in a private room or over the telephone. The interviewer will talk to you about what questions they are going to ask you at the beginning of the interview so that you will know what to expect. The interview will be audio-recorded and field notes will be taken or the interview will be transcribed.

#### **What are the benefits of taking part?**

Taking part in this research may help to build our knowledge about what helps people to become more resilient, and what challenges and opportunities are faced by staff, to help to plan services. This may benefit staff, young people, and communities in the future. Some people find that making this contribution can be rewarding and interesting.

#### **What are the risks of taking part?**

There are no known risks to taking part. We would like you to be as open as possible about your experiences, but if there is a subject that you do not feel comfortable talking about then you do not have to discuss this in your interview. You can decline to answer a question for the same reason.

#### **Will information about me be kept confidential?**

Your interview will be strictly confidential. The only time that we might need to break this rule is if you tell us something that makes us think that you, or someone else, is in danger. In that case, we will have to tell someone who can stop that danger from happening. Audio

# Appendix M: Assent Form for Young People to Provide their Permission to Participate in the QLS



## Assent Form for Young People

You are agreeing that:

- You are happy to be interviewed
- We will audio record today's conversation and type it up as a transcript
- We may write up your views in reports, which will be read by people outside of this research, but other people won't be able to recognise that it's you in the reports
- You are happy for us to re-contact you next year about arranging another interview with you

We are agreeing that:

- This form will be kept in a locked filing cabinet
- The audio recording and transcript of your interview will only be accessed by researchers involved with this project

**Please circle the answers below:**

Has somebody else explained this research to you?	Yes/No
Do you understand what this research is about?	Yes/No
Have you asked all the questions you want?	Yes/No
Have you had your questions answered in a way you understand?	Yes/No
Do you understand it's OK to stop taking part at any time?	Yes/No
Are you happy to take part?	Yes/No

If any answers are 'no' or you don't want to take part, don't sign your name! If you do want to take part, you can write your name below:

\_\_\_\_\_

My name

\_\_\_\_\_

Date

\_\_\_\_\_

Name of researcher taking consent

\_\_\_\_\_

Date

\_\_\_\_\_

Signature

## Appendix N: Confidentiality Agreement for Accompanying Adults

Confidentiality agreement for accompanying adults

Title of Project: **HeadStart Qualitative Evaluation**

This study has been approved by the UCL Research Ethics Committee (Project ID Number):  
**7963/002**

You will be given a copy of this confidentiality agreement to keep.

### **Accompanying Adult's Statement**

I

- understand what the study involves and have read a copy of the Information Sheet for Young People.
- understand that the young person's interview will be audio-recorded.
- understand that what the young person says will be treated as strictly confidential and handled in line with the Data Protection Act 1998.
- will not discuss any of the confidential information disclosed to me with anyone, under any circumstances.
- understand that this confidentiality continues even after I have completed my work on / involvement with HeadStart.

Signed

Date:

## Appendix O: Pre-Site Checklist for Researchers

### Pre site visit checklist

#### Aim of the interviews:

To ask young people about their understanding and experience of coping in difficult times, including their ways of managing or handling problems, difficult situations and feelings/emotions, and about the services or support (informal, e.g., parents, friends, school staff, and formal, e.g., HeadStart, mental health services) that they may have received.

#### Before each site visit, please make sure that you have in your folder:

- 32x copies of the YP assent form (the YP will need to complete 2 copies – 1 for them to keep and 1 for us to keep)
  - 16x copies of the YP information sheet (the YP will keep this)
  - **1x copy of the parental consent form (just in case)**
  - **1x copy of the parental information sheet (just in case)**
  - £10 Love2Shop vouchers (1 per YP)
  - Copies of the voucher receipt for YP (1 per YP - we will keep this)
  - **16x copies of the sources of support sheet for YP (the YP will keep this)**
  - **The interview schedule**
  - **The safeguarding procedure document**
  - The name/email address/phone number of the safeguarding contact at the site
  - **The HeadStart reflections document**
  - 16x copies of the YP demographics questionnaire
  - 1x copy of the confidentiality agreement for additional people in interviews (just in case another adult has to sit in on our interviews – the adult will keep this)
    - Dictaphone
    - Paper copy of your DBS check
    - Coloured pencils/pens
    - An adult colouring book scene
    - Plain paper for the YP to draw on/write on if they prefer during their interview
    - 16x copies of the YP accessible summary of the year 1 findings
    - A brief summary of the key issues raised in last year's interview for each YP
    - A list of the HeadStart interventions/support offered in that particular school

#### At the start of the interview:

- Summarise the study for the YP – what are the aims of the study, why are they involved, what does their participation in the study involve, and what we are doing with the things that they say
  - Scripts for introducing new interviewers to interviewees:
  - Give the YP a copy of the accessible summary of the year 1 findings
  - Ask the YP to read through the information sheet
  - Check whether the YP has any questions about the study
  - Check whether the YP is happy to take part
  - Ask the YP to sign two copies of the assent form (one for you and one for them)

## FAQ:

- **What is the HeadStart research project that you are part of?** HeadStart is working with schools in your area to offer lots of different types of help and support to people your age, in relation to their emotional wellbeing and coping in difficult situations now or in the future. The types of help and support offered might be having an adult to talk to in school, or having another student to talk to, or learning about mental health, resilience, and emotional wellbeing in lessons. My role is to interview you and other people your age about your understanding of coping in difficult times, and about the services or support that you may have received, as this is what HeadStart aims to help with and we want to find out about how this is working in your area.

- **Why have I been chosen to be interviewed?** Two years ago, we asked your school to suggest some young people who might be interested in this and whom we could speak with as they may have already had some experience of receiving HeadStart support or they might in the future. Your school asked for parental consent for this and your parents were happy for you to take part. If you would like any further information about this, *[name of school contact]* will be able to tell you more.

### **At the end of the interview:**

- Ask the YP to complete the demographics questionnaire
- Give the YP their £10 voucher and ask them to fill out the receipt (you keep the receipt)
- Give the YP the sources of support sheet

### **After the site visit:**

- Audio record brief reflections for each interview as separate audio files using the following structure:
  - State your name, the participant ID number and the timepoint of the interview
  - Using the HeadStart reflections document, briefly talk about two things that went well and two things that didn't go as well in your interview
  - Add any brief reflections on the interview as compared to last year's and anything else that you'd like to reflect on
- Upload the interview audio recording onto the shared drive
- Delete the interview audio recording off the Dictaphone
- Complete the young person interviewee spreadsheet
- File the YP assent form, voucher receipt, and YP demographic questionnaire in the filing cabinet at the AFC

## **Appendix P: Headstart Phase 3 Interview Schedule Time 1 of the Qualitative Longitudinal Study**

### **Talking about life:**

1. What do you like / not like about being at school?

Possible prompts:

- Favourite / least favourite subjects?
- What do you like / not like about this? Why?
- How do you handle this?

2. Can you tell me about the area that you live in? What is your area where you live like?

Possible prompts:

- Your street?
- Things to do / places to go near where you live?
- What do you like / not like about living here? What do you like / not like about this?

Why?

- How do you handle this?

3. Can you tell me about what life is like for you at home?

Possible prompts:

○ Who do you live with at home?  
○ What do you like about being at home? What do you like doing with your parents / brothers or sisters / pets? Are there are things that you do altogether as a family? What do you like about this? Why?

○ Is there anything that you don't like so much about being at home? What do you not like about this? Why? How do you handle this?

4. Can you tell me about your friendships?

Possible prompts:

- Do you have friends in school? Friends out of school?
- What do you like doing with your friends? What do you like about this? Why?
- Is there anything that you don't like so much about spending time with your friends?

What do you not like about this? Why? How do you handle this?

### **Talking about emotions:**

5. What kinds of things (e.g., activities, places, or people) can make you feel happy?

Possible prompts:

- How do you like to have fun?
- How does this connect / lead to you feeling happy?
- Can you think of an example of when you were feeling happy recently? What happened?

6. Being happy can look or feel different for everyone, so I was wondering what this looks like or feels like for you?

Possible prompts:

- What would I see / notice if you were feeling happy?
- What would you be feeling / doing?

7. What kinds of things (e.g., activities, places, or people) can make it harder or more difficult for you to feel happy?

Possible prompts:

- How does this connect / lead to you feeling this way?

8. What sorts of feelings or emotions do you experience when you are not feeling happy? (*Remember to unpack and explore different feelings/emotions as they are mentioned, e.g., 'Being sad can look or feel different for everyone, so I was wondering what this looks like or feels like for you?', 'What types of things do you worry about?'*)

Possible prompts:

- How does this affect your life / make you feel?
- Can you think of an example of when you were feeling X recently? What happened?

9. When you are having a hard time, what do you do to feel better? What do you do when you have problems / difficulties in your life?

Possible prompts:

- How do you handle it?
- Who / what helps / makes you feel better? Where do you go for help / support? What cheers you up? What do they do? What happens then?
- How does this help you?
- Does this vary / change depending on how you are feeling? Why?
- Is there anything that is unhelpful for you or that makes you feel worse?
- Is there anyone that you definitely wouldn't talk to when you are feeling this way?

Why?

10. Have you ever received any help or support in relation to this / when you are having a hard time?

*If yes,*

- What did this involve? What did you do? Who did you meet with?
- Can you tell me about how you came to receive this help or support?
- Compared to before you received this help or support, how did you feel afterwards? Did anything improve / get worse? What? Was this what you expected?
- What was helpful about this help or support?
- Was there anything that was unhelpful? What?
- Was there anything that you would have liked to have been different about the help or support? What?

*If no,*

○ Would you like to receive any help or support? What? *[If yes, remind interviewee that this interview is private and ask whether there is anyone that they would be happy to talk to about this, and if not then suggest school safeguarding contact]*

**Talking about HeadStart:** *(if HeadStart has not already been discussed)*

11. Have you heard of something called HeadStart? *If yes, can you tell me about what HeadStart is? If no, explain what HeadStart is in that area.*

12. Have you been involved in any activities or lessons as part of HeadStart? *If yes:*

○ What did this involve? What did you do? Who have you met with? What happens? When do you do it? How often?

○ Can you tell me about how you came to be involved in HeadStart?

○ Compared to before you got involved in HeadStart, how have you been feeling? Has anything improved / got worse? What? Was this what you expected?

○ What have you found helpful about being involved in HeadStart? Has there been anything that you have found unhelpful? What?

○ Was there anything that you would have liked to have been different about the activities / lessons? What?

○ Have you ever taken part / been involved in anything like this before? What?

○ Would you recommend HeadStart to any of your friends? Do any of your friends participate in HeadStart?

**Giving suggestions/advice:**

13. What advice or help would you give someone your age if they were experiencing a problem with:

○ Their friendships?

○ Their family?

○ School?

○ Their feelings or emotions?

Possible prompts:

○ Where do you think they should go? Who do you think they should speak to?

○ Is this advice that you would follow yourself if you were experiencing this? Why/why not?

**Conclusion:** “Thanks very much again for doing this interview with me today; it’s been so helpful to speak to you. Do you have any questions for me now that we’ve finished the interview? We are going to use these interviews to help us to work out how best to help young people your age when they are experiencing difficult situations or feelings. We will get back in touch with you around this time next year to see whether you’re happy to speak with us again about how things are and what may have changed since we last saw you. Would you like to choose a pseudonym for when we write up our findings? This is another name that we will use for you in our write-up to help ensure that other people don’t recognise you”

## Appendix Q: Safeguarding Procedure (HS3)

### Safeguarding procedure

#### Interviewer safety:

- [Staff member A] must be aware of the date/time/location of each of your interviews at each partnership (regardless of location).
- Only one researcher (i.e., the interviewer) needs to be present in the room during interviews in schools. However, if school policy is that another adult also needs to be present in the interview room then we must abide by this.
- If, at the end of their interview, you feel that the young person experienced their interview in a negative way (e.g., they became upset/distressed or angry), then you must record this in writing for our records.
- You must phone Emily at the end of your visit to the site (before you leave the site) to check in with her about how your interviews went.

#### Home visits

- Two researchers must be present at each home/community setting visit, but only one will be the interviewer.

#### Participant safety:

- Before starting your interviews, you must know the name and contact details of the safeguarding officer at the school that the young person attends. Should any safeguarding issues arise during the interviews, we would report them to the school safeguarding officer and they would take them forward/take action as necessary, but we would also report them to Jess (as our line manager) and the AFC safeguarding oversight group ([safeguarding@annafreud.org](mailto:safeguarding@annafreud.org)) in case they have any further advice. Let the safeguarding contact at the site know that you will be doing this.
- Discuss confidentiality and the limits to confidentiality with participants at the start of their interviews, as per the interview schedule. If you need to break confidentiality because you are concerned about an interviewee's, or anyone else's, safety then let the interviewee know that you are going to speak to your supervisor and your safeguarding contact at their school about the things that they are saying that are worrying you, in order to make sure that it does not just get forgotten. If you do this, then the site safeguarding officer needs to let the young person know specifically what will happen next (i.e., what action they will take) as they may be anxious that all sorts of things are going to happen, such as telling their parents etc.
- The types of issues arising in interviews with young people that need to be flagged as something that is worrying you with the interviewee, and then discussed with the school safeguarding contact and with Jess/the AFC safeguarding oversight group are:

- Binge or persistent drinking
- Sex with adults
- Violence at home
- Major absence of parenting or adult care
- Drug use
- Self-harm
- Suicidality (including thoughts, plans, attempts)
- Abuse

- Generally, err on the side of caution – i.e., it is better to report/discuss a potential safeguarding issue (something that makes you concerned about the interviewee's, or anyone else's, safety), even if you're not sure that it is a safeguarding issue.

- This following point only applies in very rare or extreme circumstances (such as terror of going home, a plan to make an immediate suicide attempt, explicit injuries): If you are concerned about the interviewee being at immediate risk then stop the interview and talk to the interviewee about your concerns and speak to the site safeguarding contact in the middle of the interview. You could say something like this: 'What you've told me is really worrying and I want to ensure that you are safe so I'm going to speak to [*name of site safeguarding officer*] and discuss this with them'.

### ***Home visits***

- **For young people who we are doing home visits with who are still attending school:** Collect the young person's school name from the parent/young person before the young person's interview takes place (either on the phone beforehand or in person on arrival at the house) – explain that we need this because although the interviews are confidential, the only time that we might need to break this rule is if the young person tells us something that makes us think that they, or someone else, is in danger. In that case, we will have to tell someone, such as the safeguarding lead at their school or their parent, who can stop that danger from happening. We would speak with the young person about this first. **NB** – speak with [Staff members] safeguarding board first before taking action (and see above point about immediate risk).

- **For young people who we are doing home visits with who are being home-schooled:** Collect the young person's GP details from the parent/young person before the young person's interview takes place (either on the phone beforehand or in person on arrival at the house) – explain that we need this because although the interviews are confidential, the only time that we might need to break this rule is if the young person tells us something that makes us think that they, or someone else, is in danger. In that case, we will have to tell someone, such as their GP or their parent, who can stop that danger from happening. We would speak with the young person about this first. **NB** – speak with [redacted] safeguarding board first before taking action (and see above point about immediate risk).

## **Appendix R: Sources of Support Document for All Interviewees in the QLS**

*Please note, this document is for participants in Hull. A separate document was provided agencies and sources of support for each of the 6 areas.*

### **HeadStart**

#### **Information for Young People**

**Many young people will speak to their parents, family, or friends if they need help, support, or advice about their emotional wellbeing and mental health, but some young people can find additional support useful, such as from the following organisations:**

**ChildLine** (phone and online support/advice) 0800 1111 <https://www.childline.org.uk/>

**Samaritans** (phone and online support/advice) 08457 90 90 90 <http://www.samaritans.org/>

**Young Minds** (information about emotional wellbeing and mental health in children and young people) [www.youngminds.org.uk](http://www.youngminds.org.uk)

**Mind** (gives information about where children and young people can get support with a mental health problem) <https://www.mind.org.uk/information-support/guides-to-support-and-services/children-and-young-people/>

**‘How are you feeling’ is a mental health and wellbeing site that has been co-designed with young people from Hull** (the aim of the site is to help children, young people and their families to understand emotional and mental health issues, to promote self-help tips and techniques, and to help to make the ‘system’ easier to navigate within local services) <https://howareyoufeeling.org.uk/>

**Appendix S: Demographic Form for Participants as Part of Qualitative Interviews  
in the QLS**

Demographic form for participants in the Qualitative Longitudinal Study

About Me

I am: (*age*) .....years .....months

I am: (*please tick*)

Male

Female

Other

Please specify: .....

Prefer not to disclose

I am: (*please tick*)

White

British

Irish

Any other White background

Black or Black British

African

Caribbean

Any other Black background

Asian or Asian British

Indian

Pakistani

Bangladeshi

Chinese

Any other Asian background

Mixed

White and Black African

White and Black Caribbean

White and Asian

Other

Any other ethnic group

Please specify: .....

Prefer not to disclose

Participant ID number:

## Appendix T: Interview Technique Checklist for Researchers after Conducting Interviews

### Interview technique checklist

This checklist should capture the reviewer’s global assessment of the interview as a whole, with a tick indicating that the criteria was met for the majority of or all of the interview. A cross in any box needs to be accompanied by specific comments/feedback (Designed by Emily Stapley with input from Mia Eisenstadt and Ola Demkowicz)

Criteria	Criteria met? (including your reflections as necessary)
Take care with asking too many closed questions – take a moment to think about how to phrase your questions to give the interviewee the chance to talk rather than simply respond to a series of questions	
Remember to dig into the meaning of particular words that we think we know what they mean but actually the interviewee could mean something different by them, e.g., ‘stressed’, and remember to find out about mechanisms, i.e., if something is helpful – why? How? What makes it helpful? What makes the difference?	
Remember the more neutral stance of the qualitative interviewer. For instance:  (1) If an interviewee says that someone is horrible, the interviewer wouldn’t agree or disagree with them but would explore what they mean by that and what it means for them  (2) If an interviewee discloses a difficult situation, the interviewer wouldn’t dispense advice, but would thank them for speaking about it and if need be, raise this as a safeguarding issue or remind the interviewee that they can speak to someone (e.g., a parent, friend, school safeguarding officer) about this if they feel that they need to. The interviewer could also ask the interviewee whether they mind being asked follow-	

Criteria	Criteria met? (including your reflections as necessary)
<p>up questions about a difficult situation, as they may not want to talk about it</p> <p>(3) It is important for the interviewer to not continually positively reinforce the interviewee's responses to questions nor interrupt the interviewee no matter how interesting the topic. Remember 'prizing not praising' – be specific in your comments, e.g., "it's really helpful that you've just given me so much feedback/detail"; "thanks so much for being able to talk about such a difficult topic"</p>	
<p>Take care not to jump to conclusions or make assumptions when listening, as voicing these can force the interviewee in a different direction or entirely close down the narrative - use the interviewee's words wherever possible rather than using entirely new words that risk changing meaning</p>	
<p>Try to focus less on the details around something (e.g., the time of day that something happened – unless relevant!) and more on what the interviewee thinks of it/feels about it/deals with it – this will help ensure that the interview stays on topic and that relevant detail is focused on</p>	
<p>If a safeguarding issue is raised, be clear when outlining that this information will need to be passed on who it will be passed to (school safeguarding officer's name and Jess) and that the interviewee cannot stop you from doing so, i.e. rather than "if that's ok with you", it would be better to say "how do you feel about that" so there's not a false impression that they can ask us not to</p>	

## Appendix U: Reflection Document for Researchers Conducting Qualitative Interviews

Possible points for guidance in conducting HeadStart qualitative interviews and for reflection following the interviews (for staff ME, OD, ES):

### Responsiveness to participant

- Do you feel you were responsive to the young person's state and comfort level? I.e., did they seem at ease? Did they seem frustrated or distressed at any point, and if so, did you make any changes in response to this? Did you build rapport with the young person?
  - Did you check in before exploring topics that might be difficult? I.e., *I know this might be difficult to talk about, but I wondered if I could ask you some questions about X.*
  - Did you remain neutral during the interview? E.g.:
    - Avoid agreeing with the young person's comments and instead explore what they mean
    - If the young person discloses a difficult situation, avoid dispensing advice or commenting on this; instead thank them for speaking about it, raise a safeguarding issue if needed, perhaps remind them they can speak to someone if needed
  - Did you let the young person finish their thoughts, and avoid interrupting them?
  - If a safeguarding issue is raised, be clear when outlining that this information will need to be passed on who it will be passed to (school safeguarding officer's name and Jess) and that the interviewee cannot stop you from doing so, i.e. rather than "if that's ok with you", it would be better to say "how do you feel about that" so there's not a false impression that they can ask us not to

### Interview questions

- Did you use the interview schedule to help you remember the types of questions to ask and the key areas to cover?
  - Do you feel you were appropriately flexible in your use of the interview schedule? I.e., did you follow the participant's flow in deciding which question to ask?
  - Did you ask open ended questions, and avoid using too many closed questions?
  - Did you take time to think about how to phrase your questions? Including using the participant's words where possible when phrasing follow-up questions
  - Prizing not praising – did you give specific comments that acknowledged participants' contributions and avoid reinforcing or leading? E.g., *It's really helpful that you've just given me so much detail about that.*
  - Did you make sure to follow the participant's flow and focus on the way *they* think about/feel about/deal with/experience an issue, rather than introducing your own assumptions?
    - Did you find out about mechanisms, i.e., if something is helpful – why? How? What makes it helpful? What makes the difference?
    - Did you dig into the meaning of particular words rather than assuming the young person is using them like us, e.g., upset or stressed?

## Appendix V: Example case reconstruction

### Time 2 Case Reconstruction, pseudonym: "Alice"

Gender: Female      Age: 12 years 10 months

This young person reported that the research interviews a year ago had been helpful and that before that she had been having difficulties with peers at school, *"Like last year I was really struggling but this interview has helped me a lot."* Alice described that she had been having problems with a girl being *"mean"* to her, which had been happening since primary school. Alice reported that initially when she had asked the girl to leave her alone, the participant had got *"angry"* and there had been a fight, which teachers had ignored. However, since then she had received support from a teacher in relation to this incident, which she described as helpful because she had *"got to talk to someone"*. Alice outlined that the teacher had organised a meeting between her and the girl and how she and the teacher had asked the girl to leave her alone, *"Because I said to her, um, can you stop bugging me? Like, it's really annoying and stuff."* She explained that when the girl did listen and leave her alone, she felt *"really good"* about herself.

In the previous interview, Alice had been undertaking sessions with a HeadStart peer mentor from Year 10, she described how her peer mentor had helped her a lot, particularly with dealing with the peer conflict mentioned above and with completing her schoolwork. Although Alice the peer mentoring had finished at the time of this year's interview (she wasn't sure why), Alice mentioned that she would see her peer mentor around school and her peer mentor still helped her, *"She just says like, ignore her, whatever and stuff like. If she's being rude, just ignore her and stuff. And she helps me with a lot of stuff."* Alice described how HeadStart is still running at her school, but that she did not get chosen to participate in the current year of HeadStart. When asked, she stated that she would like to carry on with HeadStart, as *"it's helped me a lot, but, and it's just fun."* Specifically, she found the games as part of the sessions, fun.

In terms of her life at school, Alice said that she finds Maths hard, although she is understanding it more. She finds that when she listens in class, she gets high scores and so she is endeavouring to listen more, *"I just need to listen, I'm trying to listen. 'Cause like I feel before I was starting to listen, but it just dropped suddenly, I don't know why."* She finds it easier to listen to some teachers than others, *"It's actually easy to listen to science more because, you know the teacher in my Maths class? He's actually like, um a thing teacher... how do you call it? I don't know a spare teacher."*

In relation to her friendships, she described that generally things had been going well but there is one girl who has been making negative comments about and being rude to her friends, *"She's like tearing our group apart."* She also mentioned the potential for a fight between this girl and others, *"How do you deal with that situation? Um, not good... 'cause I don't like seeing my friends like angry and fighting."* When conflict occurs, explained that she copes with this by telling her friends to ignore her and helping her friends to *"calm down"*. She has two groups of friends who she hangs out with. She described how she goes to a club with friends each week where they have activities.

At home, Alice's relationship with her siblings was good, she reported, but one of her siblings has been struggling with relationship problems with her friends at school, which are being managed by school staff. Alice explained that has noticed her sibling being alone a lot because of her friendship problems and this makes her feel sad, *"Really, really sad and like upset 'cause I don't want to see her alone."* When she is sad, she likes to play video games and eat food at home. She explained that she had told her sibling to *"ignore them"*, but it didn't really help. However, a teacher is helping her sibling. When asked, she also mentioned a teacher who she finds is helpful to her and at the same time refers to another difficult situation with another girl, *"She kept on reporting me like constantly, constantly she will report me. The teachers didn't even tell us like what happened. They just straight away put me in internal for no reason. I don't know what I've done. But, yeah, that teacher always helps me, like, oh if you want to talk you can come to my classroom . . . it was really good, really great to have someone."*

Alice described that she continues to love cooking, *"Oh yeah, I love cooking so much."* She also likes cleaning, and her mother gave her a reward for cleaning. She describes her relationship with her mother as *"good, great. She always buys me, she bought me these shoes."*

When asked about how life had been without a peer mentor to speak to, Alice explained that she can handle things on her own but again refers to the research interview as being helpful, *"I'm actually good on my own and I can handle it, but I still want more, more talks with you, yeah, yeah."* When asked what things she does to cope with things by herself, Alice described that she "cools down" by washing her face or eating, *"I just like breathe in and out and like take reflection time."*

### **Reported risk factors**

- Long term bullying
- Some peer conflict between her and others, and between her peers
- Sadness in relation to her sibling not having friends or being bullied
- Schoolwork difficulties – struggles with Maths and difficulties listening

### **Reported protective factors**

- Teacher support with peer conflict/bullying
- Standing up for herself in situations of peer conflict/bullying
- Some resolution to peer conflict/bullying
- HeadStart activities, including a peer mentor
- Is motivated to listen more in lessons and finds it easier to listen to some teachers than others
- Good relationships with friends and family
- Loves cooking and cleaning
- Coping strategies include washing her face, eating, playing video games, and cooling down, e.g., through breathing inhaling and exhaling slowly
- Attends extracurricular activities
- Finds the research interviews helpful

## Appendix W: HeadStart Phase 3 Time 2 Interview Schedule

### Time 2 Young Person Interview Schedule (updated from Time 1)

**Introduction:** Thank you so much for doing this interview with me. Just to remind you, you are involved in this research project because a year ago we asked your school to suggest some young people that we could speak with who may have had some experience of receiving HeadStart support at that point or who could in the future. Like last time, I have a few questions that I'd like to ask you about how things have been going in your life (good and bad things) since I last saw you, and your understanding and experiences of coping or dealing with difficult times, such as with different feelings and emotions or in situations at school or at home. If you don't want to answer a question or if it's unclear then just tell me and we can skip it, or I can explain it. We will write up what we find from all of our interviews with young people your age up and down the country and we will give you a copy of our findings. Everything that we talk about today is private or confidential unless I'm worried that any harm or danger is going to come to you or to anyone else, in which case then I would need to speak to my supervisor, whose name is Jess, and *[name of school safeguarding officer]* about what has worried me, but I would try and tell you if I was worried in this way first. You are welcome to stop the interview at any time or skip a question if you want to.

*[Bring in themes from previous interview as appropriate throughout]*

#### **1. What has been going on in your life since I *[or another person from the research team]* last saw you / over the last *[X months]*?**

Possible prompts:

- Has anything changed at school? What / why? What has been going well / less well?
- Has anything changed with your friends? What / why? What has been going well / less well?
- Has anything changed in your family or at home? What / why? What has been going well / less well?

#### **2. What has made things get better / worse / stay the same?**

Possible prompts:

- At school?

- With your friends?
- In your family?
- What do you think led to this?
- What / who helps? What / who makes things easier in your life?
- What / who does not help? What / who makes things more difficult in your life?

**3. Would you mind sharing with me an example of a difficult or hard situation / problem that you've experienced since I [or another person from the research team] last saw you? What did you do to feel better?**

Possible prompts:

- How did you handle it?
- Who / what helped / made you feel better? Where did you go for help / support? What cheered you up? What did you / they do? What happened then?
- How did this help you?
- Why did / didn't you ask for help in this situation?
- *[If unable to give a specific example: When you are experiencing a difficult or hard situation / problem, what do you do to feel better?]*

**4. Do you handle other difficult or hard situations / problems like this too? [Ask for concrete examples] Why / why not?**

Possible prompts:

- Is there anything else that you do to feel better in relation to difficult or hard situations / problems? What / why? *[E.g., things on your own? Things with others?]*
- Do you ever ask for advice? Who from? Why / why not?
- What would your family advise you to do in these situations?
- What would your friends advise you to do in these situations?
- What advice would you give others in these situations?
- Is there anything that is unhelpful for you or that makes you feel worse in these situations? What / why?
- Is there anyone that you wouldn't talk to when you are feeling this way / in this situation? Who / Why?

**5. Have you ever received any help or support in relation to this / when you are having a hard time / when you are experiencing or feeling X?**

*If yes,*

- What did this involve? What did you do? Who did you meet with?
- Can you tell me about how you came to receive this help or support?
- Compared to before you received this help or support, how did you feel afterwards? Did anything improve / get worse? What? Was this what you expected?
- What was helpful about this help or support?
- Was there anything that was unhelpful? What?
- Was there anything that you would have liked to have been different about the help or support? What?
- Would you want to receive this again? Is there another kind of support you would seek? What / why?

*If no,*

- Would you like to receive any help, or support / would you have liked to have received help at the time? What / why? *[If yes, remind interviewee that this interview is private and ask whether there is anyone that they would be happy to talk to about this, and if not then suggest school safeguarding contact and interviewee's parents]*

**6. What support is there at your school to help people with their mental health and wellbeing?**

Possible prompts:

- What does this involve?
- Have you ever used this support? Can you tell me what happened? What did you think of it? How did you feel afterwards?
- Have any of your friends or people you know ever used this support? What did they think of it?
- Have you ever had any lessons or taken part in any activities at your school around mental health and wellbeing or relationships with others? What did they involve? What did you think of them?
- Do you think that people should ask for help when they are struggling with their feelings and emotions? Why / why not?
- How do you feel about asking for help if you are struggling with your feelings and emotions?

**7. Have you heard of something called HeadStart / *[or list the HeadStart activities currently on offer in interviewee's school]*?**

*If yes,*

- What HeadStart activities *[name specific activities as necessary]* have you been involved in? What did you do? Who have you met with? What happens? When / where do you do it? How often?
- Can you tell me about how you came to be involved in HeadStart?
- Compared to before you got involved in HeadStart, how have you been feeling? Has anything improved / got worse? What? Was this what you expected?
- What have you found helpful about being involved in HeadStart? Has there been anything that you have found unhelpful? What?
- Was there anything that you would have liked to have been different about the activities? What? What do you think could have made it even better?
- *[If not still involved in HeadStart]* What do you remember from / what stands out in your mind about your involvement with HeadStart? Why did you finish being involved with HeadStart? How do you feel about this? Are any of your friends still involved in it?

*If no, explain what HeadStart is,*

- HeadStart is working with schools in your area to offer lots of different types of help and support to people your age, in relation to their emotional wellbeing and coping in difficult situations now or in the future. The types of help and support offered might be having an adult

to talk to in school, or having another student to talk to, or learning about mental health, resilience, and emotional wellbeing in lessons.

- Do you know anyone in your school who has been involved in any activities as part of HeadStart? What / why?

**Conclusion:** Thanks very much again for doing this interview with me today; it's been so helpful to speak to you. Do you have any questions for me now that we've finished the interview? We are going to use these interviews to help us to work out how best to help young people your age when they are experiencing difficult situations or feelings. We will get back in touch with you around this time next year to see whether you're happy to speak with us again about how things are and what may have changed since we last saw you. Would you like to choose a pseudonym for when we write up our findings? This is another name that we will use for you in our write-up to help ensure that other people don't recognise you.

## Appendix X: Type Descriptions and Guidance for Sorting Types

### Instructions

1. Read the case reconstructions for Time 2 for each participant.
2. Classify each of the Time 2 case reconstructions as either ('Uncertain Sources of Support' (USS), 'Multiple Sources of Support' (MSS), 'Self-Initiated Forms of Support' (SIFS) DTC (Difficult to Classify), or a new type (NT) based on descriptions of each type provided below.

### Type descriptions

#### **Ideal Type 1: The adolescent with 'Uncertain Sources of Support' in relation to risk and wellbeing.**

*Ideal type description.* The adolescent with 'Uncertain Sources of Support' tends to describe having one or more protective factors in the context of (often extensive or severe) risk and that these protective factors are either highly variable or not effective. For example, an established protective factor may also be reported as an additional source of risk or the effectiveness of the protective factor is unclear. A clear example of this can be found when a young person described a "good relationship" with their father, and then described instances of their father's maltreatment towards them and general absence. Or, in another case, an adolescent described support from a mother who is also a source of worry for the young person due to a chronic medical condition. In these cases, the extent to which the variable is protective is mixed and the full extent that a protective factor reduces a risk factor is ambiguous. Also, within this category are instances where an adolescent may describe a source of risk, such as a mental health disorder or being bullied without mention of an accompanying protective factor or coping strategy. This would be described as not being able to cope with the source of risk, not having support, not seeking help, or not feeling comfortable with the support available. For example, one adolescent, Jeremy, spoke about when he is sad, he tries to do something enjoyable to cheer himself up, such as "going over to toy stores and playing with cool toys" but that sometimes after trying to do something he enjoys he still feels like giving up anyway. "All the energy is gone out of me, and I just can't keep going on really. I've... just given up." He reported that he felt like this when his Nan died but felt it was not appropriate to be happy in a sad time. In this example the young person described a coping behaviour but how it was not effective in managing his reported feelings of depression and sadness.

Another frequent example of the uncertainty of the effect of a protective factor was an adolescent who reported enacting some type of externalising behaviour that they found helped them to release emotion. For example, one adolescent discussed smashing her phone alone in her room and hiding difficult emotions from friends and family. Other examples reported in this type included association with an older group of friends that were reported to provide protection but that mistreated the adolescent at other times. Examples were also provided of receiving therapy or emotional support and finding it unhelpful (see examples below).

Within this type a range of cases fit with the definition of the ideal type with both stronger (shares the similarities) and weaker cases (contains fewer similarities). Strong cases in this type were provided by those that stressed ambiguity in the support they received or could access or had a distinct lack of support. Weaker cases in this type were those cases where it was difficult for the researcher to perceive how uncertain the support was, but there were still indications of support being uncertain or there were some functioning protective factors.

Questions to ask for cases in this type (USS):

- How is support in relation to a risk mentioned?
- How much support in relation to how much risk?
- Is support reported as effective? Y/N
- Are there multiple risks/stressors?
- Are there risks reported without support described?
- Did they mention difficulties in coping or barriers to help seeking?
- Are there instances of a lack of coping in relation to risk/stressors?
- Are there any contradictions in descriptions of perceptions of support or relationships?
- Are any of the protective factors mentioned also in some cases risky or risk factors (in that there are negative aspects associated with it).

### **Ideal Type 2: The adolescent with ‘Self-Initiated Sources of Support’ in relation to risk(s) and wellbeing**

This type refers to the adolescent that describes a range of self-initiated protective factors in relation to risk and wellbeing. In their accounts, there is a prominence of self-initiated support over support from school (such as teachers) and family support (such as parental support) in either the presence or absence of risk. Finding support is derived by the adolescent themselves from other places, such as friends, parent’s friends, online, or extracurricular activities. The

adolescent discusses a degree of agency or self-reliance in the way that they approach problems or coping with specific stressors.

***Ideal Type Description:*** The adolescent with 'Self-Initiated Sources of Support' tends to describe the various ways in which they themselves protect themselves in relation to risk situations without drawing on externally provided support or drawing on this support in more minimal ways, such as support from parents or from school. This may include engagement in particular activities (e.g., participation in sport, listening to music, playing games), providing support to family members, supporting, or defending friends, or supporting themselves emotionally, such as managing their emotions, or in some cases financially, such as the above example. They may have reported receiving some, limited support from such sources as parents, friends, family, school, social services or in cases mental health services, but, in their opinion, this may not be effective in relation to the risks encountered or they may report to be able to address risks independently or report a range of positive coping strategies. They are also more likely to draw on self-initiated strategies or seek out friends rather than seek help from parents or school when they are having difficulties. Cases in this category emphasis self-management strategies or ways of managing their emotions largely without parents and school, though they may draw on other adults (such as dance teacher) or emphasise the role of friends and peers as providing support and/or increasing their wellbeing. They may either find support unhelpful or not seek out support when they have a challenge or difficulty.

### **Variation in cases within this type**

Stronger cases (cases that resemble the optimal case above, in this type made reference to multiple self-initiated strategies), and weaker cases (cases that are less similar to the optimal type) in this type discussed only a few self-initiated strategies or the role of themselves in instigating support or their effective self-management were less clear. A strong case may be reliance on lots of self-care strategies to manage problems, a weak case would be where self-initiated strategies are not necessarily effective.

### **Questions to ask about this type**

- How much do they say they actively access support?
- Do they reference their own role in seeking support? Y/N  
(They need to reference their own role/agency)
- Do they mention forms of support or enjoyment outside of family and school? Y/N
- Does support work/help them to manage risk/stressors/achieve goals? Y/N?

- Is the support they describe self-instigated, e.g., removing oneself from a conflict on the playground? Or breathing to manage emotions?
- How strong is the role of the family? (Individuals that report forms of support from the family support and positive wellbeing would be more eligible for MSS)

***Ideal Type 3: The adolescent with 'Multiple Sources of Support' in relation to risk and/or wellbeing***

The adolescent with 'Multiple Sources of Support'- The adolescent that reports receiving a range of effective support from school, parents and/or other external sources in either the presence or absence of risk.

***Ideal Type Description:*** The adolescent with 'Multiple Sources of Support' is characterised by participants' reports of receiving or drawing on a range of types of support or a prominent type of support from parents/family, siblings and extended family, school and/or other types of support such as from friends, HeadStart interventions, mental health services or social services, or other types of support provided from the community, such as extracurricular activities. Of the types of support described participants in this type report a type of support as positively associated with wellbeing, for example, one female participant reported that she felt happiest spending time with her family. She expressed that the support she received was effective at reducing or coping with the risks they face, such as a teacher resolving bullying at school or learning support assisting with difficult schoolwork.

Stronger cases in this type would have several of the following types of support: parental support, sibling support, teacher support, friendship support, extracurricular support and potentially support from adults as part of a religious institution or from the wider community. Weaker cases of this type would have risk factors where it was less clear if the support was sufficient to address the risk factor named.

**Questions to ask of participants classified as MSS**

- Are there multiple forms of support? Y/N (Needs to be Y)
  - Is support effective? Y/N (Needs to have some effective forms of support)
  - Does the young person speak about enjoying their life or activities or time with family?
- Y/N (Must be Y to constitute MSS)

- Do they mention family, and school and other forms of support? Y/N (Need to mention either family or school strongly as well as other types of support to be eligible)

## Appendix Y: Case Reconstruction Template

### Case Reconstruction quality and transcript checking checklist for entire sample (N= 82) by Mia Eisenstadt

- Note. Checking the case reconstructions requires bringing up the transcript and scanning the transcript for any risk and protective factors that may have been missed on the first pass. Please make sure that protective factors that are not only coping strategies but are positively linked with wellbeing. E.g., “*skateboarding makes me feel alive*” are included or statements they give about their own happiness/wellbeing or positive self-perceptions that they say. e.g., “*I’m quite a happy person*” or “*I’m quite confident*” as well as the reverse, “*I’m not that confident*” or changes in their self-descriptions e.g. “*I used to be shy.*”
  - Add age and gender at the top.
  - Centre alignment should be on the left-hand side for all titles.
  - Title should be: **T2 Case Reconstruction [Participant ID]** (no underlined titles)
  - Times New Roman font size 12.
  - Line spacing 1.5.
  - Use quotation marks for quotes from the transcript
  - Bullet points for risk and protective factors.
  - T106 is a good model.
  - Summary should be in paragraphs.
  - Avoid use of “mum”, “dad” or “Nan” unless a participant uses that language, instead should be “mother”, “father” and “grandfather”
  - If any confusion about variables that are both risk and protective, please leave in for now.
  - Remove interjections from interviewer such as: *I: Okay/mmm/Yep etc.*



## Appendix Z: Example of Independent Sorting of Case Reconstructions at Time 2 As Part of the Changes in Protective Factors Over Time Study

Please note greyed out rows designate individuals who had left the study. Participant ID numbers have been occluded to maintain anonymity.

37		MSS	Not convinced on how good his outcomes are but I think he has support
38		USS	Has support but I think it's a mixed bag
39		MSS	Poor wellbeing but good support I think (although maybe this means the support is not as good as it seems)
40		USS	His mum seems to be a central source of support but there's not much to go on
41		USS	Some references to support but doesn't seem like support from mum + friends - although maybe difficult to know which she draws on
42		MSS	Has support but isn't convinced of its utility
43		USS	Has some self-protecting stuff but has a strong support network
44		USS	Not convinced his sense of support ways of coping are that helpful
45		SIFS	Seems to sort things out for himself, even when he talks to his partners
46		MSS	Has lots of support (but also does have some self-protecting stuff)
47		MSS	Has support from family but also talks about fixing things independently
48		USS	Has support but not sure how useful it is - also has self-protecting
49		MSS	Her use is uncertain but I don't think her protection is at the moment
50			
51		MSS	support from parents (same SIFS)
52			
52		MSS	support from family/friends (same SIFS)
53		USS	says that things aren't a problem but it's not clear how much support/protection she actually has
54		MSS	Talks about feeling very supported

