Young people’s understanding of mental illness

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Abstract

Research exploring young people’s perspectives on mental health is at an early stage of development and few studies have focused in detail on mental distress or illness. This paper reports findings from a qualitative study which used case vignettes in group and individual interviews to explore the ways in which the young people who took part constructed their understanding of what constitutes mental illness. In essence, they did so by drawing on their own experiences to distinguish between behaviours with which they could identify in some way and those with which they could not. An overview of previous relevant research is provided in the Introduction, followed by a description of the methods and sampling strategies used. The main findings of the study are then presented in relation to the ways in which young people defined unusual behaviour, their understanding of the behaviours associated with different mental health problems and their attitudes to the people concerned. Finally, some ways in which health promotion might build on the findings are identified and discussed.

Introduction

Within health promotion, there is a growing acknowledgement, in theory if not always in practice, of the importance of lay understandings of health (WHO, 1986; Ashton and Seymour, 1988; Milburn, 1996). Traditional approaches to health education have been the focus of considerable criticism for their assumption that simply imparting ‘accurate’ information will lead to changes in people’s attitudes and behaviour (Tones et al., 1990). In contrast, health promotion recognizes that initiatives are likely to meet with little success unless people’s own understandings, beliefs and concerns are taken into account. Until recently, however, research has focused mainly on adults’ perspectives on physical health issues such as coronary heart disease (Davison et al., 1991). Equally, although some studies have now explored young people’s perspectives on health in general and on specific conditions, research exploring their perspectives on mental health is at an early stage of development.

When research has been carried out on adults’ views of mental health, this has been largely confined to surveys of public attitudes to mental illness which have relied primarily on quantitative methods (e.g. Brockington et al., 1993; Department of Health, 1993). Such studies give a broad impression that lay epidemiologies differ from those of many professionals in locating the causes of mental ill-health in social rather than biomedical explanations. However, surveys are able to shed little light on the important questions of how attitudes and beliefs are formed or how they might influence behaviour (Secker and Platt, 1996).
More recently, two studies commissioned by the Health Education Authority and the Health Education Board for Scotland have broken new ground in using qualitative methods to explore adults’ views on mental health issues in more detail (Pavis et al., 1996; Rogers et al., 1996). These studies provide a useful illustration of the importance of understanding lay perspectives, in that their findings challenge received professional wisdom about mental health and its maintenance. For example, both studies suggest that health promotion messages based on received wisdom about the benefits of talking through worries and problems may be ineffective, since from one lay point of view dwelling on problems is perceived to be detrimental to mental health. Further, the timing and context of personal disclosure is regarded as something to be handled with extreme caution.

Where young people are concerned, recent studies have begun to explore beliefs and views about emotional and mental well-being (Williams et al., 1989; Mayall, 1993; Hill et al., 1995; Gordon and Grant, 1997), but these have not dealt centrally with mental distress or illness. Young people’s perspectives on mental illness are, however, important on a number of grounds. To some extent, their importance lies in the foundations which may be laid in childhood, and particularly in early adolescence, for future beliefs and attitudes, since these are likely to have a significant influence on the success of community care policies (Wahl and Kaye, 1992; Scottish Mental Health Forum, 1992). In addition, embarrassment and stigma may prevent people experiencing mental distress from seeking help (Royal College of Psychiatrists, 1995).

However, young people’s perspectives are not important simply because they are the adults of the future; they are equally important in their own right. Data collated by the Office of Population Censuses and Surveys indicate that the prevalence of mental health problems in childhood and adolescence is far greater than often assumed. For example, between 14 and 20% of young people experience mental health problems in childhood or adolescence, and suicide rates for young men aged 15–19 increased by almost 45% between the late 1970s and the late 1980s (Rutter and Rutter, 1993; Maughan, 1995). These data indicate the importance of developing appropriate sources of information and support and understanding young people’s perceptions of mental distress will provide valuable information in this respect.

In 1996 the Mental Health Foundation commissioned the Centre for the Child and Society at Glasgow University to undertake a study with young people aged 12–14 exploring their views about mental health issues (Armstrong et al., 1998). This specific age group was chosen partly to facilitate data collection, since similar methods would be appropriate across the age group, but also because it was thought young people of this age would be likely to be at a stage of their development when independent attitudes are beginning to be shaped. The study was broadly based, covering both positive mental health and mental illness, and involving samples of young people with specific relevant experiences as well as a sample drawn from mainstream schools. In this paper, our intention is to focus on the views the young people in mainstream schools expressed about mental illness. In particular, we will focus on the ways in which they arrived at their understanding of mental illness and on the implications for their responses to people experiencing mental distress.

**Methods and sampling**

The study employed both focus group discussions and individual interviews to explore the young people’s views. Whereas the group discussions provided an opportunity to explore a breadth of perspectives, and enabled participants to comment on and develop each other’s ideas, individual interviews allowed us to explore more personal experiences and attitudes in greater privacy.

A semi-structured interview schedule covering themes relating to different aspects of mental illness was used to guide the discussions and interviews. However, we were concerned not to impose the term ‘mental illness’ too early in the discussion in order to explore the language and
Vignette 1  James, a 13-year-old boy showing signs of a behavioural problem whose father had left 3 years previously

Vignette 2  John, a 34-year-old man with chronic schizophrenia who hears voices and can be unpredictable when he’s ill

Vignette 3  Angela, a young woman of 17 experiencing anorexia after she and a friend started dieting 6 months previously

Vignette 4  David, 40 years old and experiencing depression which has led to him losing his job

Vignette 5  Peter, a 15-year-old boy with early onset schizophrenia who hears voices and worries about aliens

Fig. 1. Vignette portrayals of mental health problems.

concepts young people themselves used to describe behaviour typically associated with different mental health problems. For this reason, we began by asking the young people to think of examples of behaviour they found odd or unusual and to describe these to us. A series of five unlabelled vignettes describing behaviour associated with particular mental health problems was then used to elicit the young people’s responses to the person concerned. Three of the vignettes were written specifically for the project by a psychiatrist drawing on her own experience. The other two were taken, with the permission of the researcher concerned, from another study carried out at the University of Glasgow. Figure 1 provides a brief description of each vignette.

Copies of the vignettes were made for each participant so that they could be read through in turn at group discussions, either by each individual alone or as a group. Alternatively, for individual interviews or where a group preferred it, the researcher could read the vignettes while participants followed the text. After reading each vignette, the young people were asked what they thought about the way the person concerned was acting, what name if any they would give to the behaviour described and how they would feel if the person lived next door to them. At this stage, if the young people themselves did not introduce the term mental illness, they were asked whether or not they thought the people in the vignettes were mentally ill. Further questions then explored their understanding of the term.

The young people who took part in the main study were drawn from four Scottish high schools: one inner city school serving an area with high levels of deprivation; two suburban schools, both serving relatively affluent areas; and one rural school serving a mixed population. Since none of the education departments involved had a standard parental consent form, a form was designed specifically for the study. In accordance with the Centre’s code of practice, the form sought the consent of both parents and young people, allowing them to opt either in or out of the study. It was accompanied by a letter providing a brief outline of the project and an explanation of what would be involved in the group and individual interviews.

About half the young people who were invited to participate agreed to do so, with some variation between schools. Overall, 102 young people took part in 17 group discussions (six in each), while a further 18 young people were interviewed individually. Interestingly, almost twice as many girls as boys agreed to take part, perhaps as a result of girls’ greater willingness to talk about issues relating to feelings. As a result, although all 17 group discussions included both girls and boys, in several groups girls were in the majority. In these circumstances, a key task for the interviewer was to ensure that any difference of perspective amongst the boys was able to emerge. In one case, however,
where only one boy took part in a group with five girls, the girls clearly dominated the discussion, despite the interviewer’s attempts to elicit the boy’s point of view.

At the beginning of each interview, the purpose of the project was explained and the boundaries of confidentiality agreed. Although some groups were inevitably more talkative than others, the focus groups appeared to work well, with discussion flowing between group members as well as between the interviewer and individual participants. In comparison, some individual interviews were more reserved, perhaps because the young people felt less certain about talking to a strange adult without peer support. The school setting and being unused to one to one discussions with an adult may also have contributed. Partly for this reason, all the individual interviews were shorter than the group discussions. Nevertheless, they served their purpose of enabling the young people to talk about more personal issues in relative privacy. This seemed to be particularly helpful for the boys, who not infrequently prefaced what they were about to say with comments like ‘I shouldn’t really tell you this but as no-one will hear ...’.

Each group and individual interview was fully transcribed for analysis using the NU*DIST software package. The process of analysis began with developing a framework based initially on the main topics covered in the interview schedule. However, as we became more familiar with the data further themes emerged, enabling us to construct a more detailed framework which was then transposed into NU*DIST and became the ‘tree’ used to index all the data. Once this was complete, a separate report on each index was produced, illustrating all the relevant data. These were then analysed further to establish patterns and associations across themes. However, piecing together an overall picture was not simply a matter of aggregating patterns and associations, but of weighing up salience and dynamics and searching for underlying structures rather than for a multiplicity of evidence.

Despite the different social processes through which data from the group and individual interviews were produced, the themes and issues to emerge from the two types of interview were very similar. They have therefore been combined and reported together in the following section. In illustrating the main themes with extracts from the research data, any names used in the interviews have been changed. Place names have also been changed to preserve anonymity. In extracts from the group discussions, a change of speaker is indicated by the use of a slash (/). Words and phrases inserted to make meanings clear are enclosed in square brackets [ ].

### Results

One of the main themes to emerge from the interview data concerned the ways in which the young people appeared to construct their understanding of mental illness. In essence, in defining what did or did not constitute mental illness, they drew on their own experience to separate behaviours with which they could identify in some way from those which were completely out with their experience. This process of identification had a number of aspects. In some cases, for example, the young people were clearly extrapolating from their own direct experience, while in others they referred to having witnessed similar behaviour in an understandable context. Alternatively, in some cases they could see others’ behaviour as an extension of their own or could arrive at a plausible explanation for it. When behaviours could be understood in any of these terms, the young people were reluctant to label these mental illness. Conversely, behaviours with which they could not identify in any way were constructed as ‘abnormal’ or ‘other’ and labelled mental illness, a process which was both informed by and legitimated through reference to media representations.

This theme is explored here in relation to the young peoples’ ideas about odd or unusual behaviour, their understanding of the behaviour portrayed in the vignettes and their attitudes to the people concerned.
Defining unusual behaviour

An early indication of the ways in which the young people constructed their understanding of mental illness emerged from their responses to questions about what constituted odd or unusual behaviour. In arriving at their definitions, the young people implicitly drew a distinction between deviation from personal norms, i.e. from a person’s usual behaviour, and deviation from social norms, i.e. from other people’s expectations. In this respect there was no apparent difference between young people from the four schools, despite significant differences in their social backgrounds. As the following extracts illustrate, however, their understanding of deviation from personal norms was grounded in their own experience of everyday patterns of behaviour amongst people whom they knew or might conceivably know:

If they were doing things they wouldn’t normally do, like if someone is usually quiet and they were going about shouting at everybody. (Male participant, rural school)

When someone always does their hair in the morning and make it fancy and then they shove it back. Just don’t look after theirselves/they don’t get washed or nothing and normally they’re like really clean. (Group discussion, inner city school)

In contrast, where deviation from social norms was concerned, the young people drew on experiences of seeing strangers behave in ways they could not understand in terms of their own everyday experience, e.g.

Dancing about/talking to theirself/loudly/I saw this man and he was like shouting and waving his arms about and there was nobody there/going up to people and talking rubbish. (Group discussion, suburban school)

Somebody jumping up and down wi’ mad clothes/somebody walking about wi’ slippers on. (Group discussion, inner city school).

As will be seen in the following discussion, these ways of defining odd behaviour in terms of the ‘known’ and the ‘unknown’ foreshadowed the young people’s responses to the vignettes.

Understanding behaviour

The young people’s responses to James’ behaviour (Vignette 1) provide a clear illustration of the central part played by their own experience in distinguishing what was to be considered mental illness from what was not. During the first part of the interview dealing with positive mental health, many of the young people (both boys and girls) had indicated that the main way in which they themselves dealt with negative feelings was through aggression towards other people and things. From their perspective, then, James’ behaviour was not ‘abnormal’ because they could see circumstantial explanations for it with which they could identify, and could therefore understand it in terms of events which had left him feeling angry and upset. Consequently, none of the young people who took part in the research regarded James as mentally ill:

He’s probably bad because his dad left him and he’s probably not taken it in/probably thinks it’s his fault/’cause his dad left it’s probably making him upset and he’s trying to take the anger for his dad out on other people/probably missing his dad as well. (Group discussion, suburban school)

Stupid but not mentally ill/’cause he’s depressed about not seeing his dad/probably ‘cause his mum hasn’t got very much time to look after him. (Group discussion, inner city school)

This distinction the young people were making between experiences and behaviour with which they could identify in some way and those with which they could not emerged more clearly as they discussed the portrayal of depression in Vignette 4 (David). Although it was not uncommon for the young people to spontaneously describe David’s behaviour as depression, the great majority of them did not define this as mental illness. For them, as these extracts illustrate, the experiences and
behaviour described were accessible enough through their own experience to be regarded as ‘normal’:

No he’s not mentally ill I just think he’s got depression and he doesn’t care about anything but I don’t think he’s mentally ill. (Female participant, rural school)

No not mentally ill just depressed and selfish. (Male participant, suburban school)

Since the word depression was so commonly used in connection with this vignette, the young people’s understanding of the term was explored in more detail. It became clear from the ensuing discussions that for the majority of participants depression was something they had encountered as part of everyday life, regardless of the type of area in which their school was located. For participants from the inner city school, however, this appeared to be a particularly common experience and indeed we were told by local contacts there that one in five women in the area were prescribed psychotropic medication. Again, these young people’s use of their own experience in locating depression within the bounds of normality became apparent:

Depression is not mental illness/my mum’s friend used to be depressed because her boyfriend walked out. She lost lots of weight but then she went to see the doctor and he gave her anti-depressants. (Group discussion, inner city school)

Although some young people acknowledged that depression might mean different things, mental illness was not included amongst them:

Depressed can be quite a lot of things. It can be feeling really sad about yourself or it could be feeling like there’s no point in life going on and why should I bother. Depressed can make you feel pretty much of a failure. (Male participant, rural school)

It depends what you think of depression as. You can get depressed because somebody calls you a name/but would that be depression/not necessarily that might just be frustration or anger/depression might be when you feel like everything’s gone wrong and you just don’t want to go on with it. (Group discussion, suburban school)

One girl, however, disagreed with the general consensus that depression did not constitute mental illness. Like David in the vignette, her father had become depressed after being made redundant and had been admitted to psychiatric hospital. On these grounds, the girl therefore defined the behaviour described in the vignette as mental illness.

The young people’s discussion of Angela’s behaviour (Vignette 3) was particularly interesting in terms of how they were constructing their definition of mental illness. All the young people were clearly knowledgeable about anorexia and spontaneously used the term in relation to Angela. Although girls were more vocal than boys on this subject in the group discussions, the boys proved equally knowledgeable in individual interviews. However, the young people had more difficulty than with the other problems discussed so far in deciding whether anorexia could be described as mental illness. On the one hand, they appeared reluctant to say that it was, because the behaviour described could be understood in terms of experiences and people they could relate to. This group, in particular, revealed considerable depth of understanding when discussing Angela:

If she keeps on she’s just doing herself harm/may be she can’t stop though. She’s in a sort of pattern and she can’t get out of it/I suppose it’s like you smoke and you get addicted/may be she feels like she’s got some power over her. Maybe everything in her life is going wrong and that’s one thing she can control. (Group discussion, rural school)

On the other hand, most young people felt it was not ‘normal’ to behave like Angela. Although a small number of participants did unequivocally define anorexia as mental illness on these grounds, the majority resolved the dilemma, as this girl did, by using a third category of mental, or psychological, problems:
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I don’t think she’s mentally ill but she’s got a psychological problem with the way she feels about herself and the way she looks. (Female participant, suburban school)

In contrast with their response to the other vignettes, all the young people who took part in the research unequivocally defined the behaviour described in Vignettes 2 and 5 (John and Peter) as mental illness. The two characters were seen as very similar and the terms schizo, schizophrenic and paranoid were used to describe them both:

John:
Aye mentally ill like schizophrenic or something/’cause he hears voices and stuff. (Group discussion, rural school)

‘Schizophrenic or something ‘cause he’s hearing voices and mood swings and forgets routines an’ that/like there’s two people doing different stuff/you argue with your own head. (Group discussion, suburban school)

Peter:
He’s like the same as the other one/aye mental/very weird and paranoid’ (Group discussion, suburban school)

Well he’s kind of the same as what was it John because of the voices inside his head. He must be a wee bit mentally ill if he’s got voices inside his head. That’s not a very good sign. (Female participant, inner city school)

As the above extracts indicate, in defining the behaviour described in the two vignettes as mental illness, the young people made no reference to experiences of their own. Rather, John and Peter were discussed in similar terms to the strangers who typified odd behaviour for them. They did, however, draw heavily on media representations of mental illness to arrive at and legitimize their conclusions:

Schizophrenia/it’s a bit like what Jo is out of ‘Eastenders’/it’s where one person is like two people. They can be a normal person at one time and then another person takes over their body and makes them do things they wouldn’t normally do/yeah like they might hurt people or hurt themselves/they can get like lots of different personalities/and they can change from one to the other quite quick. (Group discussion, rural school)

In summary, then, the young people’s responses to the five vignettes suggest that they were drawing on their own experience to define behaviour in one of three ways: behaviour with which they could identify quite closely was classified as being within the bounds of normality; behaviour with which they could identify but which could not be described as normal was classified as resulting from mental or psychological problems, but not as mental illness; and behaviour they had difficulty in identifying with was classified as mental illness.

Attitudes to people experiencing mental distress

The young people’s attitudes to the people in the vignettes were explored through questions about how they would feel if they lived next door. Their responses to these questions revolved mainly around sympathy and fear. Interestingly, these responses were related to the type of behaviour illustrated and the age of the individual portrayed, but not to whether they were regarded as mentally ill. In some cases, participants’ own gender could also play a part.

In addition, young people at the rural school appeared less tolerant and sympathetic than participants at the other schools. Although they were not condemning or intolerant, they were more likely to be indifferent to the people in the vignettes, and were less concerned with helping or befriending them. No explanation emerged for this difference and too much should probably not be made of it, given the small number of participating schools.

Sympathy was most commonly expressed for James (behavioural problems), Angela (anorexia) and, to a lesser extent, Peter (psychotic behaviour). That these three characters were all young people themselves suggests that here too the response of the young people who took part in the research
was shaped by the extent to which they could identify with the person concerned. For example, the portrayal of James evoked a concern to understand and show sympathy:

I’d probably feel sorry for him because of his problem and people might like just ignore him. May be that’s why he’s doing that. (Male participant, suburban school)

Probably try and talk to him sometimes and try and help him a little bit. Show him that somebody actually cares. (Female participant, inner city school)

I’d feel sorry for him/yeah and like try and get to know him and try and understand the way he is. (Group discussion, suburban school)

Where Angela was concerned, sympathy was expressed by most of the girls but not by the boys, again suggesting that the process of identification was important. While the first two quotations below are from girls who took part in the research, the third is an extract from a discussion between a boy (first speaker) and two girls:

You’d feel dead sorry for them/you’d end up putting in food for them/you wouldn’t feel scared or nothing just sorry for them. (Group discussion, inner city school)

I’d like just help her to eat an’ that and tell her she’s not fat. She needs a lot of help. (Female participant, suburban school)

[She’s] stupid ‘cause she’ll end up making herself really ill or damaging herself. And like it’s only ‘cause she wants to look like the super models/yeah but like she can’t help it/I’d feel really sorry for her ‘cause like she’s probably got a problem like an eating disorder. (Group discussion, suburban school)

The attitudes of those young people who expressed sympathy for Peter are particularly interesting in that they illustrate how an understanding could be achieved, even of behaviour classified as mentally ill, through extrapolation from personal experience. For example, one group member equated Peter’s feelings to the feelings she experienced herself when watching a horror movie:

It must be scary thinking there’s aliens in your head, like if you watch ‘Aliens’ or something. (Group discussion, inner city school)

Another participant equated Peter’s feelings with those commonly experienced in childhood:

It’s like a child who thinks there are monsters under the bed, you actually begin to think it. (Group discussion, suburban school)

In contrast with their response to these three characters, sympathy was only expressed in one individual interview and one focus group toward the adult vignette characters, again regardless of whether they were regarded as mentally ill. Thus only one participant expressed a degree of sympathy towards John (psychotic behaviour). Equally, despite the general consensus that he was not mentally ill, only one member of one group expressed sympathy for David (depression) and this was because he had known someone in a similar situation. However, after he had explained about the man he knew the rest of the group appeared more sympathetic. This may have been the result of a concern to make a socially acceptable response, but it may also suggest that the young people’s attitudes could be shaped not only by their own experiences, but also by the experiences of other people which had some salience for them.

Unsurprisingly, fear was most commonly expressed in relation to those characters in the vignettes whose behaviour was portrayed as potentially aggressive or unpredictable. For this reason, all the young people said they would be frightened of John, Peter and, to a lesser degree, James.

In some cases, however, responses to Peter and John suggest that the age of these characters also made a difference in that Peter seems to have been seen as less threatening than John:

John:
I’d feel a bit scared because you don’t know if he’d turn round and do anything to you. One
minute you could be talking to him and the
next minute you could be like thrown across
the room or something like that. (Female partic-
cipant, suburban school)

If he’s verbally aggressive it’s not very safe
living next to him. (Male participant, sub-
urban school)

*Peter:* Make sure people didn’t tease him/I’d go up to
him and try and calm him down/try and get
him away from people staring at him in the
streets. (Group discussion, suburban school)

You’d probably want to go and help him and
talk to him but you wouldn’t really know what
to do/because he’s so shy it would be a bit hard
for him to make friends. (Group discussion, sub-
urban school)

Although hearing voices was a key indicator of
mental illness for the young people, they were not
necessarily frightened simply because someone
heard voices. As these extracts illustrate, fear was
only apparent when there was a threat or actual
evidence of violent behaviour:

If he was being really aggressive and was
always fighting I’d be scared but if he was just
a bit weird and quiet then you know I’d probably
not think anything of it. (Female participant, sub-
urban school)

I’d be scared/aye he doesn’t know what he’s
doing and thinks everybody’s gonna harm him/
his voices are telling him to do stuff/the voices
could tell him something and he could walk up
to you and stab you or something/aye. (Group
discussion, inner city school)

Where James was concerned, the young people’s
views were divided. While some feared that James
might be physically aggressive towards them, given
his propensity for fighting, others thought he would
be annoying but not particularly frightening. Here
participants’ own gender again seemed to play a
part at first, with boys being less likely to express
fear of James than girls in the group interviews.

In the individual interviews, however, the boys did
express more fear of James and their attitude in
the groups may therefore have had more to do
with the need to portray a certain image than with
their true feelings.

In contrast with their attitudes towards John,
Peter and James, none of the young people
expressed any fear at the thought of living next
door to David (depression) or Angela (anorexia).

**Discussion**

The findings reported above provide important
insights into the ways in which the young people’s
understandings of mental illness were constructed.
By drawing on their personal experience, or on
the experience of salient others, the young people
made judgements about what was ‘normal’
behaviour and what was not. There was little
difference, either across the four participating
schools or between girls and boys, about was
regarded as ‘normal’, although it was clear that
for young people from the inner city school depres-
sion was a particularly common fact of life.

In turn, behaviour which could not be classed
as ‘normal’, or as an extension of normality, and
was therefore inexplicable, was constructed as
‘abnormal’ and labelled as mental illness. In the
latter case, media messages about mental illness
played an important part by providing a substitute
for personal experience on which the young people
could draw to legitimate their judgements. This
impression from their responses to the vignette
characters was strengthened by their responses
later in the interviews to direct questions about the
source of their knowledge, in that all the young
people who took part in the research cited television
as their main source. As the Glasgow Media Group
have demonstrated through a content analysis of
British television and press output, the vast majority
of media messages about mental illness are nega-
tive messages which draw heavily on the kind of
‘split personality’ misrepresentation to which many
of the young people in our study referred (Philo,
1996).

However, the process of identification docu-
mented in the young people’s accounts meant that their attitudes to the vignette characters they did label mentally ill were not necessarily negative. Rather, when they could identify with the characters on the basis of age or gender, the young people appeared more likely to express sympathy for them and less likely to express fear. Conversely, adult characters with whom they were less able to identify evoked little sympathy, regardless of whether they were labelled mentally ill.

These findings suggest a number of ways in which health promotion initiatives with young people might be designed to take their own perspectives into account in addressing the stigmatization of mental illness. In the first place, the way in which the young people who took part in the study responded in group discussions demonstrates how such discussions can work to broaden individual perspectives by drawing on collective experiences. Facilitated group work could therefore be a valuable format for mental health promotion.

In addition, since the ability to identify with someone experiencing mental distress appears to play a significant part in the process of attitude formation, mental health service users could have an important role in helping young people contextualize and understand their experiences through direct personal contact. While there are a few examples in Britain of small-scale, school-based initiatives of this kind, recognition of the expertise on which service users are able to draw does not appear to be widespread. In order to facilitate its development, health promotion professionals may have a part to play by providing training for users in working with young people and making their experiences relevant for them.

However, the effectiveness even of user-led initiatives is likely to be undermined by the kind of negative media messages about mental illness documented by Philo (Philo, 1996). Following their media content analysis, the researchers at the Glasgow Media Group explored the impact of the negative coverage they found on a range of audience groups, including a number of young people. In contrast with any of the issues they had examined in previous research, they found that where mental health was concerned media messages could overturn even direct personal experience. Although it would be unrealistic to suggest that health promotion can have any immediate significant effect on major cultural institutions such as newspapers and television channels which, quite legitimately, operate within their own contexts and norms, as a longer-term strategy concerted efforts to challenge and change media messages have been shown to have some effect (Wahl, 1995). Examples include the ‘media watch’ campaign, organized in the US by the National Association for the Mentally Ill, which involves users, carers and concerned professionals contacting journalists and broadcasters to complain about offensive material. On the more positive side, as Wahl points out, both professionals and service users are in a position to provide the media with more accurate information and attractive ‘human interest’ stories.

In conclusion, then, and in keeping with health promotion principles, our research with young people suggests that we need both to provide opportunities for individual learning about mental distress appears to a significant part in the process of attitude formation, mental health service users could have an important role in helping young people contextualize and understand their experiences through direct personal contact. While there are a few examples in Britain of small-scale, school-based initiatives of this kind, recognition of the expertise on which service users are able to draw does not appear to be widespread. In order to facilitate its development, health promotion professionals may have a part to play by providing training for users in working with young people and making their experiences relevant for them.

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In conclusion, then, and in keeping with health promotion principles, our research with young people suggests that we need both to provide opportunities for individual learning about mental illness in ways which take young people’s own perspectives into account and to work towards creating a cultural environment which supports the development of more positive attitudes.

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