DOCTORAL THESIS

Exploring mental health and potential health assets in young people

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School of Health and Welfare
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There is no health without mental health.

World Health Organization, 2005

Abstract

Young people in Sweden generally claim to have a good quality of life, but also report increasing mental health problems. It is a concern that only a minority of young people seek and/or access support when encountering mental health problems as mental health is a fundamental human right and integral to a positive development in both childhood and throughout the lifespan. There are uncertainties as to how to facilitate help-seeking and promote mental health among young people and previous studies have often focused on risk-reduction. A shift from a pathological view to a resource-based perspective of mental health can be achieved by adopting a health assets' approach. This approach also ascribes due emphasis to the fact that mental health is developed within a social context, where both individual and structural health assets, such as the support system, are of importance. With this in mind, the overall aim of this thesis was to explore individual and structural health assets in relation to the mental health of young people.

This thesis is based on four studies using both quantitative (Studies I and II) and qualitative (Study III) methods as well as a scoping review method with a qualitative synthesis (Study IV). Studies I and II had a cross-sectional design and utilized data from self-reported health-related ratings collected in schools in 2011. The association between socio-economic determinants and self-rated mental health in two age groups (11-13 and 14-16) was explored in Study I, and optimism and pessimism as a bi-dimensional construct, and its impact on health-related quality of life and potential to function as a health asset was explored in Study II. In Studies III and IV, the help-seeking process was explored from the perspective of young people, firstly with constructivist grounded theory in Study III based on interviews of young people seeking help for mental health problems within a local setting, and secondly, through a scoping review examination and qualitative synthesis of national and international literature on help-seeking in Study IV.

The results identified potential health assets on both individual and structural levels. The explored health assets on an individual level were socio-economic status and socio-demographic factors (Study I), dispositional optimism (Study II) and individual resources for help-seeking (Studies III and IV), while health assets on a structural level were explored through the experience of and perceptions of young people's help-seeking process

(Studies III and IV). The individual health assets of socio-economic status and migratory background were seen to affect mental health differently for boys and girls with the boys being susceptible to an accumulation of socio-economic risk factors including family wealth affecting their mental health negatively, and the mental health of the young girls with a migratory background being affected positively (Study I).The individual health asset of optimism was found to be potentially supportive for help-seeking and mental health (Study II). Young people were optimistic about their future but there was a significant decrease in optimism and health-related quality of life, and a significant increase in pessimism, with age. Optimism was independently and positively associated with a high level of health-related quality of life among young people, even when adjusting for parents' marital status, family country background and gender. Knowledge and a desire for self-reliance were identified as potential individual health assets mainly in regard to the help-seeking process (Studies III and IV). Young people expressed how their knowledge of mental health and the support system was inadequate, rendering a feeling of insecurity, however, they also expressed a strong desire for self-reliance in regard to their mental health. Help-seeking was characterised as a dynamic and psychosocial process without sequentially fixed stages. Potential health assets on a structural level were identified as support through social networks, and a responsive, collective and accessible support system. However, young people perceived the support system as unresponsive, focused on protocol instead of person, fragmented and spread, and lacking in accessibility. The results implied that equipping young people with sufficient knowledge would capitalize on the individual health assets of self-reliance and optimism, conducive to help-seeking and mental health, but that the support system needs to improve in order to meet the particular needs of young people.

Svensk sammanfattning

Unga människor i Sverige uppger generellt att de har en god livskvalitet. Samtidigt rapporteras om en ökad psykisk ohälsa hos ungdomar vilket gör området till en nationell prioritet. Psykiska problem debuterar ofta i ungdomen och fortsätter in i vuxen ålder. Det är dock få ungdomar som söker hjälp. En stor del av tidigare forskning har ägnats åt ungdomar med psykisk sjukdom, kanske för att dessa är lättare att identifiera än ungdomar som befinner sig i en mer odefinierbar ”gråskala” av psykisk ohälsa. Detta innebär dock att även de som löper en uppbenbar risk för att utveckla psykisk sjukdom hänvisas till egna resurser och nätverk för att ta hand om psykiska problem. För att samhället ska kunna nå ungdomar för hälsofrämjande stöd och insatser, är det av vikt att vi får utökade kunskaper om hur hjälpsökande och psykisk hälsa kan förstärkas. Denna avhandling har utgått från ett resursperspektiv för att öka kunskapen om hur den psykisk hälsan kan främjas hos ungdomar. Ett sådant perspektiv betonar en syn på hälsa där både strukturella och individuella resurser anses samverka för utveckling av psykisk hälsa. Syftet med avhandlingen har varit att utforska individuella och strukturella resurser som kan ha betydelse för ungdomars psykiska hälsa.

Denna sammanläggningsavhandling bygger på fyra delstudier. Studie I, II och III har utförts inom samma geografiska område, en sydsvensk medelstor tätort. Studie I och II i avhandlingen har använt kvantitativa metoder och är tvärsnittsstudier utifrån data insamlat under hösten 2011 på skolor. Materialet gav en ögonblicksbild av ungdomars självskattade hälsa, livskvalitet och optimism inför framtiden relaterat till individuella faktorer socio-ekonomisk status och socio-demografi. Studie III och IV har utforskat hjälpsökande processen genom två olika metoder; studie III var en kvalitativ intervjustudie med syfte att undersöka hjälpsökande utifrån ungdomars upplevelse och perspektiv, där en konstruktivistisk grundad teori användes. Studie IV var en litteraturstudie – scoping review, också med fokus på ungdomars upplevelse av hjälpsökande, där en kvalitativ, tematisk analys användes, dels för att få en djupare och mer nyanserad förståelse av ungdomars upplevelse av hjälpsökande-processen, men också för att validera fynden från studie III.

Potentiella hälsorelaterade resurser identifierades på både individuell och strukturell nivå. Socio-ekonomisk status och sociodemografiska faktorer hade olika samband med psykisk hälsa för pojkar och flickor (studie I). Pojkar verkade vara mer känsliga för faktorer som välstånd och en ansamling av riskfaktorer, med en negativ påverkan på deras psykiska hälsa. Sociodemografiska faktorer utgjorde en resurs för hälsa så till vida att psykisk hälsa hos yngre flickor med utländsk bakgrund påverkades positivt. Optimism befanns vara en potentiell resurs för hälsa hos både pojkar och flickor då optimism hade ett samband med hälso-relaterad livskvalitet oberoende av sociodemografiska faktorer så som kön och bakgrund (studie II). Hjälpsökande processen definierades som en dynamisk och psykosocial process utan fasta steg eller fast ordning (studie III och IV). Ungdomar upplevde hjälpsökande-processen som svårnavigerad och uttryckte en uppfattning att stödsystemet var otillgängligt, fragmenterat och oflexibelt (studie III och IV). De såg vanligtvis inte primärvården som ett lämpligt ställe att söka vård, tyckte att åldersregler var begränsande och ansåg att de var tvungna att söka stöd på flera ställen för att få sina behov tillgodosedda, ofta utifrån medicinska kriterier (studie III och IV). Ungdomar uttryckte också att de hade för lite kunskap om psykisk hälsa och stödsystemet (studie III och IV) och de eftersträvade en självständighet (studie III och IV). Kunskap och självständighet kunde därför ses som möjliga individuella resurser för psykisk hälsa. Likaså kunde stöd från viktiga personer i ungdomars närhet, och personliga nätverk ha stor betydelse för hjälpsökande och psykisk hälsa.

Föreliggande avhandling bidrar med kunskap om möjliga resurser för att främja ungdomars psykiska hälsa. Ungdomars egna perspektiv på individuella och strukturella faktorer för att främja den psykiska hälsan var ett viktigt bidrag för ökad kunskap inom området. Utifrån ungdomars perspektiv, behöver deras kunskap om psykisk hälsa förstärkas, och de behöver förstå när, hur och var de kan söka hjälp. Optimism hade ett samband med upplevelsen av livskvalitet. Interventioner som är riktade till att öka ungdomars kunskap om psykisk hälsa och stärkande av optimism skulle behöva utvecklas tillsammans med ungdomarna själva, och här är skolan en möjlig arena eftersom man då når alla ungdomar. Ytterligare anpassningar för ungdomars möjlighet att få stöd behövs, t.ex. behöver stöd vara mer lättillgängligt och samlat så att ungdomar inte måste söka vård på flera olika ställen. Stödet behöver vara mer flexibelt, fokuserat på ungdomars individuella situation och personcentrerat.

Contents

Abbreviations

EUHPID	The European Community Health Promotion Indicator Development Model
BRIS	Children's Right in Society
BUP	Child and Adolescent Mental Health Services (Barn och ungdomspsykiatrin)
FAS	Family Affluence Scale
GT	Grounded theory
HBSC	Health Behaviour in School-Aged Children
HRQoL	Health-Related Quality of Life
LUPP	Local follow-up of youth policy
MMQL	Minneapolis Manchester Quality of Life Instrument
MMQL-PF	Minneapolis Manchester Quality of Life Instrument-Psychological functioning
SES	Socio-economic status
WHO	World Health Organization

List of scientific papers

This thesis is based on the following studies, referred to in the text by their Roman numerals. The articles have been reprinted with the permissions of respective journal.

I Hutton, K., Nyholm, M., Nygren, J.M., & Svedberg, P. (2014). Self-rated mental health and socio-economic background: a study of adolescents in Sweden. *BMC Public Health*, 14, 394. https://doi.org/10.1186/1471-2458-14-394

II Häggström Westberg, K., Wilhsson, M., Svedberg, P., Nygren, J.M., Morgan, A., & Nyholm, M. (2019). Optimism as a Candidate Health Asset: Exploring Its Links With Adolescent Quality of Life in Sweden. *Child Development*, 90(3), 970-984. https://doi.org/10.1111/cdev.12958

III Häggström Westberg, K., Nygren, J.M., Nyholm, M., Carlsson, I-M., & Svedberg, P. (2020). Lost in space – an exploration of help-seeking among young people with mental health problems; a constructivist grounded theory study. *Archives of Public Health*, 78(1), 93. https://doi.org/10.1186/s13690-020-00471-6

IV Häggström Westberg, K., Nyholm, M., Nygren, J.M., & Svedberg, P. Seeking help for mental health problems among young people – a scoping review. School of Health and Welfare, Halmstad University. [Submitted to: International Journal of Environmental Research and Public Health Special Issue "Children and Young People's Participation in Health and Well-Being]

Introduction

The self-reported mental health of young people has deteriorated since the 1980s, and the mental health of young people today is a national and worldwide public health concern (Bor et al., 2014; Hagquist et al., 2019; Potrebny et al., 2017). There is a widespread consensus that the promotion of the mental health of young people is an integral component in the ensuring of a positive development for young people and improved health and social wellbeing across the lifespan. The field of young people's mental health continuously receives a considerable amount of attention in both policy, practice and research (World Health Organization, 2014b). There are no indications that the growth of mental health problems is on the decline, and meeting the mental health needs of young people in terms of support and healthcare for children and young people is prioritized in Sweden (SOU 2021:34).

Young people's mental health is affected by a multitude of determinants; social, socio-economic, environmental and personal (Patel et al., 2018; Wille & Ravens-Sieberer, 2010). The development of mental health takes place in a social context and does not only rely on individual traits, capacities and qualities but is a social process within a social structure (Bhaskar, 2017; Katikireddi et al., 2013). The application of a critical realist theory where structure is prominent, entails needing to explore the context around young people when researching their mental health. The research on mental health thus requires incorporating determinants of different aetiology and perspectives, such as socio-economy, individual dispositions and the support structure. A major part of the resources and research has so far been focused on pathology, i.e young people with mental health disorders, and less on how to promote mental health among young people (Arango et al., 2018; Scheid & Wright, 2017). However, in order to support mental health, we need to move from a problem-based deficit model to a recognition of health assets, emphasizing positive factors, resources and capabilities within and around the individual (Garcia-Moya & Morgan, 2017; Whitehead, 2007). Research on social and contextual influences on young people, incorporating both risk factors and resources for mental health including the support system, lays the

foundation for mental health promotion and efficient mental healthcare and support services.

Background and previous research

Mental health among young people

Most young people in Europe and in Sweden claim to have a high level of quality of life, good general health and a sense of wellbeing (Currie et al., 2012; Public Health Agency, 2018; Swedish Agency for Youth and Civil Society, 2021). They generally express positive feelings about school although school-related stress is common (Hogberg et al., 2020). However, despite good general health, only a small majority of the young people in Sweden (56%) state that they are satisfied with their mental health (Swedish Agency for Youth and Civil Society, 2019). Since quality of life and well-being are closely related to mental health, it is somewhat surprising that young people in Sweden simultaneously display an increase in mental health problems. There is a general trend in Sweden of increased self-rated mental health problems as well as an increased resource utilization among young people (Brann et al., 2017; Hagquist et al., 2019; SOU 202:34; The National Board of Health and Welfare, 2013; Wiklund et al., 2012). Symptoms of depression, anxiety, pain, self-harm and sleeping problems are common, particularly among girls and increasing with age (Brann et al., 2017; Hagquist et al., 2019; Wiklund et al., 2012). More than 1/3 of young people in Sweden between the ages of 16-24 reported anxiety in 2019 and in the age group 13-18, 55% reported psychosomatic symptoms such as headache, stomach-ache and difficulties sleeping (Swedish Agency for Youth and Civil Society, 2021). The rate of suicide in other Nordic countries has decreased among young people 15-24 years old between the years 1990-2010, whereas in Sweden the rate of suicide among young people 13-24 remains at the same levels (Swedish Agency for Youth and Civil Society, 2021). Both nationally and internationally, mental health problems among young people are linked to age as well as gender; the problems increase with age and girls report a higher rate of mental health problems (Campbell et al., 2021; Hogberg et al., 2020; Reiss, 2013).

The increase in mental health problems among young people is primarily based on self-reports of psychosomatic symptoms. The prevalence of serious mental health disorders such as schizophrenia and bipolar disorder remain

mostly at the same level, which indicates that the increase concerns primarily mental health problems and not mental health disorders (The National Board of Health and Welfare, 2013). However, the increase is still alarming since it is difficult to discern who will develop a mental health disorder. The increase in mental health problems is simultaneous with improved diagnostic work and increased admittance rates for mental health in-hospital care (SOU 2021:34; The National Board of Health and Welfare, 2019). Both care for depression, anxiety and substance abuse and the number of young people who receive mental healthcare without receiving a corresponding mental health diagnosis has increased (The National Board of Health and Welfare, 2013).

Being young is traditionally regarded as a positive period in life, where resources and capacities are developed, and the foundation for health is laid down (Patton et al., 2016). However, mental health problems often originate in adolescence with an increased risk of prolonged mental health problems continuing into adulthood, sometimes developing into a mental health disorder. Studies show that 75% of mental health disorders evolve before the age of 24 and 50% before the age of 14 (Kessler et al., 2005). Therefore, it is of essence to address this issue, particularly as early intervention may potentially generate larger savings for society – and individuals (Arango et al., 2018).

Different ways to understand the concept of mental health

Mental health is regarded as a fundamental human right and integral part of health and quality of life (World Health Organization, 2005). It is a broad term that lacks a clear and single definition, complex and multidimensional, and is dependent on biological, social and lifestyle factors (Braveman & Gottlieb, 2014). Mental health can be defined in both positive and negative ways, positively defined as an asset or a resource that enables positive states of wellbeing and provides the capability for a person to achieve their full potential (Patel et al., 2018). However, mental health is often defined negatively in terms of mental health problems, with referral to symptoms associated with anxiety, depression and insomnia (European Commission, 2005). Mental ill health is often described as an overarching concept, encompassing both self-reported mental health problems as well as psychiatric diseases (The National Board of Health and Welfare, 2017). The problems may be both less serious and passing, as leading to a mental disorders (Children's Right in Society, 2017). Even when using negatively framed thresholds, mental ill health and mental disorders are difficult to define, and depend on expert consensus (Whooley, 2017). The view that working from a pathological perspective is easier, may thus be questioned.

Departing from a pathological view, also entails that mental health problems are often defined as dependent on individual lifestyle (Katikireddi et al., 2013). This implies that responsibility for mental health relies on the individual, and warrants that in order to achieve mental health, the individual must change. Although individual behaviour can influence health, lifestyle choices are consistently imbedded in structural context (Marmot & Wilkinson, 1999).

Mental health can also be positively defined, and focus on how to enable positive states of wellbeing and function (Patel et al., 2018). Such descriptions relate to how well an individual copes both from an individual but also societal perspective. The World Health Organization (WHO) defines mental health as

> "Mental health is a state of wellbeing in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community" (World Health Organization, 2018)

This definition stipulates that mental health is more than the absence of mental illness (although it does not stipulate that there has to be an absence of mental health problems), and that mental health and wellbeing are intertwined. In fact, mental health can be regarded as a foundation for wellbeing and functioning for both individuals and communities (World Health Organization, 2005). Some scholars also use the term mental wellbeing as an overarching concept, incorporating both psychosomatic health and life satisfaction (Cosma et al., 2020), and mental wellbeing is said to be foundational of good quality of life (World Health Organization, 2012). The concept quality of life is used in a similar way, being multidimensional, encompassing physical, mental, social and emotional aspects (Jorngarden et al., 2006; Ravens-Sieberer et al., 2008). Research on quality of life encompasses both objective and subjective dimensions, with a focus on function and personal assessment of different dimension of quality of life (Eiser & Morse, 2001). The wider concept of quality of life, also relates to the individual's perception of their position in life, the context of culture and the relationship to goals, expectations, and concerns (Eiser & Morse, 2001).

The concept of positive mental health can be regarded a countermove for balancing the pathogenic focus on mental ill health and mental health problems. Positive mental health is more than the absence of mental illness, demonstrated by both positive affect and positive functioning (Keyes, 2002). Promotion of positive mental health includes the enhancement of individual resources such as self-esteem and optimism as well as a sense of well-being

and resilience instead of a focus on the prevention of illness and mental health problems (Tamminen et al., 2016). According to the theory of positive mental health, mental health and mental health problems can co-exist, however, they are not a single continuum where symptoms of mental health problems imply absence of positive mental health and vice versa (Keyes, 2002).

Mental health thus entails symptoms of subjective wellbeing, encompassing both negative and positive consequences, where it is possible to have a good quality of life while still suffering from mental health problems According to a summarization and operationalization, good mental health involves 14 core domains; mental health literacy, attitudes towards mental disorders, self-perceptions and values, cognitive skills, academic/ occupational performance, emotions, behaviours, self-management strategies, social skills, family and significant relationships, physical health, sexual health, meaning of life and quality of life (Fusar-Poli et al., 2020). This operationalization places mental health above quality of life, or at least on a par with it.

Research and policy into the mental health of young people are often based on their self-ratings of symptoms such as headache, stomach pain, insomnia and loss of appetite. The definition of health by young people is described in terms of being individual, multi-facetted and positively phrased. It is not necessarily specified in this definition which aspects are included in the phenomena, but it involves a permeating belief that one can possess good health without necessarily being healthy (Michaelson et al., 2016). Mental health can from the perspectives of young people entail both negative and positive emotions, and younger children primarily define mental health as being based on relationships (Johansson et al., 2007). Young people thus tend to widen the scope of mental health to include both mental ill health, positive mental health, external factors and quality of life. This view of mental health, incorporating both the salutogenic and the pathogenic perspectives described above, engenders that improving mental health among young people must include both health promotive efforts for positive mental health as well as prevention and/or treatment of mental health problems. A holistic and interdisciplinary stance is called for when investigating the mental health of young people, encompassing both positive mental health and mental health problems by focusing on assets in the form of contextual support as well as more individually-based health assets (Wille & Ravens-Sieberer, 2010).

In this thesis, mental health was used as encompassing both positive and negative consequences of mental health. The concept health-related quality of life was used as it integrates both objective and subjective self-ratings of psychosomatic symptoms and outlook on life, and chosen because it has been shown to capture the quality of life perspective of health well for children

(Fayed et al., 2011). Although the term positive mental health was not specifically investigated in the thesis, optimism was, as one dimension of positive mental health.

Mental health, socio-economic and demographic factors among young people

Mental health is influenced by social determinants relating to economic, demographic, neighbourhood, environmental, and social factors. These factors act at both individual and structural levels, and have a crucial influence on mental health among children and young people, subsequently throughout life (Patel et al., 2018). In this thesis, socio-economic status (SES), gender, age and migratory background, related to ethnicity, were used for exploration in relation to mental health and health-related quality of life.

SES is one of the many converging factors influencing mental health that consistently shows an association with mental health problems. It is commonly measured by individual level indicators such as education, income or material wealth (Currie et al., 2012). There is repeated and convincing evidence of a negative correlation for adults between SES and physical and mental health (Allen et al., 2014; Marmot & Wilkinson, 1999). This correlation exists among young people as well, although it appears not to be quite as strong (Currie et al., 2008; Reiss, 2013). Likewise, the association between SES and positive mental health is not quite clear either, and whilst there is a graded relationship with increasing odds for a low level of positive mental health with decreasing SES among young people, there is less evidence for social class patterning with high SES leading to a high level of positive mental health (Nielsen et al., 2016).

Low financial status and low parental education are reported as impacting negatively on young people's mental health in both cross-sectional and longitudinal studies (Reiss, 2013; Wirback et al., 2014). Parental SES also affects young people's help-seeking positively through mechanisms such as education levels, a higher level of mental health literacy and recognition of mental health problems (Patulny et al., 2013). The issue of parental education is interesting as it has been shown that it does not impact the onset of mental health problems of young people, but has a significant impact on the persistence and severity of mental health problems, implying that parental education may be associated with improved access to mental health services (McLaughlin et al., 2011).

The demographic factors related to mental health, include sex, age, and ethnicity (Patel et al., 2018). Low SES is more strongly associated with mental health problems in the younger ages, aka children under 12 (Reiss,

2013). A theory concerning this phenomenon is the "equalisation in youth", which proposes that young people are less vulnerable to detrimental socio-economic factors but instead more sensitive to factors such as peer influence (West, 1997). Thus other factors than socio-economy and wealth may have great importance for mental health of young people, particularly as they get older, and it is suggested that additive health assets are capable of evening out health differences vested in socio-economic conditions and that having several health assets in fact appears to promote positive health (Paakkari et al., 2019). Optimism is one such health asset that seems to weaken the effect of low parental SES on perceived stress among young people (Finkelstein et al., 2007).

Research regarding gender differences in relation to SES and mental health consistently show that girls rate their mental health lower than boys (Campbell et al., 2021; Hogberg et al., 2020; Reiss, 2013). However, there appears to be a stronger association with SES and externalizing symptoms than internalizing the same (Reiss, 2013). This may be of importance since there is a recurring pattern of boys having more externalizing symptoms and girls more internalizing symptoms. On a macro-level, a recent, large investigation with over 500 000 young people in 73 countries, showed persistent but complex gender differences, with wealthier and more gender-equal countries having larger mental health gender gaps among young people (Campbell et al., 2021).

The findings of studies focusing on immigrant status and the relationship to mental health among young people are inconclusive (Belhadj Kouider et al., 2014; Stevens & Vollebergh, 2008). Some studies show that young people with immigrant background have increased mental health problems compared to the corresponding native population, particularly for internalizing symptoms (Belhadj Kouider et al., 2014; McMahon et al., 2017). Furthermore, a Swedish study reported that time trends of deteriorating mental health did not differ between native Swedish and immigrant young people, and that girls with immigrant background, similar to native girls, had higher ratings of self-rated mental health problems (Kim et al., 2020). However, other studies have shown how young people with immigrant background in fact do better than those from the native population in terms of mental health and quality of life and that migration background is in fact not the strongest risk factor for mental health problems (Belhadj Kouider et al., 2014; Stevens & Vollebergh, 2008).

The complex associations and findings hitherto regarding individual level factors such as SES and demographic factors, call for continued investigation of how young people's mental health can be enhanced.

Mental health and optimism among young people

Improving the mental health of young people requires the maximizing of protective factors – and the minimizing of risk factors (Viner et al., 2012). While SES of young people is mostly dependent on family situation, other protective factors at an individual level may be referred to as personality traits, cognitive components or learnt behaviours (Rotegard et al., 2010; Sun & Shek, 2012). From the framework of developmental assets, aiming at directing greater attention to positive developmental factors for young people, is the protective factor optimism, functioning as an individual level, resource-based health asset (Benson et al., 2011).

Dispositional optimism may be regarded as one dimension of positive mental health. It entails having a general positive outcome expectation of life and not necessarily as a belief in one's own personal competence, i.e. there is an inherent belief that something positive will happen (Wille & Ravens-Sieberer, 2010). Dispositional optimism is how people react when encountering obstacles and influences how individuals perceive themselves and their environment. Optimism encourages young people to hold out, even in the face of adversity (Carver & Sheier, 2001). Optimism may thus aid young people when experiencing mental health problems, by perceiving themselves as capable and by perceiving the environment as potentially helpful. This may in turn directly influence behaviours such as seeking help.

Optimism is said to be a personal, but affectable trait, and has been shown to influence various aspects of quality of life and health (Carver et al., 2010). Much research on the role of optimism in health has focused on clinical settings, and mainly adult populations (Rincón Uribe et al., 2020). Epidemiological data on dispositional optimism in groups of young people is scarce, although some results point to optimism being a protective factor; and some positive associations between optimism and a range of emotional outcomes have been found (Patton et al., 2011). A higher level of optimism has been associated with lower self-reported pain and improved emotional and behavioural functioning, as well as having a moderating effect on stress (Lai, 2009; Williams et al., 2010). It has also been pointed out that having an optimistic disposition facilitates successful transitions into young adult roles and responsibilities (O'Connor et al., 2017). A recent study showed that dispositional optimism accounted for a significant variation of mental health among young people (Burešová et al., 2020). Studies on optimism often include a focus on the associated risk for various mental health problems, thus using negative and pathological terms such as risks for substance abuse, depressive or anxiety symptoms, and suicidal ideation or behaviour (Ames et al., 2015; Dooley et al., 2015; Patton et al., 2011; Tanner et al., 2014).

However, studies explicitly exploring optimism as a potential health asset are scarce and increased knowledge on how individual assets such as optimism may be utilized for improving the mental health of young people is called for.

Operationalizing different dimensions of mental health

The way mental health is conceptualized also influences how mental health can be operationalized. If mental health is conceived as encompassing both negative and positive traits, then both these aspects need to be investigated and measured. Making sure that we measure 'the right things', is essential for gaining knowledge about how to promote mental health among young people. Subjective experiences and self-ratings are core features when exploring mental health (World Health Organization, 2005).

Establishing and measuring positive mental health is not as common as measuring mental health problems and few measures have been developed for assessing positive mental health of young people (Bremberg & Dalman, 2015; Scheid & Wright, 2017). Positive mental health involves several dimensions, such as emotional wellbeing, possibilities and function, while scales measuring mental health often try to reflect the more general states of well-being (Horwitz, 2017). Dimensions used for measuring positive mental health include a focus on variables and characteristics such as self-esteem, mastery, having meaningful relationships, social support and optimism (Keyes, 2017; Scheid & Wright, 2017). Positive mental health is often divided into either positive feelings or positive functioning when operationalized as subjective well-being. Different dimensions of positive mental health can be rated separately without claiming to reflect a full picture of young people' s mental health, and several dimensions or items can be added into an aggregate measure of mental health (Bremberg & Dalman, 2015). Some aspects of the widely-used measure for mental health of young people, Health Behaviour in School-Aged Children (HBSC) survey, are sometimes interpreted as positive mental health. This repeated cross-sectional survey conducted in several countries in collaboration with the World Health Organization (WHO), is often used for analysis and research (Schnohr et al., 2015).

Ratings and measures of mental ill health, mental health problems and psychosomatic symptoms are often presented as depicting mental health. There is an assumption that measuring problems is easier than measuring positive mental health, however, even when using negatively framed thresholds, mental ill health and mental disorders are difficult to define, and depend on expert consensus, or in effect, objectified, subjective measures (Whooley, 2017). The HBSC includes questions on what is referred to as

psychological symptoms; feeling irritable, low, anxious or having sleeping problems, and somatic symptoms; headache, stomach-ache, backache or feeling dizzy. Two or more symptoms, more than once a week in the last 6 months, is usually classified as poor mental health. Whether surveys and measures relying on psychosomatic symptoms truly represent young people's actual experience of mental health problems is a disputed field. It has been claimed that symptom checklists such as the HBSC create a negative discourse and reinforce a deficit model (Wickström & Kvist Lindholm, 2020). It has also been proposed that young people do not actually connect such symptoms with severe mental health problems, implying that measuring the symptoms of for example HBSC, does not depict mental health status among young people accurately.

There are no national, population-based studies or registers examining all dimensions of mental health in young people in Sweden (Bremberg & Dalman, 2015). Registers from healthcare services, where mental health problems are classified in accordance with diagnoses and treatment, are frequently used, these thus measure mental ill-health with a pathological perspective (www.kvalitetsregister.se). Apart from the HBSC, the voluntary survey LUPP (Local follow-up of youth policy) focuses on questions about living conditions and well-being and is sometimes used for aggregate reports (The Swedish Agency for Youth and Civil Society, 2017). One large cohort-sequential, longitudinal study including 10 cohorts with 9000 participants, the Evaluation Through Follow-Up, has been granted the status of national infrastructure by the Swedish Research Council, however, measures of mental health were only included from 2014 and onwards (Hagquist, 2020).

In order to cover the complexity of mental health and how positive mental health and mental health problems can co-exist, both aspects of mental health among young people need to be explored. Investigating and measuring positive attributes of mental health such as optimism may provide information that is just as essential as self-rated mental health problems. The subjective experience of mental health and mental health problems makes it essential to investigate both mental health and health-related quality of life through individual perspectives and self-ratings.

Help-seeking for mental health among young people

Whilst promotive factors may lead to the development of positive mental health, preventative or even supportive treatment resources may be needed in some instances. The most promising investment in the mental health population – particularly for young people - is acting early (Patel et al., 2018).

The fact that the help-seeking process for young people with mental problems often is delayed and filled with barriers is thus troublesome.

Help-seeking is usually described as a rational, agency-based process where the individual plans, decides and acts on symptoms (Pescosolido & Boyer, 2017). However, research also suggests that help-seeking is not only an individual act, but social influences play a major part enabling the help-seeking process. In fact, society's organizational support structures set the limits and stipulate the possibilities for seeking help (Pescosolido & Olafsdottir, 2013). Help-seeking must thus not only be regarded as a factor on an individual level, but rather a structural resource for young people.

In light of the high rate of mental health problems among young people, a corresponding high rate of help-seeking and use of support resources would be expected. However, studies show low levels for young people with mental health problems in seeking or accessing professional support, with only 13-34 % of young people with mental health problems seeking and/or accessing professional help (Gulliver et al., 2010; Rickwood & Thomas, 2012; Sourander et al., 2001; Zwaanswijk et al., 2007). Differences in the measurement, conceptualization and contexts of help-seeking make comparisons difficult, particularly since what is measured is often treatment delays for mental health disorders. However, more adults than young people seek help, with approximately 50% of adults with depression seeking and receiving help (Kohn et al., 2004; Rickwood & Thomas, 2012). The insufficiency to meet young people's needs is a recognized public health concern. There are lengthy delays before young people access support even in countries with good availability to healthcare (Hansen et al., 2021; Rickwood & Thomas, 2012). There seems to be a large variation between contexts, even where settings are supposedly comparable, implying difficulties in capturing the inherent problem with help-seeking (Eisenberg et al., 2012). Low levels of help-seeking and access to support are as common among those with more severe problems and a higher risk profile, as among those with fewer problems (Eisenberg et al., 2012). In fact, some studies indicate that as symptoms of mental health problems increase, the help-seeking intention decreases (M. G. Sawyer et al., 2012; Wilson et al., 2007). Research also indicates longer help-seeking pathways for those with a higher severity of symptoms (Hansen et al., 2021).

Research shows that a low level of help-seeking is more prevalent among males, young people who are "older" (18-25), males, those with an ethnic minority background and those with poor social support or scant economic resources (Patulny et al., 2013). A general preference for self-reliance has been found where young people first try self-management strategies for mental health problems, secondly turn to family and friends, and in some

instances to school staff (Gulliver et al., 2010; Rickwood et al., 2015; Zwaanswijk et al., 2007). On an individual level, social networks of trusted friends or family seem to be important (Gulliver et al., 2010; Rickwood et al., 2015). Parental SES affects help-seeking among young people through mechanisms such as education levels, a higher mental health literacy and recognition of mental health problems (Patulny et al., 2013). Individual level barriers preventing young people from seeking support for mental health problems seem to be stigma, a poor mental health literacy, as well as little knowledge of mental health services (Gulliver et al., 2010; Jorm et al., 2007). A low availability of care, restricted and/or delayed access, cost and a non-youth-friendly environment are among the structural barriers to support-seeking (McGorry et al., 2013; Patulny et al., 2013). The major care structure, primary care, is generally not recognized by young people as an available or appropriate institution for mental health help (Booth et al., 2004; Gulliver et al., 2010). Age is also a barrier whilst most healthcare structures divide young people sharply into children vs adults at the age of 18, it is unclear whether they are equipped with the help-seeking skills needed in order to navigate the system and access professional support (Booth et al., 2004; Gulliver et al., 2010). It thus appears that the support "system is weakest at the point where it needs to be strongest, namely the transition between late adolescence and young adulthood" (McGorry et al., 2013, p. 30). School is pointed out as an important arena and gateway, a structural factor providing support for young people. However, counsellors and teachers commonly have limited influence in improving the access to appropriate structures for mental health problems (Zwaanswijk et al., 2007). The enabling capacity of school, is particularly troublesome for "older" young people since most leave school at the age of 18-19 and are thus not able to utilize this structural resource.

Society faces difficulties providing easy, accessible access to mental health care and support services despite the previous research on help-seeking. Because social determinants play an important role for young peoples' help-seeking for mental health problems, difficulties in accessing healthcare or support may contribute to mental health inequalities (McAllister et al., 2018). Considering the previous predominant focus on quantitative methods, on attitudes and intentions towards help-seeking, and on individual choice and action, it is essential that the perspectives of young people are explored through their own experiences of help-seeking, incorporating their perspectives of structural resources and availability.

Theorizing and measuring help-seeking

Help-seeking is a widely-used and researched term for understanding delays in treatment and exploring possible pathways for mental health promotion. There is not just one model of help-seeking but many, which is similar to many other areas of studies within the health and social sciences. The concept analysis of help-seeking behaviour displays the theoretical basis of the original models, stating that the concept help-seeking represents an intentional action to solve a problem that poses a personal challenge (Cornally & McCarthy, 2011). The concept is said to be characterized as being a complex process with three inherent antecedents; problem recognition and definition, decision to act and selection of help source. The definition emphasizes that the efforts of the help-seeker are active and intentional. The individual is generally faced with challenges, firstly recognizing and defining personal problems, moving towards forming an intention to seek help, subsequently having to navigate through complex support structures but ultimately ending in contact with a third party (Cornally & McCarthy, 2011). Research on help-seeking is often based on psychological models of rational choice (Pescosolido & Boyer, 2017; Rickwood & Thomas, 2012). Three sociologically-based theories have been dominant in the help-seeking/service use field; the Sociobehavioural model (Andersen, 1995), the Health Belief Model (Rosenstock, 1966) and the Theory of Reasoned Action (Ajzen, 1991). Although revised versions of all three models have incorporated policy and outcomes, they are inherently concerned with individual-level factors. The Sociobehavioural model stipulates three basic categories of predictors; predisposing characteristics, enabling resources and need, where need is the ultimate factor that eventually leads the individual to act. The Health Belief Model focuses on the individuals' health beliefs, preferences, experiences and knowledge - all ultimately affecting individual decisions to seek care. The Theory of Reasoned Action focuses on motivations, assessment of risk, and avoidance of negative outcomes, eventually ending in the individual evaluation of whether or not to seek support. All three models share the assumption that individuals 'decide' to seek support, that help-seeking is an active and voluntary action, involving the individual weighing pros and cons before making a decision (Pescosolido & Boyer, 2017).

Help-seeking can also be conceptualized as social process, acknowledging the fact that onset, recognition and response are embedded in social networks where help-seeking individuals are not sole actors, making rational choices based on symptom recognition (Pescosolido & Boyer, 2017). The Network-Episode-Model is relevant in this context, as it applies a view that dealing

with health problems is a social process managed through various networks (Pescosolido & Boyer, 2017). Regarding help-seeking as a social process means that help-seeking is seen as influenced by social, psychological and contextual factors and the decision to seek help is neither a solitary, nor a logical process. WHO, noting the absence of a clear and agreed definition of help-seeking among young people, suggests the following:

> "Any action or activity carried out by an adolescent who perceives herself/himself as needing personal, psychological, affective assistance or health or social services, with the purpose of meeting this need in a positive way. This includes seeking help from formal services – for example, clinic services, counsellors, psychologists, medical staff, traditional healers, religious leaders or youth programmers – as well as informal sources, which includes peer groups and friends, family members or kinship groups and/or other adults in the community. The "help" provided might consist of a service (eg, a medical consultation, clinical care, medical treatment or a counselling session), a referral for a service provided elsewhere or for follow-up care or talking to another person informally about the need in question." (Barker, 2007, p. 49).

According to this definition, informal help-seeking may also be part of the concept. In this thesis, help-seeking refers to formal help-seeking and formal support, which in accordance with the WHO is defined as health facilities, youth centres, formal social institutions or professional care providers (Barker, 2007).

Most studies examining help-seeking for mental health, use a cross-sectional design on general community, or school, populations. Studies are often based on surveys, and have a descriptive character (Rickwood & Thomas, 2012). Standardized measures are not commonly used in studies investigating help-seeking and many studies seem to develop their own unique measures (Rickwood & Thomas, 2012). The two most used measures are the Attitudes Toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970) and the General Help Seeking Questionnaire (Wilson et al., 2005). The former scale measures a general attitudinal orientation towards seeking help, whereas the latter investigates both future intentions of seeking help and past experiences. Measuring attitudes and intentions appears to be as common a feature as measuring actual previous help-seeking behaviour in research (Aguirre Velasco et al., 2020). The rationale for this is presumed to be that intentions tend to be both reliable and consistent predictors of particular behaviours (O'Connor et al., 2014). This may provide an easy avenue with recruitment from general, often school-based populations, that act as a foundation for research into help-seeking among young people. However, others propose that the strength of associations between attitudes, intentions and behaviour is generally weak

(Rickwood & Thomas, 2012), implying that we need to do research with those who have experience of help-seeking.

Despite substantial research, help-seeking and service use remain low, and thus, it seems that current conceptual frameworks do not facilitate help-seeking behaviour of young people (Eisenberg et al., 2012). Non-help-seeking is often conceptualized as a series of barriers rather than as a process linked to social context and healthcare services (Martínez-Hernáez et al., 2014). In order to understand the nature of the process, we must acknowledge contextual factors for mental health and the help-seeking process. Access to mental healthcare and support services may not only be dependent on the individual as such, but how the individual perceives the context is crucial. Therefore, exploring user experiences and perspectives seems essential. Consequently, in this thesis, help-seeking is conceptualized as a process rather than consistently rational, individual decisions. A view on help-seeking is applied, where the context is vital, and help-seeking can only take place in relation to the support system.

Mental health services in Sweden

Help-seeking and mental health among young people are unconditionally dependent on context, in this case the support system. In order to understand the help-seeking process among young people, it is essential to have a perception of the support system, and how it works. Several reports in Sweden have stated that the mental healthcare services for young people in Sweden are fragmented, available through a variation of support structures with a lack of national coordination or directive (SOU 2021:34). The accessibility to mental health support is unequal, and there is a variation in how successfully mental health needs of young people are met. A foundational support service is the school-based health service, with all young people who attend school, being granted this access (The National Board of Health and Welfare, 2012). The school health service takes a preventative and health-promoting stance and is responsible for students' medical, psychological, psychosocial and special education needs (Nordic Centre for Welfare and Social Issues, 2016). The school-based health service provides an important environment for seeking support but has become increasingly focused on supporting difficulties in school and students' development towards educational goals (SOU 2021:34). Moreover, most young people leave school at the age of 18-19 implying that the school support does not last throughout the whole period of being young.

Swedish care and support services for mental health problems primarily consist of "First Line" (Uppdrag Psykisk Hälsa, 2015a). The establishment of

“First Line” began to evolve in the beginning of year 2000. The purpose of First line care is to facilitate access to care for parents, children and adolescents. Regional and local authorities have a joint responsibility in ascertaining proper facilities and covering relevant ages. It is not specified through which structures this should be available, but rather various actors and environments such as regular healthcare, the school and the social services are involved. Shouldering of the responsibility in offering proper, easy and accessible care and support services thus varies. Reviews have shown an unclear structure of supportive services, but common entities within First Line are Primary Care, Child and Adolescent Mental Health Services (Barn- och Ungdomspsykiatrin, BUP) and Youth Clinics (SOU 2021:34). Primary care is part of First Line with a responsibility to provide support and care to young people with mental health problems. Youth clinics are an optional commitment at local or regional level without clear and uniform guidelines from national authorities. They lack common rules, regulations or requirements regarding accessibility, availability and quality of care (The National Board of Health and Welfare, 2009). BUP is the mental healthcare and support service providing specialist psychiatric care for young people up to 18 years. Other mental healthcare and support services for young people in Sweden are voluntary initiatives by various organizations, some are represented on-line or through phone-services (Nordic Centre for Welfare and Social Issues, 2016).

Swedish reports show that existing care and support services do not reach young people with mental health problems (SOU 2021:34; Uppdrag Psykisk Hälsa, 2015a). Young people express that they do not receive enough – if any – support or care (The Swedish Agency for Youth and Civil Society, 2015). They state that their problems are regarded too lightly and that they most often, in both constructive and destructive ways, try to cope with their mental health problems themselves since support is not available and/or suited to their needs (Children’s Right in Society (BRIS), 2020). Only 15,7% of contacts with First Line, in a national survey 2014, were initiated by young people themselves, and only 30% of these contacts with First Line were by boys/males (Uppdrag Psykisk Hälsa, 2015a). The proportion of males who visits youth clinics are usually 10% yearly (The Swedish Society for Youth Centres, 2018). International research confirms this picture, stating that groups with a particularly low rate of help-seeking seem to be, among others, boys (Patulny et al., 2013). Primary care is generally not regarded as a place to turn when experiencing mental health problems (Gulliver et al., 2010). Support is said to be suited to adults, young people express they lack influence over support and care and they are affected negatively by the organization of the support (Children’s Right in Society (BRIS), 2020).

Young people have little knowledge on where to turn to access help, they are unsure of whether they can seek support themselves or if their parents need to be involved (Children's Right in Society (BRIS), 2020). Young people are often de facto dependent on parental support and involvement for executing their right to seek support. This is evident in First Line services geared at minors under 18, where only 2% initiated contact themselves (Uppdrag Psykisk Hälsa, 2015b). Existing supportive environments thus often fail to grant the rights of the young. It has been noted that few and inadequate resources are allocated and available for the group of young people in need of psychosocial support and mental health care (Uppdrag Psykisk Hälsa, 2015a). This implies that those at risk of developing severe mental health problems are left on their own, and that the importance of early intervention for the promotion of mental health and prevention of mental health disorders is overlooked (Patel et al., 2018).

Rationale

Mental health among young people is a public health priority and regarded as a fundamental human right (Patel et al., 2018). Research indicates that mental health problems among young people have increased in the last 20-30 years (Bor et al., 2014; Hagquist et al., 2019; Potrebny et al., 2017). Despite extensive research about the mental health of young people, there is a knowledge gap concerning which resources and factors should be focused on to support the mental health of young people (Hagquist, 2020). The multitude of determinants and complex associations impacting on young people's mental health, ranging from socio-economic determinants to individual resources and the structural context, complicates the issue (Patel et al., 2018; Wille & Ravens-Sieberer, 2010). Mental health problems are often defined as the individual's problem, with a focus on lifestyle and behavioural change (Katikireddi et al., 2013). However, by defining mental health as a health asset that enables positive states of wellbeing and functioning (Patel et al., 2018), a shift from a pathological view of mental health to a resource-based perspective, lifts the focus from the young person's problems and deficiencies. A health assets' approach focuses on positive health assets, and also ascribes due importance to the fact that individuals act within the structure and context of society (Garcia-Moya & Morgan, 2017).

The perspectives of young people themselves are necessary for addressing the process of help-seeking. By contextualising young people's experiences in the local context, a greater understanding of their needs may enable tailoring support to their needs (Christensen, 2004; Wickström & Kvist Lindholm, 2020). Therefore, health promotive and preventative efforts must start by identifying needs and potential resources in the local context. Exploring social determinants, dispositional attributes and the help-seeking process with a health assets' perspective, thus aids the creation of more nuanced understanding of mental health of young people and how it can be supported.

Overall aim

The overall aim of this thesis was to explore individual and structural health assets in relation to the mental health of young people.

The specific aims were:

- To explore the association between socio-economic determinants and self-rated mental health among Swedish young people.
- To explore optimism and pessimism as a bidimensional construct, it's impact on health-related quality of life and possibility to function as a health asset for promoting well-being among young people.
- To explore the process of seeking professional support for mental health problems among young people.
- To examine literature on mental health help-seeking among young people, with a particular focus on exploring young people's own perspectives as well as to validate and further develop a previously developed theoretical model describing help-seeking among young people for mental health problems.

Theoretical frameworks

Young people

Being young today can last a long time, and for how long is debatable. A variety of definitions and conceptual portrayals of this age group are thus evident. WHO defines adolescence as the ages of 10-19 years, youth as the ages of 15-24 years and the overlapping term young people for ages 10-24 (World Health Organization, 2014a). The Lancet Commission on Adolescent Health and Wellbeing also defines young people as being between 10-24 years, however interchangeably uses the term adolescence for the same population and age group (Patton et al., 2016). The term 'young people' is consistently used in this thesis, encompassing the ages of 11-25 years. Being young is a transitional period of time, entailing identity-forming issues, and the development of both physiological, cognitive, social and contextual domains, influencing the mental health of young people (Arnett, 2004; Patel et al., 2007). Endpoints are often less clearly defined with a large variation in achieving adult roles and responsibilities, including employment, financial responsibility and a life partner (Patton et al., 2016). The development of health for young people is dependent on favourable conditions, conducive to mental health. The WHO strategic document "Investing in Children: The European Child and Adolescent Health Strategy 2015-2020" stipulates that public health policy needs to balance the risk and protection focus and activities so that young people can develop skills, competencies and ultimately a robust mental health (World Health Organization, 2014b). Young people are traditionally depicted as helpless 'adults in the making', lacking capabilities and health (Wyn & Harris, 2004). However, young people are increasingly seen as proactive in their own development, in which case it is essential to reconceptualize the view of young people as being capable. The Lancet Commission on Adolescent Health and Wellbeing claims that the voice of young people needs to be strengthened for the identification of health issues to make a higher quality of mental healthcare possible by developing appropriate solutions and interventions (Patel et al., 2007; Sawyer et al., 2012). Exploring the experiences and perspectives of

young people is a prerequisite for adjusting research and policy to contemporary developments.

Seeing the bigger picture through systems theory perspectives

Social inequalities in health may be defined as systematic differences in health between different groups within society (Whitehead, 2007). Whilst being socially produced, they are potentially avoidable. This is the underlying perspective and reason for interest in the social determinants of health, namely, that society, policymakers and health workers, have a possibility to enhance health and decrease health problems among groups. In order to gain a comprehensive view of young people's mental health, determinants at both individual and structural level need to be investigated. The findings can then be conceptualized with the help of different theoretical models. This thesis utilizes two models to address the understanding of, and to depict the complexities of the phenomena. The studies performed within the thesis themselves, also add to the empirical knowledge base of the models.

Lifestyle and social determinants of health

This thesis was carried out within the academic field of Health and Lifestyle. This field is defined as interdisciplinary at Halmstad University, focusing on both individual-level factors and structural factors. Structural factors and mechanisms generate inequalities and differences in societies, define the socio-economic status of individuals, ultimately affecting power, access to resources and health (World Health Organization, 2010). Within the framework of social determinants of health, the biological/behavioural, material, and psychosocial factors as well as the health system are regarded as social determinants (World Health Organization, 2010). Several of these determinants are explored in this thesis; the material factors through socio-economy, the psychosocial factors through optimism and aspects of the health and support system for mental health through the help-seeking process.

Lifestyle choices, resources and limitations are all imbedded in the social determinants of health (Marmot & Wilkinson, 1999). In effect, the strongest determinants of the health of young people are structural factors; national wealth, income inequality and access to education (Viner et al., 2012). The social context and structure surrounding the individual thus strongly affects choices pertaining to health and lifestyle. However, both policy and research

have traditionally depicted health differences as problems belonging to individuals (Katikireddi et al., 2013) and there is tension in regard to whether lifestyle is mostly a matter of individual choice or dependent on structural factors (Cockerham, 2005; Korp, 2010). Viewing lifestyle as being exclusively dependent on individual behaviour and choice can be regarded as unacceptably reductive, whilst ignoring the importance of structural factors (Korp, 2010), rather, lifestyle as well as health are created in the interplay between structural context and individual choices (Cockerham, 2005). It has been a guiding principle in this thesis that mental health of young people takes place within a social context and is dependent on structural factors and social determinants. Complimentary approaches regarding the views about young people's mental health have inspired the use and incorporation of two models in this thesis; the European Health Development Model (EUHPID) (Bauer et al., 2006) and the Health Assets' Model (Morgan & Ziglio, 2007).

The Health Development Model – conceptualizing the complexity

The EUHPID Health Development Model was developed to provide a theoretical basis for a planning tool to identify, implement and evaluate public health and/or health promotion interventions related to both pathogenic and salutogenic approaches (Bauer et al., 2006). The model is grounded in a system theory perspective where health develops in an ongoing interaction between the individual and the environment. Using the EUHPID model in this thesis is an attempt at conceptualizing the complexity of mental health development and promotion, establishing a theoretical framework for the different studies of the thesis. An individual can, at least partially, influence her environment and thus mental health, however, persisting differences in health status are largely due to unequal distribution of structural determinants (Bauer et al., 2006). Health is not created nor lived in isolation but rather dependent on different factors at both individual and structural level. The model incorporates health as a multidimensional concept, based on the WHO definition distinguishing between three different dimensions of health; physical, mental and social health. Just as interaction between the individual and the environment is ongoing, the different dimensions of health are also highly interdependent. The model shows the web of relationships and interactions between different dimensions of health, determinants at various levels, and incorporates both salutogenic and pathogenic perspectives. Individual determinants of health are physical, mental and social, whereas environmental determinants are social, ecological and economic. The right side of the model depicts the pathogenic approach with its focus on protection

and prevention from risk factors and care of ill-health. A pathogenic perspective in mental health entails focusing on treatment of mental disease and illness and associated risk factors for developing a psychiatric condition. Health protection mainly focuses on structural factors and the reduction of risk factors within the context despite overlapping and being complementary, whereas health prevention focuses on risk factors at an individual level, pertaining for example to traditional lifestyle interventions and indicators of socio-economic status. The left side of the model outlines salutogenesis with its focus on health promotion and orientation towards resources and positive health (Mittelmark et al., 2017). Salutogenesis focuses on promotive factors, and how support and resources may lead to the development of positive health such as enhanced mental health and wellbeing. Positive health in this model includes subjective wellbeing, optimal functioning, having a meaningful life and a positive quality of life (Bauer et al., 2006).

Positive health and ill health are placed at different ends in the EUHPID model, however, this is interpreted as a purely graphic depiction. As stated in the description of the model, both analytical perspectives are simultaneous, complementary and interacting processes, accredited equal importance (Bauer et al., 2006). Ill health does thus not exclude positive health, and risk-factors as well as resources are equally important for the enhancement of young people's mental health.

Figure 1 below portrays an incorporation and modification of the Health Development model and the Health Assets model. Both are placed within a systems theory embracing the view that health is a multidimensional concept, developing through an interaction between individual and structural factors (Bronfenbrenner, 2004). A common ground in these two frameworks is that we need to be aware of the difference in the theoretical basis of pathogenic and salutogenic approaches when planning, implementing and evaluating public health and health promotion interventions. The health assets approach acknowledges that pathological perspectives are sometimes called for but focuses primarily on salutogenic resources, thus the merge overlaps the Health Development model partly. By changing the perspective from risk and illness (pathogenic) to a health assets approach (salutogenic), two objectives are reached; firstly, focus turns towards resources and strengths for health, and secondly, a systems theory is used, turning focus to both individual and structural factors, and their interdependence, as prerequisites for health. Thus, by using a health assets approach, focusing on individual level factors, maximising individual resources such as optimism and other capacities might be aimed for, whilst a focus on structural level would direct attention to the questions about optimizing health services most efficiently.

Figure 1 presents the studies in the thesis in relation to one another as well as to major concepts within the two models. Resources and assets for mental health are the predominant focus in this thesis. Studies II, III and IV thus use an explicit health assets perspective, exploring both individual determinants of mental health through dispositional optimism and individual resources in help-seeking, as well as structural factors in the help-seeking process. Study I may traditionally be referred to as having a focus on risk-factors at individual level through the study of socio-economic status. However, the results may also be interpreted through an assets based 'lens', as potential resources for mental health promotion among young people.

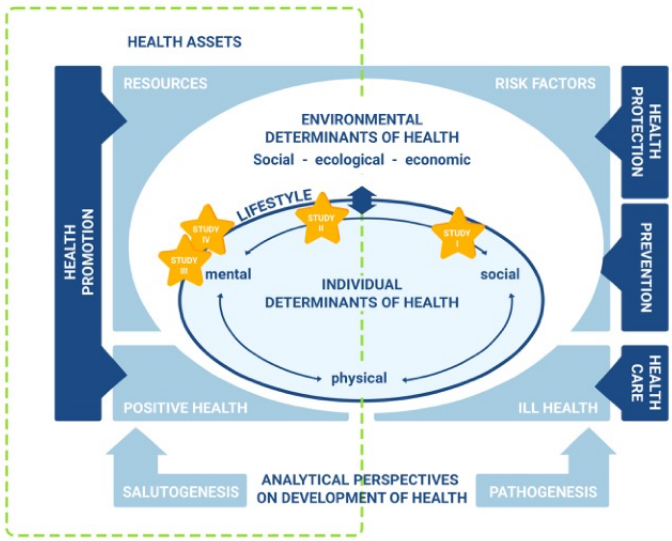

Figure 1. Incorporation and modification of the EUHPID Health Development model and the Health Assets' model

The Health Assets model – changing the perspective

By using a Health Assets model in this thesis, focus is directed on potential resources that may enhance mental health among young people. This model focuses on potential assets and capacities for creating health, and aims to understand the factors that make young people do and be well (Morgan &

Aleman-Diaz, 2016; Morgan & Ziglio, 2007). In comparison, public health work is traditionally based on epidemiological studies on causes and distribution of disease and early death. Since detrimental social determinants do not affect all individuals in the same negative way, and may in fact be counteracted by protective social factors (Braveman & Gottlieb, 2014), the disease prevention model, targeting morbidity and mortality, can be substituted with an asset approach, focused on improving general health and wellbeing (Morgan & Ziglio, 2007). An asset model of health is regarded as a system, which creates positive paradigms for building on young people's own resources, thereby promoting self-development and activity regarding health-related issues (Morgan, 2014). Using a systems theory means rethinking actors in relation to organizations and specifically how people are involved in decisions regarding their own health (Carey & Crammond, 2015). Applying a Health Assets model therefore means that we strive to understand the factors that help young people remain healthy even when they are subject to stressful events and circumstances.

The term 'health assets' has been used in different health disciplines; psychiatry, psychology, nursing and public health, focusing on slightly different aspects of health (Rotegard et al., 2010). The concept displays a variety of operational definitions, but is usually grounded in salutogenesis, emphasizing positive resources or enhancers (Van Bortel et al., 2019). Psychosocial, developmental, environmental, religious and promotive aspects, mainly relating to the individual level, are used as well as perspectives mainly focused on socio-economic factors (Rotegard et al., 2010). A division between internal and external health assets can also be seen, and sometimes referred to as microlevel vs macrolevel health assets. Internal or microlevel assets are usually regarded as individual skills and competencies, values, dispositions, as well as positive strength characteristics expressed through personality and attitude (Benson et al., 2011; Rotegard et al., 2010; Van Bortel et al., 2019). Individual resources and capacities are important, however, the assets approach extends the view of resources/assets to, not only individuals, but also groups and society (Van Bortel et al., 2019). Macro level or external assets are attained from: positive relationships with the community or organizations/institutions with community level assets relating to participation and support from community or one's social context such as family, neighbourhood and physical environment whilst policy, structural factors and health systems relate to the organizational/institutional level (Morgan & Ziglio, 2007). This way different levels for health development are incorporated. Protective factors can operate both within individuals, communities, organisations and systems such as networks for better health, preferably in an integrated manner. Due to the inherently

intrinsical nature of health, it does not suffice to place emphasis on the individual actor alone and the asset model makes this clear (Carey & Crammond, 2015).

The concept of health assets is imbedded in a framework of positive research, including salutogenesis, positive psychology and the potential of social capital, as well as the need for participatory involvement of individuals and communities (Morgan & Aleman-Diaz, 2016). Health assets as defined for young people's health are;

> "A health asset approach is a system which creates positive paradigms for building the capacities of young people to be active in their own development and strengthens their ability to connect to a range of networks that facilitate health and wellbeing gains for themselves and for others" (Morgan & Aleman-Diaz, 2016, p 2).

The salutogenic and systemic influence on the health asset model is thus evident, and with it follows the focus on positive factors for mental health rather than risk factors for disease (Mittelmark et al., 2017). Health assets are cumulative, and research has shown that an increase in health assets renders positive outcomes exponentially with comparable effects across gender, race/ethnicity, geographic residence and socio-economic background (Benson et al., 2011; Paakkari et al., 2019). Investigating mental health through a health assets approach, entails asking questions about important resources for young people's mental health and how can they be used to reduce health inequalities and enhance mental health. Even though an assets approach emphasizes the salutogenic and health-enhancing factors, it does acknowledge that in some instances, stress, disease and vulnerabilities of people bring forth needs of treatments and immediate services, thus, acknowledging the complimentary traditional, deficit model (Morgan & Ziglio, 2007).

Health assets interact at various levels, but exactly how and which health assets that constitute a link between individual health and community development is unclear (Van Bortel et al., 2019). Similarly, most studies on health assets are based on theoretical assumptions rather than robust evidence and further evidence-based work needs to be done to demonstrate the utility of the asset model (Morgan & Aleman-Diaz, 2016).

The Health Assets' model in this thesis was utilized as a general, theoretical framework, inspiring and influencing the research. Potential health assets are studied through the individual-level factors dispositional optimism, socio-economic status and individual resources affecting help-seeking. Previous research indicates that the help-seeking process is less than optimal, seeking support is thus also studied with the perspective that the

support system is a social determinant of health and a potential, structural health asset. Support structures and the help-seeking process are explored from a user perspective and both individual level and structural level assets are incorporated in the thesis.

Method

Ontology and Epistemology

Critical realism was utilized as a theoretical and philosophical starting point when writing this thesis. Critical realism cannot be described as either ontology or methodology but rather as a meta-theoretical position concerned with providing a philosophically informed account of science and social science, in turn informing our empirical investigations (Archer et al., 2016).

Critical realism presupposes that there is a reality independent of its observer and aims to map the ontological character of social reality - the facts and events we are concerned about examining (Archer et al., 2016). Although critical realism is not usually referred to as a systemic theory, it is undoubtedly so (Mingers, 2011). Critical realism sees reality as layered (realist ontology) and seeks to explore causative mechanisms for what is experienced and observed. It asserts that we cannot answer questions purely on the basis of empiricism, by examining factors through our five senses, thus knowledge is relative and filtered through an interpretive lens (constructionist epistemology). It acknowledges that individuals make meaning of their experience within a social context affecting those meanings, all within limits of material 'reality' (Braun & Clarke, 2006). Another principle of critical realism is that even though knowledge is relative, we may produce strong arguments for beliefs and theories (judgemental rationality) (Bhaskar, 2017).

Through critical realism, a deeper understanding is sought by exploring not only the empirical, but the actual and the real domain (Bhaskar et al., 2018). Phenomena within the reality are thought to hinge on various mechanisms, thus understanding requires the study of different contexts and mechanisms and the relations between them (Alvesson & Sköldberg, 2017). Critical realism encourages a holistic exploration of phenomena, advocating multiple research methods and interdisciplinarity (Bhaskar et al., 2018). Interdisciplinarity incorporates several academic disciplines and increases knowledge of phenomena and processes of relevance to both individuals and society. Thus, no particular approach or empirical investigation is stipulated, but a methodological pluralism is endorsed, furthering both explanation and interpretation. A focus on both causation, structures and processes through

the combination of statistical analyses and more in-depth methods is necessary to achieve an understanding of the complexity and heterogeneity of the social world (Archer et al., 2016; Danermark et al., 2003). The research was thus designed to include both quantitative and qualitative methods.

As variables are thought to exist in a reality that can be studied and, at least to some extent, measured, objectified measures of mental health and social determinants have been used in the research. An inherent problem with this approach is how to make comparisons between individual perceptions and experiences. Mental health is such a concept, rendering different descriptions and expressions in different contexts, societies and timespans (Hacking, 1999). Individuals may refer to a range of phenomena when using the term mental health. They may describe mental health differently and despite, to an outside observer, living under similar circumstances, they may rate their experienced mental health differently. To some extent, the dilemma may be avoided if the standpoint is used that the social sciences do not attempt to predicate development. Health-related concepts, such as mental health, are thus often used for comparing groups and evaluations of causality. The scientific starting point in this thesis is the view of mental health as a social construct, dependent on a complicated array of factors and mechanisms at different levels, affecting young people in a way that they may not have the capacity to remedy themselves, thus the necessity of including factors of both individual-level and structural level affecting mental health.

Experiences and perspectives of young people have also been studied, recognizing that both those being studied, and the researcher, will inevitably contribute individual perceptions. Reality is mediated through thinking and theories, and our knowledge about reality is both historically, socially and culturally situated (Archer et al., 2016; Chalmers, 2013). Scientific knowledge is developed within conceptual frameworks, and for this, we use theories, aiding our understanding of the world, helping us observe, interpret and draw conclusions. Furthermore, our representations and perspectives are limited and dependent on both context, concept and activity (Archer et al., 2016). A researcher cannot be independent and objective, but will influence research through personal experiences, pre-understanding and theoretical knowledge (Houghton et al., 2012). Collective paradigms influence what we are able to perceive, how we may perceive, and not least how we interpret what was perceived (Alvesson & Sköldberg, 2017). My own interpretations and limitations will thus have guided the research.

The studies in this thesis pertain to all three domains of critical realism. SES, signs and symptoms of mental health and mental health problems, optimism and help-seeking are all present at the empirical level of reality, we can experience and measure them. However, they also belong to the actual

domain, where they are events and effects that have been caused by the activation of causal mechanisms at the real domain, for example, an unresponsive support system might cause mechanisms of non-help-seeking. By using critical realism as a starting point, the complexity of mental health is illuminated and the importance of using different methods for exploring help-seeking and mental health is recognised.

Setting

Studies I, II and III were all set within a local context in a Swedish municipality, Halmstad. Sweden is considered a highly developed country with a good supply of resources in terms of social support structures, schools, healthcare etc. Halmstad has a high ranking in terms of affluence in national comparisons. When the material for Studies I and II was collected in autumn 2011, Halmstad had a population of 92 000 inhabitants and a local economy characterized by small and medium-sized companies. Halmstad is the main town in the municipality with approximately 62 000 inhabitants. In 2011, approximately 14% of the population were foreign-born (country average 15%), the unemployment rate was 7% (slightly higher than the country average 6.5%), 8% of the inhabitants received sickness benefits or equivalent (compared to the country average 7%). Approximately 4% of households received welfare benefits compared to the country average 6.5%. There were 34 public and four private schools. A societal major change was the influx of immigrants seen primarily in 2015, rendering a total of 19,4% of Halmstad's inhabitants being born in a foreign country in 2020, which is comparable with the country average. The Covid-19 pandemic is also likely to have affected both the community of Halmstad and its inhabitants but as all the studies in the thesis were performed before the pandemic, it had no influence on the results.

Support services in Halmstad between 2017 and 2019 were primarily organized according to the First Line principle. Apart from the school health services, joint responsibility for the mental health of young people was held by several support services, including primary care/general practitioners, and BUP offering specialist psychiatric services with a regional phone-service for triage, interviews, counselling, and treatment. A decision was taken in 2014 at local level to dismantle the psychiatric and psychosocial health care clinic, "Ungdomspsykiatriska mottagningen" (Region Halland, 2014). This decision was taken at the same time as national policy documents specified increased efforts for mental health, with particular focus on children and adolescents. The function of this clinic was officially held by the general Youth Clinic, although no assets in the form of staff or financial resources were transferred. The Youth Clinic was available for young people between the ages 13-23, presenting with issues of sexual orientation, relationships, venereal diseases, contraception as well as mental health problems. A youth clinic run by the Swedish Church organization was also initiated in the autumn 2016 offering supportive communication.

Design

A design containing both explorative and descriptive elements has been used in the thesis. Different perspectives on potential health assets for young people's mental health was sought by the use of both quantitative and qualitative methods.

Table1 Overview of the methodological framework

	Method	**Participants /sample**	**Instrument and data collection**	**Data analysis**
Study I and II	Quantitative method, cross-sectional survey	948 young people 11-16 years old, divided into two age groups. Recruited from seven schools.	Questionnaires: MMQL-PF FAS GESS	Descriptive analyses, regression analyses, Chi-square, independent Student's t-test, Mann-Whitney
Study III	Qualitative method	13 young people, 15–23 years old.	Open-ended individual interviews.	Constructivist Grounded Theory according to Charmaz (2014).
Study IV	Scoping review	585 young people	Methodological scoping review framework proposed by Arksey and O'Malley (2005), further developed by Levac (2010).	Thematic analysis according to Braun & Clarke (2006).

Quantitative studies (Studies I & II)

Quantitative methods with surveys and a cross-sectional design were applied in Study I and II. The aim in Study I was to examine the distribution of mental health among young people in terms of gender and age and to analyse this in relation to sociodemographic and socio-economic factors. The bi-dimensional concept of optimism and pessimism and its association with health-related quality of life was explored in Study II. In both studies the same survey material, collected in schools in 2011, was utilized.

Participants and data collection

Seven municipal schools were selected and invited to participate in the study due to them being centrally located in Halmstad and having more than 100 pupils (aged 11-13 years and 14-16 years). A total of 50 classes were invited. One class in the older age group opted out of participation. Young people between 11-13 years of age were defined as the younger age group and those 14-16 years old were defined as the older age group. A sample of 24 classes with pupils in the younger age group (n=536 pupils) and 25 classes with pupils in the older age group (n=576 pupils) were included. A total of 948 respondents (467 pupils in the younger age group and 481 in the older age group) agreed to participate and completed the questionnaires (response rate 87% and 84% respectively). The principal at each school approved participation. Prior to the study being carried out each school distributed written information to children and their parents about the purpose of the research, that participation was voluntary and that children who declined to participate could return blank questionnaires without being asked why. Questionnaires were distributed in each class following a brief introduction by the research team. Completed questionnaires were returned by each respondent directly and collected by the authors, except for two schools where the teachers distributed and collected the questionnaires in return envelopes for each class. The study sample comprised a total of 447 girls (48.7%) and a total of 470 boys (51.3%). The age groups were evenly distributed, 49.7% and 50.3%. 58 and 60 surveys respectively were omitted due to incomplete data. The total number of surveys thus amounted to n=830. This method is common in comparable research (Lauder et al., 2010) with a perceptible strength in terms of a high level of response frequency (Fowler, 2014).

Measurements

The instrument Manchester Minneapolis Quality of Life scale (MMQL) was used to measure mental health and health-related quality of life in Studies I and II (Bhatia et al., 2002; Bhatia et al., 2004). MMQL is available in two age-adapted versions and contains questions covering a number of domains. The MMQL-youth form consists of four quality of life domains; physical symptoms, physical functioning, psychological functioning and outlook on life, in total 32 items. The MMQL-adolescent form consists of seven quality of life domains; physical functioning, cognitive functioning, psychological functioning, body image, social functioning, intimate relations and outlook on life, in total 45 items. The domain "psychological functioning" (MMQL-PF) was used for measuring self-rated mental health in Study 1. This domain contains items with questions on how often you feel sad, angry, lonely and afraid, have anxiety for dying, anxiety for your health in general, and 'don't feel as good as others'. In the older age group, three more questions are included in the domain on how often you feel anxious and nervous, strong and healthy, and tired during the day. Responses were; never, seldom, sometimes, mostly and always. The instrument was originally developed to assess the self-rated health of young people with cancer, but reliability and validity have subsequently been tested with 'healthy' young people as well. Both versions of the MMQL have good psychometric characteristics and have been translated and validated in a Swedish context (Einberg et al., 2013). The MMQL was chosen due to the positive phrasing, i.e. expressions of positive health rather than ill health were generally emphasized. In study II, the aggregate measure of MMQL (all domains) was used for measuring health-related quality of life.

The socio-economic status in young people is commonly measured by indicators such as household income or family wealth, parental education, parental occupation (Reiss, 2013). The Family Affluence Scale (FAS) was used to measure socio-economic status in Study I. FAS is a resource-based indicator of SES, regularly used in work and research on young people due to it containing variables that young people can account for (Currie et al., 2008). Questions about having one's own bedroom, holidays, computers and cars within the family are answered, rendering a score between 0-9. Despite it being a relatively recent scale, some of the items can already be considered slightly out of date; for example, what constitutes a computer nowadays? A smartphone, an Ipad, a PS4? Another relevant issue is the fact that within societies with predominantly high socio-economic ratings, very few of the population rate lower scores, thus making differences harder to discern (Currie et al., 2008; Reiss, 2013). Sociodemographic factors on gender,

parental marital status and migration background were also included in the analyses.

An age-adapted version of The Generalized Expectancy for Success Scale (GESS) was used in Study II (Fibel & Hale, 1978; Fischer & Leitenberg, 1986). GESS measures optimism and pessimism as a bi-dimensional construct, by evaluating respondents' expectations of success in particular situations. Results show that GESS has reliability over time and a high level of internal consistency (Hale et al., 1992) as well as convergent validity compared to similar scales (Steed, 2002). The version used for young people has several items removed compared to the original 30 questions in the GESS-scale and includes 27 statements with an opening phrase of; "In the future I expect that I will…". The original response options of the scale had been adapted for use among children with the dichotomized responses of true or false, which was based on research within this age group (Fischer & Leitenberg, 1986).

Data analysis

The two age groups were examined separately in Study I and II, and statistical significance was assumed at $p < .05$. Mean (standard deviation), minimum and maximum values, and numbers (proportions) were used for descriptive purposes. Internal non-response was calculated according to Little's MCAR test, showing missing data was completely at random and representativity was presumed. Imputation was considered but not used due to the high response rate.

Logistic regression analyses were used to analyse the data in Study I. MMQL was used for measuring self-rated mental health in Study II, utilizing the domain Psychological functioning with the MMQL. The total score of self-rated mental health was calculated for each individual, and with a mean value for age and gender groups. The groups were dichotomized based on the scores of self-rated mental health within the group - below mean represented worse self-rated mental health and scores above mean a higher self-rated mental health. Results were reported as odds ratio (OR) with 95% confidence intervals (CI). Dummy variables were included for each school in the model in order to compensate for data being clustered. T-tests were performed to compare self-rated mental health between different age and gender groups. FAS was used in three different ways in the analyses; item-level, i.e. every item was used in the analyses for association with self-rated mental health, by comparing different FAS-levels to one another (8-9 compared to 7, 6, 5, 4, 0-3), and finally the composite FAS score, dividing the answers into groups 0-5 p=low FAS, 6-7=medium FAS and 8-9 high FAS. The FAS groups were

organized to reflect the relatively wealthy municipality rendering generally high ratings, in accordance with other studies (Currie et al., 2008). The association between self-rated mental health, FAS and parents' migration and marital status were analysed with chi-square.

Health related quality of life (HRQoL) was measured by the MMQL score in Study II and computed by summing the scores for each subscale and item and dividing the sum by number of items in the questionnaire. Higher scores were dichotomized into above mean (high) and below mean (low) scores. Optimism and pessimism were measured using the GESS scale. All negatively answered items were rated as 0 and positively answered items were rated as 1. Higher numbers indicated higher levels of optimism and pessimism respectively. The model included five manifest independent variables (gender, parents' marital status, family country background, optimism, and pessimism) and HRQoL as the manifest dependent variable. Chi-square, independent Student's t tests, and Mann–Whitney were conducted to compare dependent and independent variables between age groups. School affiliation and cluster were adjusted for by including dummy variables for each school in the regression model, with students representing Level 1 and schools representing Level 2. Multivariate logistic regression models were used to calculate the associations between self-rated HRQoL, optimism, and pessimism in two models, the first including gender as a covariate, and the second including gender, parents' background and marital status as covariates. Optimism and pessimism scores were categorized according to age-specific quartiles into four groups in the regression models. The statistical analyses were carried out using SPSS statistics version 20.0 (IBM, New York, USA).

Qualitative study (Study III)

Design

A qualitative design with an explorative approach was used in Study III. Open-ended interviews with young people were analysed with constructivist grounded theory methodology. Grounded theory (GT) with a constructivist approach was chosen because of its focus on actions and processes, and its aim to develop theoretical analysis and the goal of informing policy and practice (Charmaz, 2014). Grounded theory is used as an inductive method when the aim of the research is to generate a theoretical base for understanding the studied phenomena. Using the method means to seek and

learn about processes both from a social and a psychological perspective, taking into account historical, cultural and social constructions. Assumptions on which individuals construct meaning and actions are explored. It also means that the researcher tries to see the context and existing structures and hierarchies of power, networks and relationships in which the processes take place. The studied individuals are regarded as the foundation of the processes. The relationships between different systemic levels are thus explored (Charmaz, 2014).

Participants and setting

Recruitment was performed via two local support services providing mental health support for young people; the Ecclesiastic Youth Clinic opened in autumn 2016 and the established general Youth Clinic run by the regional healthcare services. These clinics both provide services where young people can initiate contact themselves and book appointments. The regional Youth Clinic is open for ages 13-23. Its remit is to work with health promotion primarily in the areas of reproductive health and mental health, the latter through supportive and counselling talks. The Ecclesiastic Youth Clinic is open for young people aged 14-25 and they are welcome to present with any issues. Professional support is available for young people through therapeutic and supportive counselling, free of charge. The interviewees were twelve females and one male ranging from the age of 15 to 23. A mental health assessment was not carried out, and the primary inclusion criteria were solely met by the young persons' own perspective of experiencing mental health problems and seeking help. The range of problems and the timespan in which they had experienced difficulties was wide. Some of the participants had experienced mental health problems for years while others only for a few months.

Data collection

The interviews were performed between March 2017 and May 2019. The staff who met the young people acted as recruiters and "gate-keepers", checking the inclusion and exclusion criteria and presenting written information about the study for the first time. The young person who showed interest was asked to complete a form stating her/his interest in participating, and this form was passed on to the researcher without the recruiter being aware of the content. If the young person expressed an interest in participating in the study, the researcher tried to contact her/him soon after finding out and a meeting was set up. The researcher presented an overview of the research

project and provided an opportunity for the potential participant to ask questions at this meeting. It was carefully explained that participation was voluntary and could be terminated at any time. Informed consent was obtained in two copies prior to the interviews. The parents of the participating young person were not informed.

The interviewees were asked broad, open-ended questions and allowed to tell their stories (Lewis, 2015). The interviews were performed at the clinic's premises, or sometimes at a nearby psychiatric outpatient's clinic. The interviews began with an open exploratory question asking about experiences concerning seeking support. The researcher used an attitude of openness, in order to encourage the perspective of the interviewee to be expressed freely and to find the main concern of the interviewee (Morse et al., 2009). Themes of interest were the processes that take place in the temporal sequence leading up to young people seeking, and utilizing, professional support. The interviews lasted between 45 and 90 minutes. They were audiotaped and transcribed by the researcher. Participants were also asked to complete background data on age, gender, migratory experience, living arrangements, main activity (whether they were students, working etc) and a subjective assessment of wealth. Sampling continued until similar themes kept re-emerging and saturation was reached (Charmaz, 2014).

Data analysis

A constant comparison of the collected qualitative data for sorting and comparing concepts and categories is used in a GT study (Charmaz, 2014). Data are analysed as they are collected, and this analysis guides future sampling (Charmaz, 2014; Lewis, 2015). The coding and analysis thus started as soon as the first interview was carried out and continued throughout the study. The material from the first interviews were examined line by line, and incident by incident, and coded with initial coding through close examination of the data. Focused coding was subsequently employed, using the most significant and frequent initial codes, advancing the theoretical direction. A selection of transcripts and coding was reviewed and discussed with the research team, modifying the interview guide slightly to allow for further exploration. New interviews were compared to previous data and coding. The categories in turn were sequentially grouped together, conceptualized to a higher theoretical level and thereby developed into a number of core categories. As grounded theory provides a non-linear research process, in some instances the focused codes were compared and sorted into theoretical codes and subsequently conceptual categories, exploring how initial and focused codes relate, in others, the synthesizing of data went straight from

focused codes to conceptual categories. The findings were corroborated by a researcher joining in the process towards the latter stages. This researcher had particular expertise in grounded theory and undertook an individual analysis in order to crosscheck findings, which were then discussed. The written and the recorded material was reviewed several times, thereby providing an in-depth understanding of the participants' experiences. Memos were kept throughout the data collection process. The analysis and data collection are performed simultaneously in accordance with the methodology and the constant reflection and memo-taking are used to enhance analytical thinking, allowing the development of more theoretical codes and tentative categories. The program NVivo was used to assist with data management.

Scoping review (Study IV)

Design

Study IV was performed as a scoping review, in which a broad window is maintained for inclusion and a broad area of interest is responded to rather than focusing on a specific research question or evaluation of clinical interventions (Arksey & O'Malley, 2005; Tricco et al., 2018). This scoping review used the methodological framework originally proposed by Arksey and O'Malley, further developed by Levac (Arksey & O'Malley, 2005; Levac et al., 2010).

Data collection and data analysis

Framework stage 1; identifying the research question

The broad aim was to examine literature on mental health help-seeking among young people, with a particular focus on exploring young people's own perspectives as well as to validate and further develop a previously developed theoretical model describing help-seeking among young people for mental health problems. The target population of interest was defined as young people with experience of mental health problems, and/or experience of help-seeking for mental health problems, thus entailing that a user perspective was sought. Mental health problems were defined as referring to commonly experienced problems of depression and anxiety as well as behavioural and emotional problems. Considering the concept of help-seeking, the term is used for understanding the delay of care and to explore possible pathways for mental health promotion. Conceptually, help-seeking

behaviour was regarded as a process influenced by social, psychological and contextual factors (Pescosolido & Olafsdottir, 2013). The specific objectives of the research were to: 1) map general characteristics of published literature where the perspectives of young people seeking help for mental health problems were in focus, 2) synthesize the knowledge of the help-seeking process from the perspectives of young people and 3) validate and present the previously developed theoretical model of "Lost in space" describing help-seeking among young people for mental health problems in accordance with the recommendations of the developed scoping review model (Levac et al., 2010).

Framework stage 2; identifying relevant studies

The search strategy was developed with the help of a health librarian. Three health related databases were included: Medline/PubMed, PsycINFO and CINAHL. Searches for studies in English between 2010-2020 were performed. The search terms used subject heading terms where possible, adapted to each database. Search terms were designed to reflect the target population (adolescents/adolescence, young adult, children, teenager, emerging adulthood, young), the health outcome of interest aka variations of mental health and mental health problems (psychosomatic problems, emotional problems, behavioural problems, depression, anxiety, psychological distress, suicidal ideation, self-injurious behaviour, self-destructive behaviour) and the concept of interest aka help-seeking (combined with behaviour, attitudes and characteristics). The searches were conducted during summer 2020.

Inclusion and exclusion criteria

Studies were eligible for inclusion if they investigated help-seeking among young people with mental health problems between 11-25 years of age. Studies had to deal specifically with young people's own perspectives, experiencing or having experienced mental health problems and/or help-seeking. A broadening of the inclusion criteria to also encompass those with mental health problems but no experience of help-seeking was an attempt to discover whether there were any published studies where the researchers had managed to investigate non help-seeking behaviour.

Studies on particular groups/populations were excluded since the intention was to capture help-seeking amongst the target group of young people with mental health problems. For example, studies on treatment interventions for young people with a diagnosed disorder and/or interventions delivered in clinical settings were excluded. Similarly, studies where help-seeking attitudes or potential help-seeking intentions among a general population

without personal experience of the issues of interest were excluded. We also aimed to focus on a particular age group, which entailed that studies that did not specifically focus on young people, i.e. studies with a more population-based perspective, encompassing wider age groups were thus excluded. At least 90% of the population was stipulated to be within the intended age limits of 11-25 in order to be included. Theses, comments, editorials, consensus statements and other opinion-based papers were excluded as well as studies solely exploring the perspectives of others than the help-seekers themselves (families, helpers, professionals etc).

Framework stage 3; study selection

All identified studies from the database searches were imported to EndNote and duplicates removed. Screening was carried out with a sequential, stepped approach, and an iterative process involving the research team (Levac et al., 2010). Firstly, titles and periodically abstracts were screened by KHW who discarded obviously irrelevant studies based on the exclusion criteria of age, content (as in not dealing with help-seeking), specific populations or not dealing with the young people's own perspective. In the second step of study selection, abstracts were screened independently by three members of the research team (KHW, PS, MN) to determine eligibility based on the defined inclusion and exclusion criteria. In the third step of study selection, KHW examined the full-text articles of the remaining articles to determine eligibility. This full-text examination was discussed with all members of the research team. Disagreements between the reviewers were discussed with a fourth reviewer (JN).

Framework stage 4; charting the data.

Data charting was performed in accordance with the scoping review standards, using a developed form for the extraction of information from each study concerning; authorship, year of publication, journal, source of origin, design, population and age group, aims of the study, methodology, and important results (Arksey & O'Malley, 2005; Levac et al., 2010). A descriptive numerical summarization presenting the extent, nature and scope of included studies was done (Levac et al., 2010).

Framework stage 5; collating, summarizing, and reporting results

In order to synthesize the knowledge and aggregate findings from the included studies, a qualitative thematic analysis was included (Levac et al., 2010). A thematic analysis, with an abductive approach, was used (Braun & Clarke, 2006; Raholm, 2010). The previous grounded theory study of help-seeking among young people for mental health problems; "Lost in Space"

(Westberg et al., 2020) was used for the deductive process in the analysis. A categorization matrix was developed from this theoretical model emanating from properties of themes in the original subcategories and categories.

The analysis began with reading the findings in the included articles several times, then identifying and inductively coding text and quotes in relation to the research questions of the study (Braun & Clarke, 2006). In this phase, data was inductively scrutinized to discover patterns, experiences, expressions and perspectives with codes being close to the data. The deductive process involved going back to the data and placing the inductively derived codes into themes and subcategories of the theoretical model. Codes that did not match the theoretical model subcategories, contributed with new aspects to existing themes of the model and in some cases, generated new themes, broadening the understanding of help-seeking for young people with mental health problems. KWH performed the data analysis and to enhance the quality and validity of the analysis, the data analysis was discussed continuously within the research team.

Ethical considerations

Research ethics and guidelines have been consistently considered throughout the project and adjusted in accordance with the prerequisites of each study. A reflexive engagement needs to be practiced when doing research considering issues of the necessity of the research in relation to harms and benefits, previous experience of both researcher and young people that can affect the research, assumptions about what it is to be young, and issues of power (Powell et al., 2013). The ethical principles for research originally stem from the Declaration of Helsinki, safeguarding the wellbeing of individuals partaking in research. The principles also include non-maleficence and beneficence, information and informed consent, and the right to confidentiality (World Medical Association, 2013). A researcher should constantly balance the benefits and the potential risks for participants undertaking the research. Safeguarding the individual comes before the interests of the research and researcher (Swedish Research Council, 2017). Extra vigilance should be taken when the research concerns vulnerable populations and participants such as children (Powell et al., 2013).

The United Nations Convention of the Rights of the Child draws attention to the protection and provision of the rights of children and young people, but also stipulates that young people have a right to agency and participation (Office of the United Nations High Commissioner for Human Rights, 1989). In order to attain an increased relevance for the research, it is important to explore young people's perspectives and experiences, not least in terms of questions about healthcare that concern them directly (Clarke, 2015). A guiding principle when involving young people in research is that they will somehow be able to benefit from the research they participate in, focus is thus particularly directed towards beneficence (Alderson & Morrow, 2011). By enabling young people's participation in the public discussion and the process of decision-making, both the principles of justice and beneficence for young people, as well as increased validity for future health promotive work, particularly in regards to organization, structure and resources, are possible (Powell et al., 2013).

Research on sensitive personal information needs to be approved by an Ethical Board in Sweden (SFS 2003:460). Ethical approval for Study I and

II was obtained from The Regional Ethical Board (Reg.No. 2013/55 and Reg.No. 2016/1003). Study I and II were both based on the same data from a cross-sectional survey. The survey was undertaken in a school setting, and the principles of autonomy and confidentiality were regarded as it was emphasized that participation was voluntary and confidentiality guaranteed (Powell et al., 2013). Written information on the voluntary nature of the upcoming survey was sent to the guardians of the young people prior to the questionnaires being administered in the different schools. All the young people were initially informed when the questionnaires were to be administered that completing the questionnaires was voluntary and optional and that no questions would be asked if they declined to complete any information. They were also comprehensively informed about the aim of the survey, how their answers might contribute to developing a survey on young people's health-related quality of life and optimism, and how this survey would be used for the evaluation of a local intervention. The participants had a possibility to return a blank questionnaire without it being evident, being as the questionnaires were placed in envelopes and then handed to the researchers. It has to be considered that the administration of a survey in a classroom might reduce the degree of voluntarism, through the presence of staff and researchers encouraging participation, and from peer pressure.

The Regional Ethical Review Board in Lund, Sweden granted formal approval for Study III (Reg.No. 2017/29). Consent by the legal guardians for participating in scientific studies is required for young people under the age of 15 (2003:460). Approval for Study III was first sought for the inclusion of young people from the age of 13, without the consent of legal guardians. The rationale for this was that young people can on their own seek mental health support from the Youth Clinic at the age of 13. This request was not approved by the Regional Ethical Review Board, and approval was instead granted for the inclusion of young people from the age of 15 without the consent of their legal guardians. This is correct in terms of the Swedish legislation and it is reasonable to think that the Board considered the benefits from including young people under the age of 15 were insufficient in relation to the exposure to possible risks and that sufficient information could be obtained from the participants from the age of 15. However, the fact that a group of young people were excluded from voicing their concerns and relating their experiences, because they were not old enough, is worth considering.

According to the principle of informed consent, comprehensive oral and written information were provided to the participants prior to the interviews (Swedish Research Council, 2017). Interested young people were given ample time to consider participation due to the sequential, two-step recruit-

ment strategy. The young person was first briefed orally about the study at the youth support service and then given written information. The young person was asked to note in this written information if she/he was interested in participating. The professional supporter was unaware of the response, there was thus according to the requirement of right to utilization no risk that the young person's access to, or quality of support was affected (Swedish Research Council, 2017). The information was subsequently passed on to the researcher who tried to contact those young people that had indicated an interest in participating. Some who had noted an interest in participating did not answer when contact was attempted. This was interpreted as the young person having a change of mind. The aim of the study, the data collection and retention of material, and how the results were to be used for publication was explained at the time of the interview. The young person was informed about possible advantages and disadvantages, as well as how participation was voluntary with a possibility of withdrawing consent. No consent was withdrawn at the time of the interview, nor later. An effort to make the interviewees feel safe and comfortable was made during the interview, with a preparedness to provide advice about external support. Performing research with vulnerable groups, such as children or patients, always actualizes a notion of power. Power is nested in the social representations of roles and functions, thus being 'the researcher', 'the professional' and 'older' would have reinforced the interviewees notion of lacking control and power whilst being 'younger, 'a patient', and 'the one with problems' (Christensen, 2004). Being the interviewee generally leaves little room for engaging in a critical manner towards the researcher and it was therefore important to follow the young person in a careful and respectful manner. The open-ended approach to the interviews allowed the interviewees to elaborate or avoid certain topics. They were very open and eager to share their stories, which resulted in long interviews with great detail. It is, however, important to note that the research questions were the core concerns and interests in the research, and were, at least not initially, a concern and interest to the young people (Christensen, 2004).

Both anonymity and confidentiality are essential, ethical principles when performing research on humans (World Medical Association, 2013). A researcher must safeguard the integrity and the right to privacy of the individual participants. These issues were considered for Study I and II where no names or personal identity numbers were collected, identification was thus not possible. During the in-depth interviews with young people in Study III about personal experiences, particular care was taken to honour confidentiality and protect participants' identities by not providing information or quotes that could be associated with any individuals. The measures taken to

prevent the divulging of sensitive information was described to the young people as the fact that no data, at this point, would be shared with others outside the research group. The raw data of both the survey and interviews were kept securely locked at Halmstad University, and only the interviewer/researcher had the possibility to link the interviews to individuals.

Results

This thesis explores health assets at individual and structural levels in relation to mental health among young people. The studies focus on health assets at an individual level i.e SES and sociodemographic factors (Study I), dispositional optimism (Study II) and individual resources for help-seeking (Study III and IV), whilst health assets at the structural level were explored through the experience and perceptions of young people's help-seeking process (Study III and IV). The main results of each study will be described in the following chapter.

Socio-economic status and mental health (Study 1)

In order to achieve the overall aim of the thesis to explore individual and structural health assets in relation to young people's mental health, an understanding of mental health and SES among young people from a local perspective was sought. The findings showed no statistical differences between SES of boys and girls, including parents' marital status and parents' migration status. Self-rated mental health decreased with age for both boys and girls. In a comparison of self-rated mental health between groups, girls rated their mental health significantly lower compared to boys, both in the younger age group and in the older age group. The findings showed a complex pattern, often at item level, of associations between SES and self-rated mental health, diverging between groups. The individual level factor of parents' marital status did not indicate an increased risk for self-rated mental health below mean for either gender or age group, however, girls in the younger age group with parents born abroad had a lower risk for self-rated mental health below mean. Boys in both age groups seemed to exhibit a greater risk of self-rated mental health below mean when having several risk factors (low family affluence, divorced parents, migratory background), whereas there was no such association between SES and girls' self-rated mental health. Self-rated mental health was the subscale with the lowest mean score in the younger age group, compared to the other subscales in the health-related quality of life instrument, whereas in the older age group the physical

and cognitive functions had the lowest mean scores in the health-related quality of life instrument.

The main findings of this study were the association between SES and boys' increased risk for low self-rated mental health, boy's mental health being susceptible to an accumulation of risk factors, and parents' migratory status affecting younger girls' self-rated mental health positively. In conclusion, individual SES may not be a self-evident asset for mental health among young people, and other factors should be investigated as potential resources for mental health promotion of young people in affluent communities.

Optimism and mental health (Study II)

Optimism and pessimism as a bi-dimensional construct were explored as potential individual level health assets in Study II. There was no difference between the age groups (11-13 and 14-16) in terms of gender, family structure and migration factors. Young people in both groups were optimistic about their future with high ratings of optimism and low ratings of pessimism. There was a significant decrease in optimism and a significant increase in pessimism with age. Significant differences were also seen in health-related quality of life between the two age groups with the older age group having lower ratings. There were significant differences between the two age groups regarding the subcategories of mental health, physical function and outlook of life in the health-related quality of life instrument, with the highest mean scores for the younger age group and decreasing mean scores in the older age group. Young people in both age groups who reported high levels of optimism were more likely to report higher levels of health-related quality of life compared to those reporting lower levels of optimism, even when controlling for gender, parents' marital status and family country background. Likewise, those who reported high levels of pessimism were more likely to report lower levels of health-related quality of life.

In order to further explore the possibility of optimism to function as a potential health asset, optimism and pessimism ratings were divided into different levels and the association between high levels of optimism/low levels of pessimism and high vs low health-related quality of life was explored. The associations between high levels of optimism and high levels of health-related quality of life, as well as between low levels of pessimism and a low level of health-related quality of life remained significant. In analyses adjusted for gender, the associations persisted in the younger age groups, but in the older age group an impact on the relationship between

optimism and health-related quality of life was seen. When adjusting for both parents' marital status, family country background and gender the associations persisted in both age groups. In conclusion, optimism was a factor associated to health-related quality of life among young people, and may have the potential to function as a health asset, thus providing an additional approach for mental health promotion.

Help-seeking for mental health (Study III and IV)

The support system, regarded as a structural factor for young people's mental health, and individual resources as potential health assets were explored in Study III and IV. This was carried out by investigating the process of help-seeking for mental health problems from the young people's own perspectives. The findings showed that help-seeking was a dynamic and psychosocial process without sequentially fixed stages, where young people expressed an unfamiliarity and insecurity, lack of knowledge of mental health issues, a longing for self-reliance and in some contexts, a presence of stigma. Young people did not apprehend the support structures as responsive or available. The results implied that young people had a sense of powerlessness in relation to their experienced problems and the support system when a systems perspective was utilised.

The results from Study III, according to the constructivist grounded theory method, generated a theoretical model of help-seeking which was subsequently elaborated, incorporating results from Study IV, see figure 2. The model describes the help-seeking process with individual and structural aspects on both experiencing mental health problems, available support and receiving help. The process of help-seeking consists of three categories; Drifting, Navigating and Docking. The process is non-sequential, with young people describing how they move in between the three categories during a prolonged period of time. Young people with mental health problems are met with a fragmented support system, producing a feeling of drifting, navigating through the support system for accessing adequate support, and eventually docking – finding support.

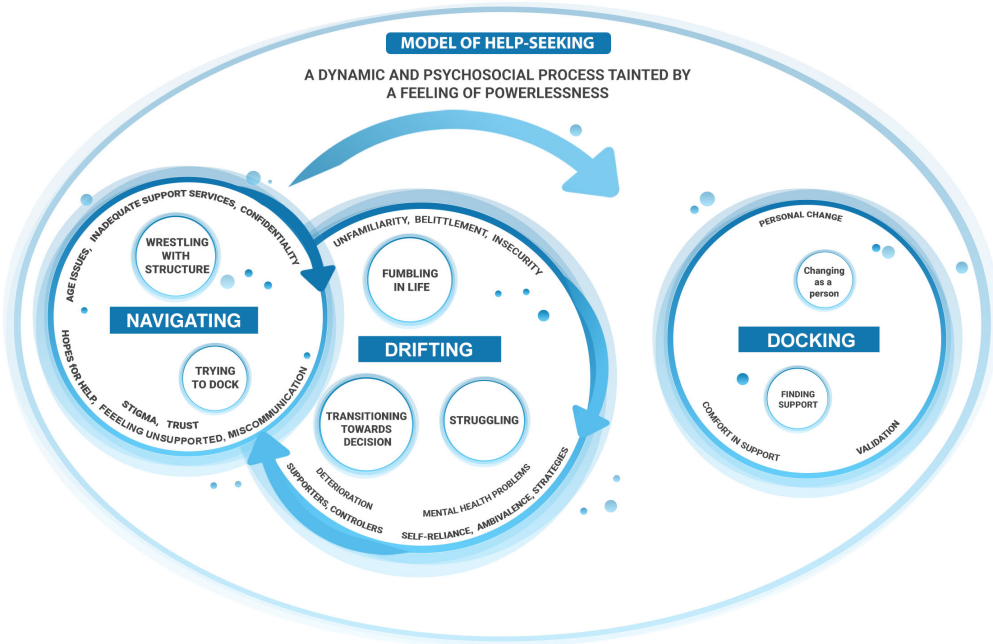

Figure 2. Theoretical model of the help-seeking process

Drifting involved three subcategories; *Fumbling in life, Struggling and Transitioning towards decision*, depicting the period in time before actual help-seeking initiatives were taken. *Fumbling in life* meant individual difficulties such as unfamiliarity, not recognizing oneself, feeling different and not knowing what was going on with a direct reference to not having enough knowledge of mental health or mental health services. The young people expressed a general feeling of unfamiliarity and a lack of knowledge regardless of the help-seeking context, which often led to a sense of insecurity, and belittlement of experiences. Belittlement was done by young people whilst trying to normalize their experiences, expressing that they were not ok, but doubting that their problems were sufficient to warrant getting help. From a health assets' perspective, knowledge may then function as a resources, reducing unfamiliarity and increasing self-confidence.

The subcategory *Struggling* entailed symptoms of mental health problems, loss of function and employing a multitude of strategies to cope with experiences. Strategies were more or less continual and relentless attempts to deal with mental health problems and could be labelled according to type and character being destructive/constructive, or approach/avoidant. A strong wish for self-reliance when facing mental health problems was consistently

emphasized by young people with descriptions of wanting to be strong, trying to cope on one's own, having a sense of responsibility to manage one's life and mental health problems. This longing for self-reliance was sometimes particularly strong where the person had previous experiences of mental health problems and mental health support. Consequently, a wish self-reliance was identified as a potential health asset, containing positive expressions of wanting to cope. Some of the findings suggested gendered traits in the help-seeking process. However, this was inconsistent as issues of self-reliance were found, not only among males, but across different genders. Having a sense of ambivalence was common, both towards admitting to having mental health problems, but also to seeking help. Young people expressed simultaneous and contradictory feelings and thoughts towards both themselves and their problems, others and help-seeking per se. They were often hesitant to seeking help, whilst at the same time expressing a need and a longing for help.

The subcategory *Transitioning towards decision* in the category of Drifting entailed descriptions of how a decision to seek professional help was eventually reached. Such a decision could be either sudden, or slowly evolving. The importance of significant others was found. Significant others coached, supported, guided or took control over the help-seeking process, which was in some instances perceived as being negatively controlled, for example by school or legal measures, and referrals to support services appearing as punitive rather than helpful.

The help-seeking process was also described as a period of time with attempts at finding support, personal reflections, hopes and longings and encountering structural barriers, thus forming the category **Navigating**. This contained the subcategories: *Trying to dock* and *Wrestling with structure*. The subcategory *Trying to dock* focused on the experiences, hopes and desires of receiving help. The results showed how young people hoped to receive help, but also many examples where they were not helped, not recognized, treated like a child and not taken seriously. They described miscommunication as a lack of understanding and discrepant focus in between young person and supporter. Young people claimed they were not understood, and in some cases they did not understand the supporter. The importance of reformulating negative and medical terminology to positive and informal terms emerged from the young people's perspective. The results showed how support was perceived as instrumental rather than person-centred, with negative references to professionalism and a reliance on medication, indicating the importance of trust. There were poor expectations regarding therapeutic outcome, signaling a lack of trust in professional supporters, perceiving treatment as impersonal and protocol-driven. A lack of trust was depicted as

arising from limited prior contact, from anxiety about seeking help, from concerns about professional competence and negative perceptions of professionals whereas familiarity facilitated the help-seeking process. In all, young people expressed a feeling of being unsupported with continued efforts to seek support elsewhere. The results also showed that in some contexts, young people had a strong sense of shame about seeking help, perceiving it as a display of weakness. Fear of social consequences, ridicule and a longing to fit in made young people describe a feeling of shame, embarrassment, thoughts of what others would think and say and efforts to conceal both mental health problems and help-seeking.

The results showed how young people often encountered difficulties in the help-seeking process, and the subcategory *Wrestling with structure* entailed descriptions of obstacles in the process, ranging from unhelpful guardians, age-limits for support, issues of confidentiality, to structural issues of a fragmented support system. Being a minor was as an obstacle both in independently accessing help, and also in assumptions and apprehensiveness that confidential information would be communicated to parents. There was ample material on what was perceived as inadequate support services, with references to structural obstacles such as access, waiting times, resources, an inadequate chain of support, and a lack of coordination between supporters. Young people voiced feelings of not being met by professionals in an appropriate and timely manner, how they were passed on whilst being referred to other supporters with reference to diagnostic thresholds or not being the 'right' medical specialty. There was also a perceived lack of resources making access difficult. Support use was described as inconsistent, with repeated attempts at initiating and discontinuing help. Primary care was usually not regarded as suitable option for seeking support.

The material also included some, albeit fewer, results concerning the latter part of the help-seeking process, aka the category **Docking**. In Docking, the subcategory *Finding support* was described as positive experiences of being validated, accepted, recognized and listened to. The importance of comfort of support and initial positive contact was emphasized. There were also descriptions of negative outcomes and unwanted consequences from having sought help, such as social services becoming involved. The subcategory *Changing as a person* entailed descriptions of positive personal development, finding a more positive outlook on life, sometimes with references to own determination and decisiveness.

The help-seeking process, based on the findings in Study III and IV, was thus described with references to both individual factors and resources, or a lack thereof, as in having a sense of shame, a lack of knowledge, a strong desire for self-reliance and the experience of having mental health problems.

The whole process was tainted by structural limits and a lack of resources, where young people regarded help-seeking as difficult and support structures as largely unavailable, unresponsive and fragmented.

Methodological reflections

Quantitative and qualitative research stem from different paradigms and views of the world. The methodology, the results as well as the quality criteria for evaluating quantitative and qualitative research thus usually differ, however, both aim at achieving trustworthiness (Polit & Beck, 2010). Specific quality criteria have been developed for the different methods within each paradigm for the assessment of research in order to ensure trustworthiness and the criteria may thus vary. The studies of this thesis can therefore be evaluated by using different criteria. However, all the studies were based on the notion that those who are affected by a policy, should also be involved in the research leading up to policy decisions. This has meant that young people were seen as proactive in their own development, and is in line with the United Nations Convention on the Rights of the Child (Office of the United Nations High Commissioner for Human Rights, 1990), the Lancet Commission on Adolescent Health and Wellbeing (Patel et al., 2007), and a general development of thinking that young people are experts on their own lives (Bradbury-Jones & Taylor, 2013). Acknowledging young people as capable agents, entitled to rights to be heard, has brought forth changes for research and researchers. Young people are seen as active, rather than passive, and research is carried out with, rather than on, young people (Alderson & Morrow, 2011). Young people were seen as active participants in Study III, while there was no more involvement in Study I and II than young people's perceptions being heard.

Trustworthiness in quantitative studies (Study I and II)

Statistical analyses are an important tool within the social and health sciences, where it has sometimes been expressed that numerical regularities are the closest thing to causal explanations and predictions (Rosenberg, 2016). However, numbers are not worth anything without them satisfying the stipulated quality criteria of reliability and validity, i.e. whether our data are trustworthy, can be repeated and are relevant (Polit & Beck, 2010). The issue

of external validity refers to generalizability and the extent to which results from a study can be applied in other contexts and to other groups (Kazdin, 2010). Study I and II were situated in a local context of an affluent society, and the results have to be regarded with this in mind.

The internal validity refers to the confidence of the tested causal relationship being trustworthy and not influenced by other factors or variables (Polit & Beck, 2010). This was considered from several angles. A cross-sectional method was used in Study I and II and although this is useful for studying the impact of independent variables on dependent variables, such analyses do not determine causality and limits the assertion of direction (Altman, 1992). A longitudinal study would have provided more data on change, and possibly a greater understanding of causality between the variables. Statistical significance was assumed at $p < 0.05$ in the analyses, which is a commonly used value. However, this must be regarded as a limitation since the p-value does not reveal anything about the effect size, context or the difference between the different associations (Ivarsson et al., 2015). There is no defined standard for least acceptable response rate, but rates between 50-60% are not uncommon (Fowler, 2014). Our response rate was considerably higher and the reason could presumably have been the method of administering surveys in the classrooms. The external non-response rate was 14%, mainly due to absence from the school on the day when the data was collected, and the internal loss was 17%, due to incomplete answers. Because the informants where anonymous, there was no possibility of performing a non-response analysis. There is no knowledge as to why students were absent from school, however, it is likely that some of the absence would have been due to health issues including mental health problems. This may have affected the results.

An inherent validity issue with using self-report instruments concerns which information we can actually obtain. The HBSC serves as an example of this, as it measures psychosomatic symptoms which are commonly interpreted as mental health problems, but may actually illustrate what young people refer to as ‘everyday problems’ (Wickström & Kvist Lindholm, 2020). Another issue with using similar instruments, is of course the fact that no answers or results will be obtained unless they are asked for and included in the survey. The risk of missing relevant information seems obvious. However, the instruments used in the studies are commonly accepted and widely used. The variables used in the studies were based on ontologically, subjective measures, i.e. phenomena exists because they are experienced by individuals or groups, and direct translations of experience; mental health, health-related quality of life and optimism (Maul, 2018). The MMQL instrument, and the domain psychological functioning (PF) was used for

measuring self-rated mental health In Study I (Bhatia et al., 2002; Bhatia et al., 2004). Although this instrument was originally developed for children with cancer, it has been tested to work with 'healthy' children and young people as well (Einberg et al., 2013). Participants were recruited from various contexts/schools, for the studies, and certain steps were taken to safeguard internal validity. Dummy variables were included for each school in Study I in the model in order to compensate for data being clustered (Rice & Leyland, 1996). The model was then forced to predicate the same value on the dependent variable, whereas the independent variable could vary. The dummy variables thus functioned as confounders, reducing potential variation between schools. The participants were level 1 and the schools were level 2 in the multilevel analyses in Study II, and an intra-class correlation test was performed to ascertain whether differences between groups were related to school-affiliation. In order to acquire a clear difference between groups, those who were dichotomized to below or above mean of self-rated mental health. The scores were high in all groups, a common effect when measuring quality of life that may lead to a decreased sensitivity of the instrument (Fayers & Machin, 2007). Using a different cut-off point for self-rated health might have been possible; however, this would have meant that power was lost in the analyses. A previous study had shown validity for extracting the factor psychological functioning through psychometric testing, Cronbach's alpha 0,81 in the younger age group and 0.83 in the older age group (Einberg et al., 2013). No further testing of the instrument was carried out.

FAS was used to measure affluence and SES from a material point of view (Currie et al., 2008). It was originally developed in 1997, and revised a few times to reflect changes in leisure patterns and technological developments until its final version in 2001/2002. It is to be noted that FAS is not bias-free, for example, the number of cars and the possibility of having an own bedroom may vary according to rural/urban domicile (Currie et al., 2008). FAS may be criticized for rapidly becoming obsolete due to changing conditions in society, and particularly the vast transformation with smart phones. Sweden is an affluent society, and Halmstad is a wealthy municipality, and so the cut-off points for FAS were adjusted to not lose power in the analyses. This made differences between individual and sub-groups harder to discern, which was a limitation. FAS thus has its limitations but also the positive attribute that young people can report on the sought variables. FAS was therefore used in the light of difficulties obtaining valid measurements from young people on variables such as parental education and occupation.

In order to study dispositional optimism, the bi-dimensional instrument GESS was used for measuring both optimism and pessimism (Fibel & Hale,

1978). The GESS was chosen because it had previously been adapted for self-reports by young people, focusing on future expectations for personal success and allowing for the simultaneous existence of both optimism and pessimism (Fischer & Leitenberg, 1986). This instrument had previously been validated internationally, but not been psychometrically tested in Swedish conditions. In order to address reliability issues, internal consistency was measured through Cronbach's alpha for both optimism (0.70-0.82) and pessimism (0.64-0.69). The fact that Cronbach's alpha for pessimism was lower may be explained by a fewer number of questions for pessimism than for optimism (Tavakol & Dennick, 2011). A forward-backward translation of the instrument was performed, as well as a face validity analysis by experienced researchers. In order to rule out conceptual overlap between measures of optimism, pessimism and the subscale Outlook of Life in the MMQL, Spearmans' correlation was used to assess collinearity, but no such collinearity was found.

Trustworthiness in qualitative studies (Study III and IV)

Qualitative studies seek answers to the questions of how, what and why (Bourgeault et al., 2013). They help us understand human experience by focusing on social processes and practices. It is stipulated in qualitative research that people perceive situations and phenomena differently, thus in effect, perceive reality differently (Malterud, 2011). This is also in line with critical realism, where a deeper understanding is sought, and knowledge is regarded as something constructed by both the researcher and the participants (Bhaskar, 2017). Achieving a greater understanding of such perceptions, experiences and behaviour may help to address phenomena that relate to the use of healthcare and help-seeking (Bourgeault et al., 2013).

An understanding of help-seeking for mental health problems was sought in Study III and IV. This was carried out in Study III by interviewing young people and analyzed with constructivist grounded theory (Charmaz, 2014). GT has its roots in both symbolic interactionism but also in more quantitatively oriented scientific traditions (Alvesson & Sköldberg, 2017). It entails that human beings are agents, acting towards situations, objects and people, and that meaning results from individual interpretation (Bourgeault et al., 2013). Charmaz expanded GT by maintaining that in the same way the agents (in this thesis - the young persons) interpret the world, so do the researchers (Charmaz, 2014). This view was utilized when seeking the perspective of young people, in line with social constructionism and the view that theory can only offer an interpretive portrayal of the world and not an

exact picture. Empirical data is thus studied in GT and subsequently brought to a higher level of abstraction through the researchers' interpretation. A theory and researcher-driven analytical process was performed in Study IV through an abductive analysis (Fletcher, 2017). This is similar in many ways to the retroduction of critical realism, with retroductive analysis utilizing both previous theoretical models, existing theories and new data for knowledge generation, rejecting, supporting or modifying existing theories (Bhaskar, 1979; Fletcher, 2017).

Quality criteria for qualitative research vary depending on the method used but for constructivist grounded theory these may be credibility, resonance, originality and usefulness (Charmaz, 2014). Credibility pertains to the confidence in the truth concerning data collection and analysis, both in terms of sufficiency of material, systematic comparisons and the researchers' reflexivity (Polit & Beck, 2010). Credibility was strengthened by interviewing young people of various ages during 2017 and 2018 at two different support services, both general healthcare and ecclesiastical. A majority of the interviewees were female which is a limitation and it would have been preferable if more young men could have been included. It may be that they were not interested in participating, however, it is perhaps more likely that this reflects the present rates of help-seeking, with exceptionally low help-seeking among young men. Every step of the research process including design, coding and analysis were thoroughly scrutinized within the research team, which comprised of different professions and experiences. Systematic comparisons were thus carried out between different team members, with an external researcher also contributing to the comparisons and data analysis.

It is, however, important to acknowledge that the findings in grounded theory studies may be more than systematic analyses, bringing the researcher's philosophical and disciplinary context into the enquiry (Engward & Davis, 2015). This is perhaps even more so in constructivist grounded theory, where the researcher is allowed to be seen, however, constructivist grounded theory requires strong reflexivity through the research process (Charmaz, 2014; Charmaz & Thornberg, 2021). Reflexivity can be defined as the process of recognizing constructs that implicitly and explicitly influence the research process, and of identifying and acknowledging the limitations of the research and the researcher (Engward & Davis, 2015). Reflexivity concerning my background and position is thus without question of great importance for this thesis. I have a background as a trained psychiatric nurse with 20 years clinical experience. I had a pre-understanding of the research area but tried to refrain from passing on my preconceived notion of help-seeking as being a difficult process for the individual. The

purpose of a grounded theory study is to explore the aspects of a social process that are of concern to the participants (Charmaz, 2014). Individual reflections, as well as those done within the research team, were necessary for keeping this focus and gaining a methodological self-consciousness. My previous experience may have been beneficial in many ways bringing an understanding of mental health and mental health problems, and also with a thorough experience of talking to, and interviewing people, even at times when they are not doing well. However, a core task as a psychiatric nurse is to support the person you have in front of you. This stance had to be carefully refrained from when interviewing participants (Study III), whilst still allowing for an atmosphere of trust. In order to achieve this, a pilot interview was carried out, and supervisors assessed the interview technique.

Having a pre-understanding might also 'limit the horizon', making one overlook areas of importance. One way of gaining a fuller, perhaps more abstract understanding of the findings in the studies, has been by the use of critical realism and the theoretical models. Another way has been the continuous discussions with my supervisors and co-writers, consistently reminding me to stay close to the material and to view the material from various perspectives. In order to enhance the validity of the qualitative studies, all analyses were performed in collaboration with an experienced qualitative research team, adding to the trustworthiness of the method.

Resonance is achieved when conceptualizations are relevant to participants and readers, but also when they provide insight and are applicable to others (Charmaz & Thornberg, 2021). In order to achieve fit of data-gathering strategies to the participants' experiences, a slight alteration to the interview guide was carried out during the research process and the interviews. An example is when young people were keen on sharing how they struggled to deal with mental health problems and described help-seeking as only one of a multitude of strategies they used. The interviews thus had to allow for this, incorporating this as an important issue and finding of the interviews. Analytical rigour was improved by member-checking the analysis with one interviewee.

Claims have been made that young people are particularly sensitive and need to be protected (Bradbury-Jones & Taylor, 2013). The interviews in Study III were all performed individually, and thus the issue of peer pressure potentially affecting young people in particular, was avoided. However, it is important to point out that any participant partaking in sensitive research should to be protected, and that the relevant issue in regards to young people, is a consideration of age and context (Bradbury-Jones & Taylor, 2013). The interviewees in Study III may have been in a vulnerable position, both in terms of their mental health, but also in relation to the researcher. Particular

consideration was paid to this circumstance, and efforts to allow the interviewees to talk freely without interrupting was made. The interviews were also recorded and transcribed verbatim, thus contributing to a correct representation of young people's experiences.

Originality and usefulness both relate to the offering of new insights and conceptualizations of a known problem as well as the issue of transferability (Charmaz & Thornberg, 2021). This cannot be solely assessed by the researcher, but also involves how the outside reader perceives and assesses the material (Malterud, 2011). Recruitment was carried out at both the general Youth Clinic and the Ecclesiastical Youth Clinic and some of the interviewed had sought support at both clinics. All the interviewees had parents who were born in Sweden, one person had foreign heritage but was brought up in Sweden. There was a mixture between living with both parents, living primarily with one parent, living with a partner or living on one's own. Most were students, either in compulsory school or further education. The resonance and usefulness of the results should thus be considered in the light of this context and it remains to be seen to what extent the results can inform policy, practice and further research.

Study IV adhered to the quality criteria applicable to both the literature review and the qualitative analysis. The identification, screening, selection and data charting was performed in accordance with a pre-defined framework (Arksey & O'Malley, 2005). Three databases were used for screening. The inclusion of other databases, particularly Scopus, for screening was discussed but discarded, partly due to Scopus only providing a limited use of MeSH-terms. In retrospect, additional databases may have generated further findings, but time-limits when the research was being performed also restricted the selection of databases. Scoping reviews are primarily evaluated in accordance with the Prisma-ScR Checklist, containing 20 items (Tricco et al., 2018) and key items such as the Prisma diagram and table of included articles have been included. However, in order to synthesize the knowledge of the help-seeking process from the perspectives of young people, a thematic, qualitative analysis was included and the study needs to be primarily evaluated on criteria relating to this method (Braun & Clarke, 2006; Levac et al., 2010). The quality criteria for Study IV may thus focus on aspects of credibility, dependability, transferability and confirmability (Lincoln & Guba, 1985 as cited in Nowell et al., 2017).

A thematic analysis is used for both reflecting reality and unravelling the surface of reality, whilst identifying, analysing and reporting patterns/themes (Braun & Clarke, 2006). Both semantic and latent, underlying themes were coded and compared to previous codes. This enabled coding of more data than would have been possible with only semantic data and was conducive

for the abductive analysis comparing new codes with the categorization matrix and the codes from Study III. Abductive reasoning is initiated with a theory and conjectures that direct attention to asking certain questions (Raholm, 2010). This entails a potential risk that researchers may become 'prisoners of conceptual deduction' (Raholm, 2010, p. 267), consistently departing from previous theories and concepts, making valid conclusions but not necessarily generating new knowledge. This could seriously hamper credibility, and whilst coding was carried out by one author, triangulation with several members of the research team, was a technique that was used to allow further conceptual development, and not to become entangled in the initial theory (Lincoln and Guba, 1985, as cited in Nowell et al., 2017). A distinct tracing and documentation of the research process was attempted in order to improve dependability. This included presenting the number of codes, and although the prevalence of codes is not usually relevant for the formulation of themes, this was carried out for the purpose of clarification and the traceability of the analysis. Continual notes on all research meetings, search strategies and data-base searches have been kept in order to enhance transparency and dependability. Considerable care needs to be applied when appraising transferability in qualitative studies. Data from research carried out in other developed parts of the world was utilized in Study IV with a high level of agreement between the findings in Study III and IV. Providing broad descriptions through elaboration, and additional clarifications of the themes in the help-seeking model, has been attempted in order to facilitate the possibility for transference and the use of the results in other contexts (Lincoln and Guba, 1985, as cited in Nowell et al., 2017). Confirmability is said to be established when the credibility, dependability and transferability criteria have all been adhered to. It also pertains to the issue of neutrality and inter-subjectivity, thus, interpretations must not be based on subjective preferences and viewpoints (Korstjens & Moser, 2018). The qualitative studies (III and IV) revolved around the same theme, it can thus be suggested that the validity and in effect the trustworthiness of the findings in Study III were strengthened by the use of a different method in Study IV, as well as additional and different sources, and the constant triangulation with other researchers of the team, which could also be said to add to the confirmability of the findings.

Young people are far from a heterogenous group, and it is thus reasonable to expect that some findings will only be applicable to certain contexts and groups, however, the findings of dispositional optimism and the desire for self-reliance may be more universal characteristics of young people with a higher degree of external validity than contextual factors related to socio-economic status and the support system.

Discussion

The foremost concern of this thesis was to explore individual and structural health assets in relation to the mental health of young people. The perspectives of young people were explored, as they are foundational for the planning and execution of any health promotive work. Overall, the results identified potential health assets at the individual level for young people's mental health, but also highlighted the importance of structural factors in the form of the support system. Mental health is developed and supported through the interaction between individuals and the context, thus by giving young people the opportunity to strengthen individual health assets in a supportive context, they may be able to safeguard and develop their mental health.

Health assets and mental health from an individual perspective

The contribution of individual health assets to the mental health of young people has been identified in this thesis. SES, regarded in this thesis as a potential health asset, but traditionally studied as a risk factor, showed a complex pattern of associations and its' effect was not self-evident for all young people (study I). The mental health of boys appeared to be more negatively affected by SES and family affluence compared to the mental health of girls. Migratory background was found to be a potential health asset for younger girls (study I) and dispositional optimism was demonstrated as affecting health-related quality of life positively and independently of gender and family background (study II). Potential health assets, mainly in regard to the help-seeking process, relate to young people expressing a strong desire for self-reliance and asking for increased knowledge about mental health and the support system (study III and IV).

Socio-economic and socio-demographic factors

Several health assets on an individual-level were identified as potential contributors to mental health among young people. SES was one, but which had a varying impact on the mental health of the girls and the boys, with the latter seemingly being more negatively affected by family low wealth and being particularly vulnerable to the accumulation of risk factors (Study I). No such conclusive effect of SES and family wealth on mental health was found among the girls. The results contribute to a less-than-clear picture of correlations between SES and mental health among young people, where evidence are sometimes contradictory (Reiss, 2013). In some studies, SES has been shown to function as a health asset, having a positive relationship with mental wellbeing (Clarke et al., 2011), whereas other studies have found less evidence for SES to function as a health asset for positive mental health (Nielsen et al., 2016). Affecting mental health problems and a low level of positive mental health is potentially achievable by improving SES. However, the evidence of SES functioning as a health asset for the improvement of positive mental health and mental wellbeing is contradictory and varying in relation to different gender and age groups.

Financial hardship is a strong risk factor for the onset of mental health disorders and parental SES influences help-seeking among young people through factors such as family stress, parental mental health and awareness of problems (McLaughlin et al., 2011; Patulny et al., 2013). The impact of low SES on mental health is stronger in younger ages, and particularly where there is an accumulation of risk factors (Campbell et al., 2021; Halldorsson et al., 2000; Reiss, 2013). This was not evident in the results (study I) where only boys seemed to be particularly susceptible to an accumulation of risk factors. A possible explanation for the variation of associations between SES and self-rated mental health found in Study I is suggested by the theory 'equalisation in youth', in which it is proposed that economic status is more strongly associated with mental health problems in the younger ages and that comparisons with peers become more important for 'older' young people (Reiss, 2013; West, 1997). The perceptions and experiences of young people highly influence their mental health, shown by studies on how perceptions of relative wealth play a dominating role for young people's self-rated health (Goodman et al., 2007). However, no measures of perceptions of wealth were investigated in study I, and consequently can only be hypothesized.

Socio-demographic factors; gender, parental marital status and migratory background were included in the analyses in Studies I and II and generated some findings concerning potential health assets. Gender is a relevant issue in regards to mental health, since the increase in reported mental health

problems can generally be attributed to an increase among girls (Bor et al., 2014). Several explanations for why girls should display and report higher ratings of mental health problems have been suggested, including a higher level of pressure about school performance, self-imposed demands, a high sense of responsibility and a greater inclination to report problems (Bor et al., 2014; Hogberg et al., 2020; Wiklund et al., 2012). In contrast, qualitative findings suggest that the understanding of mental health problems by the boys and the girls are largely consistent across age and gender groups and that girls are not necessarily more willing than boys to report emotional symptoms (MacLean et al., 2010). The field of gender norms is outside the scope of this thesis, however, it has been argued that girls generally have a less empowered position than boys (Landstedt et al., 2009) and that gender norms place a double burden on girls, whilst expectations to thrive and develop are placed on top of the traditional gender roles and expectations (Campbell et al., 2021). Another important aspect is how research on the macro context indicates that countries with high equality between genders, display larger variations in the mental health of adolescent boys and girls (Campbell et al., 2021). This finding is particularly relevant in the Swedish context, as it has been shown that the largest gender gap for ratings of psychological distress among young people has been found in a Swedish population. This is also relevant with the aspect of SES being more strongly associated with the externalization than the internalization of mental health problems, i.e., girls who are more affected by internalizing problems such as anxiety, depression and psychosomatic problems seem to be less affected by SES than boys (Reiss, 2013). Even though no conclusive evidence across genders of an existing association between individual-level SES and risk-reduction enabling mental health prevention was found in the investigated group (Study I), there is still substantial and compelling evidence that such an association exists. When planning mental health promotion from a health assets' perspective, it is important to acknowledge that social processes may affect boys and girls differently and that initiatives for strengthening health assets need to be specific for the intended group.

The results demonstrated how girls with migratory background had a lower risk for low self-rated mental health, which could thus be potentially regarded an individual health asset (Study I). Other research has shown both negative and positive effects of having a migratory background, however a higher rate of internalizing mental health problems among young people with migratory background compared to native young people has been suggested (Belhadj Kouider et al., 2014). A recent Swedish study showed how immigrant adolescents reported more mental health problems than their native peers (Kim et al., 2020). Establishing the mechanisms between a

phenomenon like this, is complicated. Being as mental health is created in the interaction between the individual, the group and the environment, it is relevant to consider the mechanisms behind the empirical findings, i.e. is this a factor at group level, for example social cohesion and social support; does it have anything to do with the equality issues at country level or is it truly an individual level health asset, and if so, in which contexts and from which migratory backgrounds? The results from young people in Europe, in fact suggest that being of migratory background is not the strongest risk factor for mental health problems (Belhadj Kouider et al., 2014). The questions are thus numerous, and whilst the results regarding the migratory effect on mental health were slightly surprising (study I), they also render a possibility of promoting mental health among young people with less focus on wealth and more focus on other potential individual health assets.

Whilst factors such as SES, gender and migratory background may be less modifiable for mental health promotion initiatives, other factors may offer greater possibilities.

Self-reliance, knowledge and optimism

Research suggests that immaterial health assets have a possibility to level out affluence-based inequalities (Paakkari et al., 2019). These health assets may refer to factors such as self-esteem and health literacy and emphasizes the importance of focusing on other individual-level, non-material factors as potential health assets for young people. The individual factors self-reliance, knowledge and optimism were identified in this thesis as important, potential health assets for mental health. Young people had a strong desire for self-reliance, they wanted to be autonomous and in control of their own lives (Study III and IV). This finding is corroborated in other studies showing that young people want to assert themselves, trust in their own capabilities and regulate their emotions (Tollefsen et al., 2020). This drive for autonomy and self-reliance, prompted continual attempts and strategies for coping with their own mental health. Other scholars have suggested that self-reliance is related to negative individual factors such as a fear of stigma and not wanting to show signs of weakness, implying delayed help-seeking and a worse mental health (Aguirre Velasco et al., 2020; Spence et al., 2016). However, from a health assets' perspective, this ambition exemplifies a potential health resource that can be encouraged and promoted. The results showed how young people often had a salutogenic perspective in regard to mental health, where they were focused on improvement through continual strategies, wanted to be more self-reliant, listened to, find an understanding, and improve their mental health (Study III and IV). Self-reliance also entailed young people continually

attempting strategies of both avoidant and approaching character in order to enhance their mental health. The life-style issue is relevant in terms of the combined EUHPID/health assets' model, being placed in between the social determinants of health, and the individual determinants. Young people tried to feel better by adopting behavioural change, aka changing lifestyle, but their individual efforts were affected by obstacles related to both structural and individual resources, for example not having enough knowledge and not being able to access the support system. This means that even when young people depart from a salutogenic way of thinking with attempts at seeking help or feeling better, their lifestyle and attempts at enhancing mental health, are influenced by the context, or with a critical realist view; structure always comes before agency (Bhaskar, 2017).

Knowledge was identified as a potential health asset for mental health (Study III and IV). Young people relayed that knowledge of mental health, mental health problems and the support system was insufficient (Study III and IV). They expressed that they 'did not know what was going on', they had difficulties describing what they were experiencing to others, and they did not know where to seek help. The results thus showed how knowledge pertains to both recognizing and assessing symptoms, being able to express oneself, and knowing both when and where to turn for help when needed (Studies III and IV). Other studies have cited health literacy as a main facilitator for help-seeking among young people, which seems important through mechanisms such as awareness of service availability and symptom recognition (Aguirre Velasco et al., 2020). Knowledge relates to both individuals and the system as it is offered through structural resources, aka in educational settings. It can be defined as an individual health asset, a skill and a capacity, and is of importance both for young peoples' individual capacities, but also as extended resources through being a parental health asset. Other research has shown that parental education has a significant effect on the duration of mental health problems among young people, and also how severe these problems become (McLaughlin et al., 2011). The fact that parental education level has no impact on the onset of mental health problems implies that parental education should be regarded an important factor and health asset, facilitating young people's help-seeking and access to support (McLaughlin et al., 2011). Low educational levels reflect a disadvantage in relative social position, which inhibits access to resources, knowledge and social structures that promote health and wellbeing (Wilkinson & Pickett, 2007). The interplay between individual factors and structural factors is thus evident, where the knowledge and education issue, working through mechanisms such as increased knowledge of the support system and how to

manage the help-seeking process, contributes to improved mental health among young people.

The results from this thesis showed that optimism may function as an individual-level health asset, having a protective effect on low health-related quality of life in young people, even after socio-demographic factors age and gender were taken into account (Study II). The results are corroborated by other cross-sectional studies showing associations between high optimism and reduced stress-levels (Finkelstein et al., 2007), high optimism and reduced psychological distress (Tanner et al., 2014), and prospective studies finding some protective effects against the risks for primarily depressive symptoms and substance abuse (Patton et al., 2011). Dispositional optimism together with social support have also been found to be the strongest predictors of positive mental health compared to socio-demographic factors in young people (Burešová et al., 2020). Can optimism thus be regarded as a health asset, affecting the mental health of young people positively? Dispositional optimism may be regarded as a personality trait and a learned behaviour (Sun & Shek, 2012). It is said to relate to goal attainment and the use of more problem-focused coping strategies. (Carver et al., 2010; Carver & Sheier, 2001). It is also presumed to be an affectable trait, thus, optimism may be enhanced in individuals and it has been highlighted how optimism is correlated with a healthy lifestyle, and with optimistic people using healthy choices and healthy behaviours (Conversano et al., 2010). Such choices, might include seeking help when encountering mental help problems. It is plausible, that optimism predisposes young people to take action when needed, thus facilitating the help-seeking process, and other studies indicate that optimism and self-esteem influence the relationship between depressive symptoms and help-seeking intentions among young people (Kenny et al., 2016).

Many studies and reports are based on self-ratings of psychosomatic symptoms, which also applies to the quantitative studies in this thesis. The results from the studies (I and II) indicated a high level of health-rated quality of life, optimism and outlook on life, similar to other Swedish research (Wiklund et al., 2012). This may indicate that positive mental health and mental health problems can exist simultaneously and that the existence of psychosomatic symptoms may not simultaneously negate having a positive mental health and a high quality of life (Keyes, 2002). In related research, this phenomenon is seen as the increase of psychosomatic symptoms among young people in Sweden between 2002-2018 is not accompanied by proportionate decrease of life satisfaction, thus high levels of psychosomatic symptoms exist simultaneously with moderate levels of life satisfaction (Cosma et al., 2020). The adjusted EUHPID/Health Assets' model

graphically displays positive health and ill health as opposites, while accompanying text describes health as simultaneous, complementary and interacting processes of equal importance (Bauer et al., 2006). The results of this thesis thus support the model and the holistic view of mental health.

Other scholars have claimed that reporting young people's emotional reactions as pathological, creates a negative discourse and turns everyday problems into ill-health, in need of a cure (Wickström & Kvist Lindholm, 2020). A focus on psychosomatic symptoms may reinforce a view of young people as ill and lacking resources, contrary to a focus on salutogenic factors and adopting a health assets' approach. Constant measurements of psychosomatic symptoms also place the burden of problems on individuals, when in fact they are complex social problems (Wickström & Kvist Lindholm, 2020). As previously pointed out, focusing on individual traits and behaviour implies a risk of 'victim-blaming', and a risk of disregarding the complex social mechanisms behind a phenomenon (Katikireddi et al., 2013). It is thus problematic that despite the findings concerning the impact of structural-level factors on young people's mental health (Viner et al., 2012), interventions for promoting mental health are consistently suggested at an individual level (Fjellfeldt, 2021).

The majority of studies on individual health assets are focused on young people (Van Bortel et al., 2019). The reasons for this are not clear, but invites a discussion about whether young people are particularly suitable for mental health promotion initiatives focused on individual traits, capacities and dispositions. The focus of school intervention programmes is aimed at individuals' thoughts and emotions, however young people regard mental health as a complex social and relational matter (Wickström & Zetterqvist Nelson, 2018). This is not to say that thoughts and emotions cannot be affected, in fact, the tradition of psychotherapy rests on this presumption. Meanwhile, it has been shown that the strongest determinants of young people's health are structural factors such as national wealth, income and education (Viner et al., 2012). It is interesting to reflect on how young people – perhaps more so than adults – are reliant on the context and structural limits, affecting their mental health and health-related quality of life.

The adjusted EUHPID/Health assets' model relates to the results by including both risk factors and resources, as well as the different stages of enhancing mental health from health promotion to healthcare. The support system needs to cover all these aspects, and need to be a resource for both promotion, protection, prevention and healthcare.

Rethinking the role of the young people, as actors in relation to the organizations, can entail giving them the means to be involved in decisions and development affecting their own mental health. A focus should thus be

aimed at giving young people access to knowledge about mental health and the support system by more mental health literacy initiatives, enhancing self-reliance and a feeling of optimism. Potential initiatives might be general measures and the introduction of knowledge about mental health in schools. Other initiatives for increasing optimism may also contribute to facilitating help-seeking and enhancing mental health. Targeted measures, focused on groups where a particular vulnerability has been established, i.e. boys and young people with low SES, could be particularly beneficial as having several health assets appears to protect from health problems such as psychosomatic symptoms and also promotes positive health (Paakkari et al., 2019). The complex interaction between the individual and the context entails that equal importance needs to be ascribed to both individual and structural levels, which leads us to health assets from a structural perspective.

Health assets and mental health from a structural perspective

Health assets on a structural-level were primarily identified in regard to the support system and the help-seeking process through the perspectives and experiences of young people (study III and IV). Several structural factors were identified as having the potential to function as health assets, although in most cases an amelioration of the structural conditions was requested by the young people. Social networks supporting – and sometimes – controlling, were important health assets with the potential to facilitate the process of help-seeking (study III and IV). An accessible, collective and responsive support-system was regarded as conducive to help-seeking and mental health. A person-centred approach by professionals was identified as a potential health asset, as well as age-related alterations to the support-system, potentially reinforcing help-seeking possibilities. However, these health assets were potential, in a true sense of the word.

Although self-reliance was sought, support from others was identified as a potential health asset for mental health, particularly in the help-seeking process (Studies III and IV). A social network was markedly important for girls (study IV), but generally, the social network of family and friends was used as a health asset, mitigating mental health problems, alleviating the severity of problems and the need for professional support (study III and IV), There is a vast amount of literature, highlighting the protective effect of social support on various aspects of health. For example, the importance of social networks has been demonstrated in studies where the relationship between

depressive symptoms and help-seeking intentions among young people with low and moderate levels of social support was affected negatively (Kenny et al., 2016). Furthermore, low levels of social support have been associated with worse psychological problems, independently of gender and SES (Gecková et al., 2003) and high levels of family support, including parental surveillance have been shown to reduce the likelihood of low mental health (Rothon et al., 2012). This suggests that young people's perceptions of accessible support from the individual's personal and close network, can have a major impact on both help-seeking and/or mental health. The results in this thesis identified how important others from the personal network would in some cases exert control (study IV) in an effort to affect the help-seeking process. However, control was often viewed negatively by young people (Study IV). Other scholars have also focused on parental style, showing how both supportive and authoritative parenting styles contribute to increased help-seeking intentions, but not to actual help-seeking (Maiuolo et al., 2019). It thus seems important that support is offered and not coerced, in order to improve the young people's own potential for utilizing health assets and improving mental health. Another important factor worth considering is how the effect of social support does not appear to be dependent on gender, but is unevenly distributed and with lower levels among boys (Gecková et al., 2003). If social support is to be utilized as a potential health asset, improving low levels of social support particularly among boys with low SES, might have a considerable effect on the help-seeking process and mental health.

Young people repeatedly expressed in Studies III and IV that they did not perceive the support system as being accessible. Different variations on this theme were cited, relating to a perception that others would not have the time to help them, that their mental health problems would not qualify for getting help, that waiting times were too long and, in some contexts, that costs and distances posed problems (Studies III and IV). Other studies have shown how there is a perceived inaccessibility of the support system across different groups of young people, in terms of resources, entry requirements, and coordination between services (Aguirre Velasco et al., 2020). However, a collective support system was also identified as a potential health asset, with expressions of how accessing help occurred through cooperation and coordination between different supporters (Study IV). Unfortunately, this potential health asset was mostly referred to as a deficiency, with young people talking of how they had to look for support at different locations and from different services and how their contacts would have to be spread-out. This was expressed as being complicated, too much to deal with and interfering with one's life (Study III and IV). A support system organized according to medical specialities, is by definition siloed, and usually entails

entry requirements according to diagnostic thresholds (Mei et al., 2020). Such support relies on referrals between supporters and will be fragmented, something the young people noted and experienced. Considering the fact that young people often present with diagnostically confusing symptoms (McGorry et al., 2006), and how they regard mental health as a complex social and relational matter (Wickström & Zetterqvist Nelson, 2018), it is not surprising that young people regard the support system as fragmented and inaccessible.

The results identified potential health assets at a structural level through the use of a person-centred approach and the supporters' ability to meet young people responsively. Young people felt more comfortable when the supporters did not use medical language, and emphasized the importance of using positive and informal terms for improving communication between the young person and the supporter (Study IV). Other studies have confirmed this finding, emphasizing the importance of having young staff who are skilled, respectful, welcoming and allow shared decision-making (Hetrick et al., 2017). According to law, young people, children and adolescents should have a right to voice their concerns and attention should be paid to their views in regards to issues concerning their own health (SFS *2018:1197*). This is important not only from a legal point of view, but also because research has indicated the importance of personalized support and the potential benefits of involvement in mental health decisions, not least for young people (Grim et al., 2016; Teleman et al., 2021).

With regards to different arenas for support, it is first and foremost the primary healthcare services that have the responsibility for support and treatment of mental health problems. However, the results showed that primary care services were not usually regarded as a suitable option by young people (study III and IV). Other important arenas for help-seeking are Youth clinics which have become increasingly concerned with mental health issues (The Swedish Society for Youth Centres, 2018). The number of boys seeking help from these clinics is low, and a speculation may be that this is related to communication not being directed at boys' specific needs, or that boys do not identify or want to be identified with what is regarded as primarily 'female issues'. Age-related issues were found to have the possibility of influencing help-seeking and mental health (Study III and IV). Young people expressed how they felt 'too young' or 'too old' for certain support structures. Being a minor often constituted an obstacle, both in terms of perceptions of not being able to access support oneself, and also in terms of issues of confidentiality. Young people believed that the information they shared with a supporter, would be passed on to guardians.

It can be hypothesized young people's expressions of not being able to find help, in effect relates to a salutogenic state of mind, i.e young people want help, but perceive it as inaccessible and unresponsive. This quality implies there are possibilities of improved ways of reaching young people by focusing on structural factors of accessibility. Capitalizing on the young people's individual health asset self-reliance, would entail adjusting support structures so that young people can seek help themselves. Research has shown promising results on integrated support services for young people (Hetrick et al., 2017). These integrated centres focus on meeting young people's needs in one place through multidisciplinary support with a consideration of the context (Halsall et al., 2018; Hetrick et al., 2017). Reports of integrated support services show that more young people seek help from these centres compared to traditionally organized support, and also how mental health outcomes are improved with functional and symptomatic recovery (Hetrick et al., 2017; Patulny et al., 2013). Such comprehensive and youth-friendly services have also been shown to increase help-seeking and access to support among boys (Patulny et al., 2013). National recommendations for improving young people's right to support seem to place the focus on increased cooperation between different support systems, and by reinforcing primary care with additional resources and responsibilities (SOU 2021:34). The precariousness of this is pointed out in the same report, as enabling a multitude of actors to cooperate and collaborate is inherently difficult. Additionally, it does not take into consideration young people's preference for a collective and youth-friendly support system. Studies in a Swedish context have pointed out that youth health clinics are available throughout Sweden, providing services to build upon with multi-professional teams and expertise on mental health that can be easily contacted (Goicolea et al., 2018). This is said to create trust among young people and enhance the accessibility of mental health support. Implementing youth health centres in Sweden would be a major, but not impossible task, that would address the issue of fragmentation. Creating low-threshold youth health centres, where young people are met in accordance with the principle of clinical staging would also allow for early interventions without having to adhere to traditional, diagnostic criteria for entry (McGorry et al., 2006).

Underlying assumptions regarding the accessibility and utilization of support have been questioned, claiming that a low rate of support-seeking might be understood as a sign of resilience, rather than being a sign of existing barriers (Ingvarsdotter, 2011). This may be correct in some groups and contexts, however the results showed boys to be particularly sensitive to an accumulation of risk factors (Study I). A low level of help-seeking among boys should not be considered to be an individual trait of exceedingly

outstanding resilience, but rather indicative of mechanisms relating to gender and other underlying structural factors, pointing to the complexities of the social systems in accordance with critical realism and systems theory (Wahto & Swift, 2016). Structural changes at youth health centres, in the form of greater inclusiveness, would benefit all young people with a need for mental health support. However, in order to reach underrepresented groups, structural level health assets need to be strengthened according to the preferences and needs of particular groups. These results provide additional foundation to the EUHPID-model, with SES mainly functioning as a risk factor, and individual and structural health assets including the support system functioning as structural resources, all influencing mental health.

Conclusion

This thesis explored potential health assets at individual and structural level in relation to mental health for young people. Three studies were performed with a population of young people 11-23 years of age in a local context between 2011-2017, and one study focused on young people's (11-25) experiences of the help-seeking process through examination of international literature. Individual health assets SES and migratory background were seen to affect mental health differently for boys and girls in a school setting. The boys were susceptible to an accumulation of socio-economic risk factors including family wealth affecting their mental health negatively, and the mental health of the young girls with a migratory background was affected positively. The individual health assets optimism, knowledge and a desire for self-reliance were found to be potentially supportive of help-seeking and mental health. However, individual health assets function in relation to the context, and help-seeking was seen to be hampered by perceived structural barriers and challenges in finding and obtaining support. Young people claimed to have inadequate knowledge of mental health and the support systems. This contributed to young people experiencing a sense of insecurity and powerlessness. The support system was perceived as: inaccessible - lacking resources; fragmented - adhering to medical specialties and widely spread, often with entry requirements based on diagnostic thresholds; and unresponsive - with a focus on the protocol and not the person. Equipping young people with sufficient knowledge would capitalize on the individual health assets of self-reliance and optimism, conducive to help-seeking and mental health. Shifting the perspective to how the support system can potentially function as a health asset would mean that support was easily accessible, collective as in having services in one place, and responsive as in person-centred.

Implications

Implications for practice

Three of the studies in this thesis were carried out in a local context during 2011-2017. The population consisted of young people between 11-23 years, contributing experiences and perceptions on mental health and the help-seeking process. This aided the identification of potential health assets at both individual and structural levels, and the findings can be translated into practical services and implications.

- Young people experience a lack of knowledge about mental health, mental health problems and the support system. This suggests that this area of knowledge should be improved and implemented in school settings. Young people need to know how to help themselves, when to seek help and where to seek help.

- Optimism seems to be independently related to young people's health-related quality of life, regardless of gender and socio-demographic background. Strengthening young people's social and emotional skills and predispositions, may be a feasible way to foster salutogenic outlooks. Mental health promotion initiatives in school settings appear to be a plausible arena for this, however, other networks also have a possibility to promote such health assets.

- Young people perceive the support system as inaccessible and fragmented. Addressing the potential of support systems to function as health assets entails the support systems needing to accommodate young people's explicit needs and requests. Prompt adjustments of support systems to meet the needs of young people, are warranted. An inclusiveness may be furthered by creating integrated youth health centres. This would be beneficial to all young people in need of mental health support, but perhaps extra beneficial for help-seeking among boys and other marginalized groups.

- Young people perceive the support system as being unresponsive Participation and influence of young people is strengthened by implementing a person-centred approach, thus capitalizing on young people's desire for self-reliance.

- The perspectives of young people need to be strengthened for developing appropriate and efficient mental health promotive initiatives and improving the support system. This not only pays due attention to the fact that young people have a right to be involved in issues regarding their own health, but is a prerequisite for policy and organizational issues of support system design.

Implications for future research

- Research on how to strengthen immaterial health assets, i.e. optimism might be conducive to initiatives for mental health promotion among young people. Further research on the nature of, and potential arenas for, interventions promoting optimism among young people is needed.

- The findings indicate that knowledge about mental health is a health asset for young people, pointing out the importance for further research on how to introduce an understanding of mental health in school settings.

- Extended research on how the support system can accommodate young people's needs in relation to help-seeking for mental health is essential from a structural perspective. An important issue for this research is to involve young people and actually make use of their experience. Further research is also imperative for the group of 'older young people', particularly since they no longer have access to the school arena for support.

- A large, and inherently heterogenous group in need of particular consideration and research is boys. Boys consistently rate their mental health higher than girls, but at the same time, evidence points to boys being more susceptible to an accumulation of risk factors, and issues relating to wealth affecting mental health negatively. Due to help-seeking ratings being particularly low among boys, further

research on which type of support system that fits their needs is needed.

- The perspectives of young people need to be strengthened for developing appropriate and efficient mental health promotive initiatives and improving the support system. Young people have a right to be heard, and their participation in research also increases its validity, producing higher quality research, and hopefully improved relevance and applicability for policy and organizations. This not only pays due attention to the fact that young people have a right to be involved in issues regarding their own health, but is a prerequisite for policy and organizational issues of support system design.

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Barney Glaser, founder of Grounded Theory, is alleged to have said ’The royal road to success is through confusion’. Many times have I felt how true this is. I knew that doing a PhD would take a long time, but I did not fathom quite how long. I have, more or less, studied all my life, but was accepted at Halmstad University in 2014 to the doctoral training in the field of Health and Lifestyle. It has taken longer than I expected to accomplish this training, whilst life has a tendency to come in between you and your plans. Anyway, here we are, at the end of a new beginning. I would like to express my sincere gratitude to all who have contributed to this journey and project.

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Self-rated mental health and socio-economic background: a study of adolescents in Sweden

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Abstract

Background: Adolescents' mental health is a major public health issue. Previous research has shown that socio-economic factors contribute to the health status of adolescents. The present study explores the association between socio-economic status and self-rated mental health among adolescents.

Methods: Cross sectional data from the Halmstad Youth Quality of Life cohort was collected in a town in Sweden. In all, 948 adolescents (11–13 younger age group and 14–16 older age group) participated. Information on self-rated mental health was collected from the subscale Psychological functioning in the Minneapolis Manchester Quality of Life instrument. The items were summarized into a total score and dichotomized by the mean. Indicators measuring socio-economic status (SES) were collected in a questionnaire using the Family Affluence Scale (FAS) and additional factors regarding parents' marital status and migration were added. Logistic models were used to analyze the data.

Results: Girls were more likely to rate their mental health below the mean compared to boys. With regard to FAS (high, medium, low), there was a significantly increased risk of self-rated mental health below the mean among younger boys in the medium FAS score OR; 2.68 (95% CI 1.35;5.33) and among older boys in the low FAS score OR; 2.37 (1.02;5.52) compared to boys in the high FAS score. No such trend was seen among girls. For younger girls there was a significant protective association between having parents born abroad and self-rated mental health below mean OR: 0.47 (0.24;0.91).

Conclusions: A complex pattern of associations between SES and self-rated mental health, divergent between age and gender groups, was shown. The total FAS score was only associated with boys' self-rated mental health in both age groups, whereas parents' migratory status influenced only the girls' self-rated mental health. Because of the different association for girls' and boys' self-rated mental health and SES, other factors than SES should also be considered when investigating and exploring the mental health of adolescents in affluent communities.

Keywords: Adolescents, Self-rated mental health, Socio-economic status, Family affluence scale

Background

Deterioration of mental health among adolescents is considered to be a substantial public health concern, motivating preventative interventions [1]. It is argued that interventions designed to reduce health inequalities early in childhood may help move children onto healthier lives, with the hope of maximising health, including mental health, outcomes across the life course [2].

Studies have shown the impact of socio-economic status (SES) on present and future mental health [3,4]. In relation to mental health, studies have focused on psychological distress (including symptoms of depression, anxiety and stress) or mental health in the form of depression and bipolar disorder. An association between low SES and self-reported mental health in adults, including psychological distress, has been found in several studies [5-10]. However, the link between low SES among adolescents and mental health in later life is less clear [3,4], as is the association between SES and youth mental health [3,11,12].

Income, education and occupation are common indicators used as a basis for measuring adult SES [13,14]. However, measuring SES in adolescents is difficult as

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adolescents may be unwilling or unable to specify their parents' economic status and educational achievement, leading to high levels of missing data [13,15]. The Family Affluence Scale (FAS) is a widely used standardized instrument for measuring adolescent SES [13]. It comprises four items; car ownership, own bedroom, family holidays and computer ownership; it is therefore a resource-based indicator of SES. Factors such as migration and marital status are also often included in studies regarding health and SES [16]. These factors are important determinants of socio-economic resources available to adolescents [17]. Experience of separation or divorce in the family has been found to affect the health of adolescents in a negative way [18,19]. However, the research has shown divergent results of the effect of living in a single-parent household [20-24]. An increased prevalence in mental and psychological health problems among migrants has also been shown [25-27].

In the present study, we explore the association between SES and self-rated mental health among Swedish adolescents between 11–16 years old, using FAS and additional factors regarding parents' status as a measurement of SES.

Methods

Subjects and data collection

Halmstad is a municipality in south western Sweden with a high ranking in national comparisons of affluence [28]. At the time when this study took place, autumn 2011, it had a population of 92 000 inhabitants and a local economy characterized by small and medium-sized companies. Approximately 14% of the population were foreign-born (15% country average), the unemployment rate was 7% (slightly higher than the country average 6.5%), 8% of the inhabitants received sickness benefits or equivalent (compared to the country average 7%). Approximately 4% of households received welfare benefits compared to the country average 6.5% [29]. There were 34 public and four private schools in total. Halmstad is the main town with approximately 62 000 inhabitants.

On the basis of being centrally located in Halmstad and having more than 100 pupils (aged 11–13 years and 14–16 years), seven public schools were selected and invited to participate in the study. A total of 50 classes were invited. One class in the older age group opted out of participation. A sample of 24 classes with pupils in the younger age group (n = 536 pupils) and 25 classes with pupils in the older age group (n = 576 pupils) were included. 948 respondents (467 pupils in the younger age group and 481 in the older age group) agreed to participate and completed the questionnaires (response rate 87% and 84% respectively). In the younger age group and in the older age group, the questionnaires of 58 and 60 adolescents respectively, were excluded due to missing data. The final sample consisted of 830 adolescents.

Adolescents answered self-report questionnaires consisting of the Minneapolis Manchester Quality of Life instrument, (MMQL), the FAS scale and questions regarding parents' migration and marital status. Adolescents of 11–13 years were defined as the younger age group and those of 14–16 years were defined as the older age group. The principal at each school approved participation. Before the study was carried out the school distributed a written information to children and their parents about the purpose of the research, that the participation was voluntary and if the children or the parents declined to participate, they could decide not to fill in the questionnaire without having to explain why. Questionnaires were distributed in each class following a brief introduction by the research team. Participation was voluntary and children who waived participation could return blank questionnaires. Completed questionnaires were returned by each respondent directly and collected by the authors, except for two schools where teachers distributed and collected the questionnaires in return envelopes for each class.

MMQL and self-rated mental health

MMQL is a self-assessment instrument available in two age appropriate versions, the MMQL-Youth form for children aged 8–12 years [30] and the MMQL-Adolescent form for children aged 13–20 years old [31]. Both versions have been designed to cover the same areas of self-rated health related quality of life through age-specific questions [30,31]. The MMQL-Youth form consists of four quality of life domains; physical symptoms, physical functioning, psychological functioning and outlook on life/family dynamics (divided into 32 items). The MMQL-Adolescent Form consists of seven quality of life domains; physical functioning, cognitive functioning, psychological functioning, body image, social functioning, intimate relations and outlook on life (divided into 45 items). In this study we only used the subscale psychological functioning to determine self-rated mental health (MMQL-PF). The reliability and validity of MMQL has been assessed in a study of healthy children and children with cancer in the USA [30,31]. Both instruments have good psychometric characteristics and are available in versions translated and validated in a Swedish context [32]. The subscale psychological functioning contains items about how often you; feel sad, angry, lonely and afraid; have anxiety for dying, your health, in general and; don't feel as good as others. In the older age group three more questions were asked about how often you feel; anxious and nervous, strong and healthy or tired during the day. The responses in each item are based on the number of points in the scale; "Never" = 5; "Seldom" = 4,

"Sometimes" = 3, "Mostly" = 2 and "Always" = 1. All items were summarized into a total score in the different age- and gender-groups and further dichotomized by the mean. Below mean was categorized as "1" and above mean as "0".

Socio-economic variables

Family affluence scale

Using the FAS-scale, adolescents' SES was characterized by parental ownership of cars (Does your family own a car, van, or a truck? (0 = no, 1 = yes, one, 2 = yes, two or more), sharing or not sharing a room (Do you have your own room? (0 = no, 1 = yes), number of holidays per year (During the past 12 months, how many times did you travel away on holiday with your family? (0 = not at all, 1 = once, 2 = twice, 3 = more than twice), having computers at home (How many computers does your family own? (0 = none, 1 = one, 2 = two, 3 = more than two) [13]. A composite FAS score was calculated by adding the responses for the four items ranging from 0–9 [13].

FAS was explored in three different ways. Firstly, each item was analysed in association with self-rated mental health. Secondly, the FAS scale was analysed using the whole range of the scale (i.e. 0–1, 2, 3, 4, 5, 6, 7, 8–9) with 8–9 as a reference. Thirdly, the composite FAS score, in order to reflect the relatively wealthy municipality, was recoded into low (0–5), medium (6–7) and high (8–9) with "high" as reference.

Additional factors regarding parents' status

Parents' marital status was measured by the question "Are your parents divorced?" The answers were coded as 1 (=yes) and 0 (=no) using "not divorced" as reference. Migration of parents was measured by the question "Was your father born in Sweden?" and "Was your mother born in Sweden?" The answers were added together and then coded as both parents born in Sweden (=0) or one or two parents born outside Sweden (=1). The category "not born abroad" was used as reference.

Statistical methods

The statistical analyses were carried out using SPSS statistics version 20.0 (IBM, New York, USA). Continuous variables were expressed as mean and standard deviation (SD). Chi-square and independent student t-tests were conducted to compare MMQL-PF, FAS, parents' marital status (not divorced and divorced) and parents' migration status (parents not born in Sweden and parents born in Sweden) between gender and age. Gender and age groups were analysed separately, i.e., the reference point (mean) was specific for each age and gender group. Significance was assumed at $p < 0.05$. Logistic regression was used in the analyses. Results were reported as odds ratio (OR) with 95% confidence intervals (CI). Adolescence school affiliation was adjusted for by including dummy variables for each school in the regression model [33]. The association between self-rated mental health (MMQL-PF), FAS and parents' migration and marital status were analysed. Scores of MMQL-PF below mean represent worse self-rated mental health and scores above mean represent a higher self-rated mental health.

Ethical consideration

Permission for the study was obtained from the local ethics committee at Halmstad University (Dnr 90-2011-2863). The participants were guaranteed anonymity, were informed that participation was voluntary and told that they did not need to fill in the questionnaire if they did not want to or if their parents objected.

Results

In general, girls rated their mental health significantly lower compared to boys, both in the younger age group ($p = 0.002$) and in the older age group ($p < 0.001$) (Table 1). There were no statistical differences between boys' and girls' FAS scores, parents' marital status and parents' migration status.

Self-rated mental health and family affluence scale

The FAS items were significantly and differently associated to gender and age (Table 2). For girls, there was only an association with FAS and self-rated mental health at item level. In the younger age group, there was a significant protective association between self-rated mental health below mean and not having an own bedroom OR: 0.23 (95% CL: 0.08; 0.61). Having none to one holiday with your family was associated with an increased risk of rating below the mean compared to having two or more holidays for girls in the younger age group OR; 1.90 (95% Cl 1.08; 3.36) and boys in the older age group OR; 1.96 (1.11;3.45).

Secondly, the FAS scale was used comparing the highest score (8–9 FAS score) to 7, 6, 5, 4, 0–3 FAS score. Boys in the younger age group were likely to significantly rate their mental health below mean when having FAS score 7 compared to boys with a higher score (11–13 years, OR; 3.58 (95% CI 1.62; 7.92)). No such trend was seen among girls or older boys. Thirdly, in comparison, FAS was grouped into scores high, medium, and low. There was a significantly increased risk of self-rated mental health below the mean among younger boys in the medium FAS score OR; 2.68 (95% CI 1.35;5.33) compared to boys in the high FAS score. For older boys, a significantly increased risk was apparent in the low FAS score OR; 2.37 (95% CI 1.02;5.52) compared to boys in the high FAS score. There was no significant association between self-rated mental health and the total FAS score in girls.

Table 1 Characteristics of respondents, distribution of self-rated mental health, family affluence scale, parents marital status, migration

Characteristics	Variable	*Younger age group*					*Older age group*				
		Boys (n = 207)		Girls (n = 207)			Boys (n = 232)		Girls (n = 199)		
		Mean	SD	Mean	SD	p value	Mean	SD	Mean	SD	p value
Self-rated mental health		4.17	0.49	4.0	0.59	**0.02**	4.01	0.57	3.81	0.56	**<0.001**
		n	%	n	%	p value	n	%	n	%	p value
Family affluence scale (FAS)											
Does your family own a car?	No to one car	108	52.2	115	55.6	0.116	117	50.4	104	52.3	0.705
	Two and more	99	47.8	92	44.4		115	49.6	95	47.7	
Do you have your own bedroom for yourself?	No	30	14.5	28	13.5	0.777	19	8.2	24	12.1	0.181
	Yes	177	85.5	179	86.5		213	91.8	175	87.9	
During the past 12 months, how many times	Not at all to once	106	51.2	106	51.2	0.999	131	56.5	112	56.3	0.969
did you travel away on holiday with your family?	Twice to more than twice	101	48.8	101	48.8		101	43.5	87	43.7	
How many computers does	None to one	22	10.6	24	11.6	0.754	15	6.5	12	6.0	0.852
your family own?	Two to more than two	185	89.4	183	88.4		217	93.5	187	94.0	
FAS score	Low (FAS 0–5)	63	28.3	70	32.3	0.385	50	20.4	54	25.2	0.483
	Medium (FAS 6–7)	93	41.7	91	41.9		129	52.7	105	49.1	
	High (FAS 8–9)	67	30.0	56	25.8		66	26.9	55	25.7	
Marital status	Not divorced parents	159	68.7	156	68.7	0.666	168	67.5	152	69.1	0.733
	Divorced parents	69	30.3	71	31.3		81	32.5	68	30.9	
Migration parents place at birth	No parents born abroad	149	63.4	144	62.3	0.391	157	62.5	145	65.0	0.483
	Parents born abroad	86	36.6	87	37.7		94	37.5	78	35.0	

$p < 0.05$.

Self-rated mental health, parents marital status and parents migration

Table 3 presents adolescents' self-rated mental health and its relationship to parents' migration and marital status. In the younger age group there was a significant protective association for girls with parents born abroad and self-rated mental health OR: 0.47 (95% CI 0.24;0.91). No such trend was seen in the older age group for boys or girls. There was no association for any age group when having divorced parents.

Discussion

In this study, we utilised two assessments of SES, both from the adolescents' perspective through FAS and through additional factors regarding parents' status. An association between self-rated mental health and the total FAS score was only apparent for boys in both age groups. Parents' marital status did not seem to indicate an increased risk for self-rated mental health below mean for either gender- or age group. A positive association was seen for girls' self-rated mental health in the older age group having parents born abroad.

Boys in both age groups seemed to exhibit a higher risk of self-rated mental health below mean in association to FAS. This result was evident in all different analyses of FAS. There was a lack of association between the total FAS score and girls' self-rated mental health, however, at item level (having an own bedroom and number of holidays) there were associations in opposing directions. These item-level findings might be factors that could influence the total FAS score for girls and the opposing association between the different items might affect the total FAS score for girls. The opposing associations for individual items may cancel each other out resulting in no association between the total score and girls' mental health. Other research in Nordic countries has similar findings [34], suggesting that girls' lower self-rated health may be affected by different parameters compared to boys [12,34,35].

The theory of equalisation in youth suggests limited association between SES and self-rated mental health. It proposes that adolescence is characterised by a relative equality of health due to changes in social class patterns during transition from childhood, youth and subsequent

Table 2 Odds ratio (OR) with 95% confidence interval (95%CI) for self-rated mental health below the mean by family affluence

	Younger aged group				*Older age group*			
	Boys		**Girls**		**Boys**		**Girls**	
	OR	**95% CI**	**OR**	**95% CI**	**OR**	**95% CI**	**OR**	**95% CI**
Family affluence scale (FAS)								
Items								
Does your family own a car?								
Two and more	1.0	(Reference)	1.0	(Reference)	1.0	(Reference)	1.0	(Reference)
No to one car	1.46	(0.82;2.59)	1.27	(0.63;2.31)	1.16	(0.66;2.05)	1.04	(0.55;1.95)
Do you have your own bedroom for yourself?								
Yes	1.0	(Reference)	1.0	(Reference)	1.0	(Reference)	1.0	(Reference)
No	0.72	(0.32;1.63)	0.23	(0.08;0.61)	1.14	(0.41;3.20)	1.09	(0.42;2.86)
During the past 12 months, how many times did you travel away on holiday with your family?								
Twice to more than twice	1.0	(Reference)	1.0	(Reference)	1.0	(Reference)	1.0	(Reference)
Not at all to once	1.47	(0.84;2.55)	1.90	(1.08;3.36)	1.96	(1.11;3.45)	0.92	(0.50;1.69)
How many computers does your family own?								
Two to more than two	1.0	(Reference)	1.0	(Reference)	1.0	(Reference)	1.0	(Reference)
None to one	0.88	(0.36;2.19)	0.60	(0.25;1.47)	1.77	(0.58;5.40)	0.62	(0.18;2.13)
Numbers of FAS score:								
9–8	1.0	(Reference)	1.0	(Reference)	1.0	(Reference)	1.0	(Reference)
7	3.58	(1.62;7.92)	0.71	(0.31;1.61)	1.28	(0.57;2.84)	1.17	(0.56;2.63)
6	1.78	(0.75;4.24)	0.79	(0.34;1.82)	1.74	(0.81;3.71)	0.90	(0.37;2.19)
5	1.68	(0.67;4.22)	1.51	(0.59;3.87)	2.41	(0.85;6.85)	0.45	(0.17;1.21)
4	1.75	(0.61;5.00)	0.79	(0.30;2.10)	1.26	(0.36;4.39)	0.36	(0.08;1.72)
1–3	1.87	(0.47;7.36)	0.70	(0.16; 3.08)	5.19	(0.90;29.71)	2.97	(0.49;18.16)
FAS score categories								
High (score range: 8–9)	1.0	(Reference)	1.0	(Reference)	1.0	(Reference)	1.0	(Reference)
Medium (score range: 6–7)	2.68	(1.35;5.33)	0.75	(0.37;1.52)	1.58	(0.80; 3.14)	1.04	(0.51;2.15)
Low (score range: 0–5)	1.74	(0.82;3.69)	1.06	(0.50;2.27)	2.37	(1.02; 5.52)	0.56	(0.24;1.34)

Table 3 Odds ratio (OR) with 95% confidence interval (95%CI) for self-rated mental health below the mean by parental migration and parental marital status

	Younger aged group				*Older age group*			
	Boys		**Girls**		**Boys**		**Girls**	
	OR	**95% CI**	**OR**	**95% CI**	**OR**	**95% CI**	**OR**	**95% CI**
Parents migration								
No parents born abroad	1.0	(Reference)	1.0	(Reference)	1.0	(Reference)	1.0	(Reference)
Parents born abroad	0.92	(0.49;1.72)	0.47	(0.24;0.91)	1.48	(0.79;2.77)	0.63	(0.31;1.28)
Parents marital status								
Not divorced	1.0	(Reference)	1.0	(Reference)	1.0	(Reference)	1.0	(Reference)
Divorced	1.20	(0.63;2.29)	1.18	(0.64;2.19)	1.15	(0.64;2.08)	1.50	(0.79;2.88)

adulthood [5]. The diminished effect of social class on self-rated mental health has been suggested to relate to other influences than SES and background, such as school and peer groups. In the same strain, the subjective social status (SSS) has been proposed as a predictor of health [36]. The theory of SSS suggests that health of individuals is related to the individuals' perception of his/her relative wealth and position in the social hierarchy. Some groups, more than others, seem to rely more on relative comparisons within the group that can be difficult to measure with traditional and absolute SES measures [36]. Although no data was collected on SSS in our study, it is possible that SSS explains the different results of self-rated mental health between older and younger boys as the importance of SSS might change with age, however the importance of SSS in this regard has to be evaluated in future studies.

Parents' migration status in our study showed an impact only on girls' self-rated mental health. Other studies have shown varied results [26,37-43]. A review on the mental health in first and second-generation immigrant boys and girls showed no unequivocal results, both higher and lower levels of mental health problems were found [39]. Worse scores of health outcomes have been found for girls with immigrant parents, interpreted as illustrative of the difficulties for adolescent girls in adjusting and accommodating two cultures [38]. However, other researchers propose that adapting to a new culture and society is easier for second-generation immigrant girls, enabling them to embrace new opportunities in their adopted country, leading to improved mental health [44]. In our study, having parents born abroad acted as a protective factor for self-rated mental health among younger girls. For older girls, or boys of any age, no positive or negative results were seen.

Regarding the other aspect of parents' status we investigated, research shows that children of divorced parents are affected negatively [37,41]. Our study could not show any association between having divorced parents and a risk of self-rated mental health below mean. It might be important to explore whether it is the family structure *per se*, or the characteristics of households and community contexts that affect the mental health of adolescents [42]. The few associations in this study between parents' migration, as well as marital status, and adolescents' self-rated mental health might indicate that these parental factors are of less importance and might rather be considered mediators of SES as previously suggested [26].

Strengths and limitations

The cross-sectional design of the study implies a weakness since the causal mechanisms cannot be inferred, nor can the results from this study population be generalized. The primary sampling unit was the school. The collection of data was not through traditional random cluster sampling. The schools were included based on particular characteristics such as having a size large enough to avoid identification of students and proximity to central Halmstad. The homogeneity of the sample influenced our choice not to use multi-level models. This might be a limitation, however, we did not foresee that the results would have changed significantly. The study was based upon self-reported data, which strengthens the results as they are based on children's own perceptions of their mental health.

This study used FAS as SES indicator. The FAS scale primarily measures socio-economic position from a material point of view and is recognized as a good measurement of adolescent SES [45]. The possibility of social bias, through cultural and structural surroundings, cannot be excluded in the FAS reports or in the self-reported mental health score. FAS is a culturally and time-sensitive tool and needs recurring evaluation with consideration of material trends and opportunities [13]. For example, present use and possession of smartphones and tablets, in fact, provides adolescents with constant availability of digital social interaction, information flows and tools. However, this is not specified or well accounted for in the original design of the FAS scale and might have influenced our results. The lowest category of FAS was categorized as 0–5 items compared to other studies where the lowest category has been defined as 0–3 items, due to the fact that Halmstad is a comparatively wealthy town [13]. The chosen cut-off point for MMQL-PF was the mean. The reason for this was the relatively high rating scores of the scale and a possible lack of power with a more extreme cut-off point.

We also chose to add the factors parents' migration and marital status to reflect the multiple and contextual aspects of SES. However, the present marital status does not necessarily reflect the current family structure where parents might be re-married or cohabitating, hence generally providing more resources and higher SES than a single-parent household. We chose this question considering the age structure of the sample. However, retrospectively, a more poignant question could have focused on current living conditions and family structure rather than marriage.

Conclusions

This study shows a complex pattern of associations between SES and self-rated mental health. The results diverged between age and gender groups. The main conclusion is that the total FAS score was only associated with boys self-rated mental health below mean in both age groups, whereas parents' migratory status influenced only the girls' self-rated mental health. However, since the association for girls' and boys' self-rated mental

health and SES differed, other factors than SES should also be considered when investigating and exploring the mental health of adolescents in affluent communities.

Competing interests
The authors declare that they have no competing interests.

Authors' contributions
The study was originally initiated and designed by PS and JN. The data collection was done by PS and JN. MN has provided the statistical analysis. The manuscript was drafted by KH and MN with supervision of PS and JN. All of the authors have contributed to this study with interpretation of the results as well as to the drafting of the final version. Critical revisions for significant intellectual content were made by all authors. All authors read and approved the final manuscript.

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Article II

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Optimism as a Candidate Health Asset: Exploring Its Links With Adolescent Quality of Life in Sweden

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This study aims to understand the role that optimism could play in the context of a health asset approach to promote adolescent health-related quality of life (HRQOL). Adolescents (n = 948), between 11 and 16 years old from a medium-sized rural town in Sweden, answered questionnaires measuring optimism, pessimism, and HRQOL. The findings indicate a significant decrease in optimism and a significant increase in pessimism between early and midadolescence. The study has allowed us to present associational evidence of the links between optimism and HRQOL. This infers the potential of an optimistic orientation about the future to function as a health asset during adolescence and by implication may provide additional intervention tool in the planning of health promotion strategies.

The sustainability of health and well-being for future generations relies in part on our ability to create the conditions necessary for the healthy growth and development of young people (Conversano et al., 2010; Patel, Flisher, Hetrick, & McGorry, 2007). Early to midadolescence marks a particularly important time for families, schools, neighborhoods, and wider environments to ensure these conditions are set. Adolescence is a transitional stage of development between childhood and adulthood. It is also argued that health-related problems in adulthood seems too originate in adolescence, particularly between the ages of 11 and 18 (Kessler et al., 2005). The perceived physical, social, and psychological changes and the transition itself influence adolescent's health-related quality of life (HRQOL) and well-being (Conversano et al., 2010; Eccles et al., 1993; Holmbeck, Paikoff, & Brooks-Gunn, 1995). The most recent World Health Organization strategic document "Investing in Children: The European Child and Adolescent Health Strategy 2015–2020" (WHO, 2014) synthesized accumulated evidence that recognizes the many factors that can impact on children's ability to do well during this crucial development period. These factors relate to their own genetic susceptibilities, to their family, to their environment (particularly school), and life events. The strategy argues that the challenge for policy is to strive for a balance between risk and protection activities so that young people can acquire the necessary skills and competences to secure them a productive and healthy life. In this way, young people will be more able to deal with growing academic expectations, changing social relationships with family and peers, and physical and emotional changes associated with maturation. Marmot (2010) argues that policy responses that seek to maximize protective factors while minimizing risk factors accumulated over the life course can be successful in achieving health and well-being goals. In the context of young people's well-being, Morgan (2010) proposed a health asset terminology and approach to support the development of an evidence base, which could support such activity.

A health asset approach has been defined as

> a system which creates positive paradigms for building the capacities of young people to be active in their own development and strengthens their ability to connect to a range of networks

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> that facilitate health and well-being gains for themselves and for others. (Morgan & Aleman-Diaz, 2016)

It has two elements. The first is to understand through epidemiological research the ability of known potential health assets to explain different health-related outcomes. The second is to determine whether there is sufficient evidence for particular concepts to be useful in the practice of improving health and to find ways of translating the theoretical into a set of actions for change.

This article proposes the concept of optimism as a potential health asset and seeks to explore its association with a well-known proxy measure of well-being —HRQOL. It provides a first step to understanding whether optimism can be put to practical use in the development, implementation, and evaluation of health promotion programs.

Identifying and Understanding Key Health Assets

Although it would be naive to think that asset-based approaches can remove all the risks associated with young people growing up, strengthening protective factors in schools, at home, and in local communities can make important contributions to reducing risk for the vulnerable (Fonagy & Higgitt, 2000; Heijmens Visser, Van Der Ende, Koot, & Verhulst, 2000; Morgan & Ziglio, 2007; Rutter & Smith, 1995). For the purpose of this study, health assets not only can be any resource that can ameliorate the effects of exposure to risk in a positive direction, but can also operate in an additive protective way that still enables positive adaptations independent of risk exposure (Brooks, Magnusson, Spencer, & Morgan, 2012; Morgan & Ziglio, 2007). This definition and the development assets identified by the Search Institute (www.searchinstitute.org) provide a useful framework for selecting a set of candidate assets that can be tested and developed as valid indicators to link and explain possible pathways to well-being. So far, assets have been classified into two broad types: external assets, those attained through positive relationships with others; and internal assets, the competencies and values that young people develop as a consequence of the social support and empowerment gained from the former (Benson, Scales, & Syvertsen, 2011). The concept of optimism in this context is included as an internal development asset. Optimistic young people have a positive view about their personal future which in turn helps them to secure healthy growth and development. The health asset framework calls for robust evidence that allows potential concepts (or candidate assets) to be tested through empirical research. This testing involves an iterative process to clarify definition and measurement so that health assets can be used in further empirical work to explain the phenomenon (HRQOL in this instance) of interest. This knowledge can then be used to inform health programs. This study begins that process for the concept of optimism.

Optimism: Its Conceptualization and Measurement as a Health Asset

Intuitively the concept of optimism has the potential to be a health asset as it can facilitate the achievement of well-being through positive thinking about the future. Benson et al. (2011) have already identified it as one of 40 development assets for young people. More generally, Lindstrom and Ericsson (2010) included it in their "salutogenic umbrella" of concepts that are important in positively framing the delivery of health promotion programs. This article has the intention to contribute to a better understanding of how optimism (and its associated concept, pessimism) can be included in a health asset approach and what issues need to be addressed in its further development.

There seem to be two prominent theoretical models of optimism defined in the literature: dispositional optimism (Carver & Scheier, 2014) and attributive style optimism (Gillham & Reivich, 2004; Orejudo, Puyuelo, Fernandéz-Turrado, & Ramos, 2012). In the first model, *dispositional optimism* is described as the predisposition to expect positive outcomes when confronting major problems and having expectations that future goals will be attained (Scheier & Carver, 1985). Dispositional optimism is thus a predictor of successful adaptation to stressful encounters, helping individuals to deal with problems in life rather than avoiding them and giving up (Carver & Scheier, 2014). In contrast, the second model, *attributive style optimism*, is described as a pessimistic explanatory style where adolescents expect that they will not have the ability to control stressful events or create positive outcomes in life (Gillham & Reivich, 2004).

Our ability to develop and utilize optimism as a health asset relies on good measurement. A number of studies have identified issues in the operationalization of both concepts (optimism and pessimism), which may have implications for measurement in health outcomes studies (Hertzberg, Glasmer, & Hoyer, 2006; Nes & Segerstrom, 2006). They can either be measured as two different concepts

(bidimensional) or as opposite ends of a single range or continuum (unidimensional; Nes & Segerstrom, 2006). In measurement terms, different scales may assess different dimensions of the same phenomena or completely different phenomena depending on how the instruments have been operationalized. Dispositional optimism has been described as "the generalized expectancy that one will experience positive outcomes in life" (Magaletta & Oliver, 1999) and has been studied among adolescents both as a bidimensional and a unidimensional construct. One of the first instruments in this area is the Generalized Expectancy for Success Scale (GESS; Fischer & Leitenberg, 1986), a bidimensional instrument that examines generalized future expectations for personal success and failure. Other instruments are the Optimism–Pessimism Test instrument, a unidimensional instrument that examines general tendency to expect positive or negative outcomes (Stipek, Lamb, & Zigler, 1981), and the youth life orientation test (Ey, Hadley, Allen, Palmer, & Klosky, 2005; Monzani, Steca, & Greco, 2014), a bidimensional instrument that examines positive and negative general expectations.

This study uses the GESS instrument (in a larger questionnaire) as an objective measure of optimism and pessimism for assessing adolescent's future expectations. The advantage of GESS is that it focuses on future expectations for personal success and has been adopted for use as a self-report instrument among adolescents.

The Status of the Evidence on Optimism as a Health Asset

There is no known research that explicitly explores the potential of optimism as a health asset. However, a more general evidence base exists that highlights its links with a range of health-related outcomes. Optimism has been commonly understood to be a protective factor in relation to health-related outcomes, although this relationship predominantly relates to adult populations (Carver, Scheier, & Segerstrom, 2010; Conversano et al., 2010). Studies have demonstrated that high levels of dispositional optimism among adults relate to a wide range of positive well-being outcomes (Conversano et al., 2010; Scheier & Carver, 1985), whereas lower levels have been associated with medical illness or health crises (Carver et al., 2010). Furthermore, individuals who have a pessimistic explanatory style more commonly use avoidance-coping strategies (Carver & Scheier, 2014; Folkman & Lazarus, 1980; Rasmussen, Wrosch, Scheier, & Carver, 2006) and have more negative outcomes (Fibel & Hale, 1978; Scheier & Carver, 1985; Strunk, Lopez, & DeRubeis, 2006). Research has also shown that there is an inverse correlation between optimism and depressive symptoms and suicidal ideation among adults (Hart, Vella, & Mohr, 2008; Hirsch & Conner, 2006; Chang & Sanna, 2001; Steele & Wade, 2004; Van der Velden et al., 2007). There are some adolescent studies that have shown positive correlations between optimism and health-related outcomes (Alarcon, Bowling, & Khazon, 2013; Bamford & Lagattuta, 2012; Ben-Zur, 2003; Vacek, Coyle, & Vera, 2010), effective coping strategies and the adoption of good health behaviors (Jones, DeMore, Cohen, O'Connell, & Jones, 2008), and better emotional functioning (Williams, Davis, Hancock, & Phipps, 2010). As might be expected, pessimistic orientations about the future have been shown to have the opposite effect on health outcomes for adolescents both in the general population (Reppucci, Revenson, Aber, & Reppucci, 1991; Strunk et al., 2006) and in health care (Sulkers et al., 2013; Williams et al., 2010). There are also some examples of optimism being used in health promotion intervention studies as an outcome, but these have contradictory findings (Johnstone, Rooney, Hassan, & Kane, 2014; Patton et al., 2011). These contradictions may suggest that our understanding of the protective aspects of optimism is not sufficiently well articulated for the idea to be translated into actions for practice. In part disentangling the concept has been complicated by the inextricable link to pessimism. For example, it has been argued that high levels of optimism can lead to an underestimation of health hazards, whereas high levels of pessimism can be beneficial in preparing for unpredictable outcomes (Patton et al., 2011; Reppucci et al., 1991).

Overall, the body of published research available to assess the relationships between optimism and a range of health-related outcomes is varied. Much of it has been carried out in the context of health care settings studying such outcomes as surgery, cancer, and heart disease, and among adults. That said, review level research exists that suggests that the relationship is positive (Carver & Scheier, 2014; Carver et al., 2010). A recent review by Okado, Howard Sharp, Tillery, Long, and Phipps (2016) examined the role of optimism in pediatric cancer patients. They found that it was linked to fewer difficulties with pain, higher quality of life, and stronger mental health functioning. In contrast, pessimism was associated with poorer outcomes in behavioral, physical, and emotional functioning.

The review did recognize, however, summarizing the data across studies was difficult due to definitional issues and design and methodological limitations. The field of optimism and mental health is also scattered. A review by Conversano et al. (2010), however, concluded that optimism has an important moderating role in the association between feelings of loss of hope and suicidal ideation. Carver and Scheier (2014) reviewed a range of epidemiological research that studied long-term prospective associations between optimism and health outcomes in large samples. Optimism was shown to have a relationship with social relations and social support. However, it was recognized that this association could be tautological and that having strong social networks and social support could lead to someone being optimistic. Much of the work on optimism has taken place in health-related contexts, as people confront the transitions imposed by health crises. The early work shows that optimists fare better emotionally and psychologically than pessimists when confronting health problems.

Our study is set in the context of prevention, specifically to understand the skills, competences, and attributes that are supportive (or protective) for healthy adolescent development. There is little or no research in this area. Although there are some examples of studies carried out among young people to look at the role of optimism in a range of health specific outcomes. For example, Wray, Dvora, Hsia, Arens, and Schweinle (2013) studied the relationship between optimism and alcohol use among 14–18 years using a cross-sectional design. These results suggest that those who have more positive expectations of the future report lower levels of alcohol use at age 14, whereas those with more negative future perspectives report higher levels of alcohol use at that age. However, they also found gender differences. Girls tended to be more optimistic than boys. Patton et al. (2011) found positive associations between optimism and a range of emotional outcomes, substance abuse, and antisocial behavior among early adolescents. The extent of the relationship also differed by gender. Carvajal (2012) found that optimism systematically decreased during early adolescence suggesting that it is important to recognize the concept as dynamic and changing throughout the development years.

The Current Study

This study explored optimism as a health asset to promote well-being among adolescents. Specifically, it uses data from a survey carried out in a medium-sized rural town in southwest Sweden among 11- to 16-year-old adolescents. We explore optimism and pessimism as a bidimensional construct and its impact on HRQOL among adolescents in two separate age groups (11–13 years and 14–16 years). The inclusion of these two age groups helped us observe differences that provide insights into issues relevant to this key transition stage (Holmbeck et al., 1995). Previous research has indicated age, gender, and sociodemographic characteristics to have a potential impact on the relationship between optimism and health-related outcomes (Biehl et al., 2014; Hutton, Nyholm, Nygren, & Svedberg, 2014; Meade & Dowswell, 2016; Orejudo et al., 2012). Measures were therefore included to control for these factors.

Hypotheses

Hypothesis 1—There is an association between adolescent's self-rated optimism and pessimism and HRQOL.

Hypothesis 2—The association between adolescent's self-rated optimism and pessimism and HRQOL changes when gender and sociodemographic characteristics are taken into account.

Method

Study Design and Research Context

This study had a survey design and used cross-sectional data from a medium-sized rural town in southwest Sweden collected in 2011. At the time of the data collection, the number of residents in the municipality was about 92,000 and there were 36 municipal and 4 private schools in the municipality with approximately 9,000 youth in primary school.

For participant recruitment, pupils from junior high schools were invited to participate. The schools' catchment areas represent both urban and rural areas with socioeconomic characteristics representative of the municipality. The study included measures of HRQOL, optimism/pessimism, and a range of proxy measures of socioeconomic status.

Participants

The sampling frame included pupils from municipal schools selected on the basis of having a total of more than 100 pupils and for pupils in Grades 6–9 (age 11–16 years old) and centrally located in the town. As a result, seven public schools (from a total of 34 public and 4 private schools) were included. A total of 50 classes from these 7 schools

were invited to participate in the study, and pupils were selected using a nonprobability purposive sampling technique. This resulted in a sample of 24 classes with pupils aged 11–13 years old (n = 536 pupils, younger age group) and 25 classes with pupils aged 14–16 years old (n = 576 pupils, older age group). One class (14–16 years) decided not to participate. For the purpose of this study, we classified the younger age group as early adolescent and the older age group as midadolescent. A sample of 948 respondents (n = 467 [11–13 years old] and n = 481 [14–16 years old]) completed the questionnaire yielding a response rate of 87% and 84%, respectively (nonresponse was almost exclusively due to absence from school during the day of data collection).

Measures

Health-Related Quality of Life

The Manchester–Minneapolis Quality-of-Life (MMQL) instrument was chosen to measure HRQOL as it has been shown to better capture the QOL perspective of health in comparison with other health status and QOL instruments developed for children (Fayed, Schiariti, Bostan, Cieza, & Klassen, 2011). Furthermore, the items used have a mainly positive phrasing, which is important for how each item is perceived and for the child's experience of contributing to the questionnaire (Fayed et al., 2011). The MMQL instrument exists in two forms, which take account of the characteristics of two age groups, the MMQL–Youth form for 8- to 12-year-olds and the MMQL–Adolescent form for 13- to 20-year-olds (Bhatia et al., 2004; Einberg, Kadrija, Brunt, Nygren, & Svedberg, 2013). Both versions of the instrument have good psychometric characteristics in terms of face and content validity: internal consistency (Cronbach's alpha from .88 to .92) and stability (intraclass correlation coefficient [ICC] from .43 to .78). They have also been translated into Swedish (Einberg et al., 2013). The MMQL–Youth form consists of four quality-of-life subscales: physical symptoms (9 items), physical functioning (6 items), psychological functioning (8 items), and outlook on life (9 items), comprising 32 items in total. The MMQL–Adolescent form consists of seven quality-of-life subscales: physical functioning (6 items), psychological functioning (11 items), outlook on life (3 items), cognitive functioning (9 items), body image (6 items), social functioning (8 items), and intimate relations (2 items), with a total of 45 items. All scales were constructed and scored using Likert method of summated ratings and a 4- or 5-point response scale (Bhatia et al., 2004). We computed subscales scores and an overall QOL score by summing the scores for each subscale and all items and dividing the sum by number of items in the questionnaire where higher scores indicating better outcomes (Bhatia et al., 2004). For example, the subscale of psychological functioning using the MMQL–Adolescent form has a 5-point response scale and 11 items. We computed the total score by summing the participant's response on the 11 items (the sum ranged from 15 to 55) and then we divided it with 11 according to the number of items in the subscale. HRQOL was used both as a continuous variable (in multilevel analysis) and as a categorical variable (in logistic regression). Categorization was achieved according to the age-specific mean of HRQOL, where below mean was categorized as "0" and above mean as "1."

Optimism and Pessimism

The GESS (Fibel & Hale, 1978) was used to assess optimism and pessimism relevant to the study population. The response options of the scale have previously been adapted for use among children; from a Likert scale to more simplistic true or false responses (Fischer & Leitenberg, 1986). This adaption was based on research within this age group and was shown not to diminish the validity of the instrument. The age-adapted version includes 27 statements constructed with the same opening phrase, "In the future I expect that I will . . . ." Sixteen items were phrased in the direction of success (optimism scale) and 11 items phrased in the direction of failure (pessimism scale). The optimism scale was scored using a range of 0–16 points, higher numbers indicating a higher level of optimism. The Cronbach's α for optimism in this study was .701 in the early adolescent group and .817 in the midadolescent group. The pessimism scale was scored with a range of 0–11 points, higher numbers indicating higher level of pessimism. The Cronbach's α for pessimism was .638 in the early adolescent group and .689 in the midadolescent group. It could be argued that there is an overlap between measures of optimism and pessimism and the Outlook of Life subscale in the MMQL scale; however, assessment via Spearman's correlation showed this not to be the case (Table 1). Furthermore, we found no collinearity between optimism and pessimism as indicated by the Spearman's correlation test ($r < .5$; Table 1). Optimism and pessimism were used both as a continuous variable (in multilevel analysis) and as a categorical variable (logistic regression).

Table 1
Correlation Between Optimism, Pessimism, and Dimension of Health-Related Quality of Life–Outlook of Life

	Optimism *r*	Pessimism *r*
Early adolescence group		
Outlook of life	.10[a]	−.09[a]
Optimism	—	−.37[a]
Pessimism	−.37[a]	—
Midadolescence group		
Outlook of life	.24[a]	−.23[a]
Optimism	—	−.44[a]
Pessimism	−.44[a]	—

[a]Based on Spearman's correlation (*r*). All correlation coefficients are significant $p < .05$.

Sociodemographic Characteristics

Sociodemographic characteristics of participants were assessed early on in the questionnaire. Data relating to parental status were obtained from an initial section on sociodemographic characteristics. Adolescents were asked to answer questions on age, gender, parent's marital status, and family country background. Gender was measured by the question "Are you a boy or a girl?" and the answer was coded 1 (girls) and 2 (boys). Parents' marital status was measured by the question "Are your parents divorced?" The answers were coded as 1 (yes) and 0 (no). Family country background was measured by the question "Was your father born in Sweden?" and "Was your mother born in Sweden?" The answers were added together and then coded as 0 (both parents born in Sweden) and 1 (one or two parents born outside Sweden).

Procedure

Adolescents answered a self-report questionnaire consisting of two validated scales, one for measuring HRQOL (MMQL) the concepts of optimism and pessimism (GESS) and questions regarding their sociodemographic characteristics. Questionnaires were distributed to each class following a brief introduction by the researchers. Participants were also given the possibility to ask questions about the study or specific questions during completion of the questionnaire. Completed questionnaires were returned to the researchers by each respondent. However, in two schools, teachers distributed and collected the questionnaires in return envelopes from each class.

Ethics Clearance

The principal at each school approved participation in the study. Prior to data collection, each school distributed written information to children and their parents about the purpose and structure of the study. The written information indicated that participation was voluntary, and if children or their parents declined to participate, they could decide not to fill in the questionnaire without having to explain why. The participants were guaranteed anonymity. The study design was approved by the regional ethics committee in Lund (Dnr 2016-1003).

Analytic Approach

The two age groups were examined separately and statistical significance was assumed at $p < .05$. Mean (standard deviation), minimum and maximum values, and numbers (proportions) were used for descriptive purpose. Chi-square, independent Student's t tests, and Mann–Whitney were conducted to compare MMQL, optimism, pessimism, gender, parent's marital status, and family country background between age groups. We used SPSS statistics version 20.0 (IBM, New York, NY) and Mplus version 7.2 (Muthén & Muthén, 1998–2015, Los Angeles, CA) for statistical analyses. Multilevel models were used to analyze simple linear regression analysis with manifest variables in clustered data. The data were selected and clustered from seven different schools, where in the analysis, the students represented Level 1 and the school represented Level 2. The degree of dependence of observation was measured by the ICC, using Mplus. Our model included five manifest independent variables (gender, parent's marital status, family country background, optimism, and pessimism) and one manifest dependent variable (HRQOL).

In further analyses using SPSS and logistic regression, adolescents' school affiliation and cluster were adjusted for by including dummy variables for each school in the regression model (Rice & Leyland, 1996). Multivariate logistic regression models were used to further calculate the associations between self-rated HRQOL, optimism, and pessimism. Scores of self-rated HRQOL were dichotomized into above mean (high) and below mean (low) scores. In the regression models, optimism scores and pessimism scores were categorized according to age-specific quartiles into four groups. Cut-off points in the early adolescents group were 13 (q1-reference), 15 (q2), and 16 (q3) in optimism and 0 (q1-low), 1 (q2), and 3 (q3-reference) in

pessimism. Cut-off points in the midadolescent group were 14 (q1-reference), 15 (q2), and 16 (q3) in optimism and 0 (q1), 1 (q2), and 3 (q3-reference) in pessimism. Results were reported as odds ratios (OR) with 95% confidence intervals (95% CI). Two multivariate models were used: The first model included gender as a covariate and the second model gender, parent's country background, and marital status.

Missing Data

A number of adolescents (n = 153) who had agreed to participate did not complete the total HRQOL. The extent of missing data on the statements of optimism and pessimism varied from 0.6% to 7.3% in the early adolescents group and 0.2% to 11.0% in the midadolescent group. On the sociodemographic characteristics variables (gender, parent's marital status, and family country background), the extent of missing data ranged from 0.6% to 3.0% in the early adolescents group and 0.2% to 2.5% in the midadolescents group. We used the full information maximum likelihood approach to produce the maximum likelihood estimation of parameters using Mplus.

Results

The purpose of this study was to explore optimism as a health asset to promote well-being among adolescents, we used two hypotheses to explore: (a) There is an association between adolescent's self-rated optimism and pessimism and HRQOL and (b) the association between adolescent's self-rated optimism and pessimism and HRQOL changes when gender and sociodemographic characteristics are taken into account. Tables 2 and 3 summarize the descriptive statistics for HRQOL, optimism and pessimism, gender, parent's marital status, and family country background by age group. The mean of total HRQOL indicates lower in the older age group (M = 3.87, SD = 0.39) compared with adolescents in the early adolescent group (M = 4.35, SD = 0.37; Table 2). Adolescents in both age groups were quite optimistic about their future, with high mean optimism and low mean pessimism scores (Table 3).

Table 4 presents the regression coefficient estimates from multilevel models. The interclass correlation was zero (ICC = .000), which indicates that the variance between school (Level 2) and HRQOL was negligible. We found that self-reported optimism was significantly associated and positively related to HRQOL within level (Level 1) controlling for gender, parent's marital status, and family country background, which means that adolescents in both age groups who reported high levels of optimism were more likely to report higher levels of HRQOL than adolescents reporting lower levels of optimism. Furthermore, in both age groups, the student's self-reported pessimism was significantly associated and negatively related to HRQOL within

Table 2
Mean (SD) and Minimum and Maximum Scores in Health-Related Quality–of-Life (HRQOL) Total Scores and in Different Dimensions of HRQOL in Early Adolescence Group and in Midadolescence Group

	Early adolescence group (n = 467)			Midadolescence group (n = 481)		
	M (SD)[a]	Minimum scores	Maximum scores	M (SD)	Minimum scores	Maximum scores
HRQOL total score	4.35 (0.37)	2.71	5.00	3.87 (0.39)	1.73	4.69
The different dimensions of HRQOL						
Physical function	4.19 (0.59)	2.29	5.00	3.87 (0.57)	1.00	5.00
Psychological function	4.08 (0.55)	2.13	5.00	3.95 (0.59)	1.00	5.00
Outlook of life	4.47 (0.52)	2.19	5.00	4.10 (0.83)	1.00	5.00
Physical symptoms	4.52 (0.33)	2.88	5.00	[b]		
Body image	[b]			3.98 (0.68)	1.13	5.00
Social function	[b]			4.28 (0.64)	1.00	5.00
Intimate relations	[b]			4.10 (0.75)	1.25	5.00
Cognitive function	[b]			3.27 (0.25)	2.33	4.22

Note. Missing data (early adolescence, midadolescence): HRQOL total score (67, 84), physical function (19, 19), psychological function (27, 33), outlook of life (30, 12), physical symptoms (26, a), body image (a, 28), social function (a, 16), intimate relations (a, 18), and cognitive function (a, 28).
[a]The mean was based on: all items in the Manchester–Minneapolis Quality-of-Life (MMQL) instrument were summarized and dividing by the number of items into a total score. [b]Missing value due to differences in MMQL version according to age.

Table 3
Mean (SD) and Minimum and Maximum Scores in Optimism, Pessimism, and Sociodemographic Characteristics in Early Adolescence Group and in Midadolescence Group

	Early adolescence group (n = 467)			Midadolescence group (n = 481)		
	M (SD)	Minimum scores	Maximum scores	M (SD)	Minimum scores	Maximum scores
Generalized expectancy for success scale						
Optimism sum score	14.42 (2.12)	2	16	13.93 (1.00)	1	16
Pessimism sum score	1.53 (1.72)	0	10	1.93 (1.96)	0	11
		n (%)		n (%)		p[a]
Sociodemographic characteristic						
Gender						
Girls		229 (49.4)		227 (47.2)		.51
Boys		235 (50.6)		254 (52.8)		
Parent's marital status						
Divorced parents						
No		316 (69.6)		322 (68.1)		.62
Yes		138 (30.4)		151 (31.9)		
Family country background						
One or two parents born outside Sweden						
No		282 (62.3)		296 (63.0)		.82
Yes		171 (37.7)		174 (37.0)		

Note. Missing data (early adolescence/midadolescence): optimism sum score (105, 141), pessimism sum score (85, 124), gender (3, 1), parents marital status (13, 9), and family country background (14, 12).
[a]Based on chi-square test, $p < .05$.

Table 4
Estimates (SE) for the Performed Multilevel Linear Models

	Health quality of life		
	Estimates (β)	(SE)	p
Early adolescence group			
Optimism	.24	(.05)	< .001
Gender (girls/boys)	.24	(.04)	< .001
Parents marital status: divorced parents (no/yes)	−.07	(.02)	.002
Family country background: one or two parents born outside Sweden (no/yes)	.10	(.05)	.05
R^2	12.2%		
Pessimism	−.26	(.04)	< .001
Gender (girls/boys)	.25	(.05)	< .001
Parents marital status: divorced parents (no/yes)	−.04	(.02)	.07
Family country background: one or two parents born outside Sweden (no/yes)	.10	(.05)	.07
R^2	12.9%		
Midadolescence group			
Optimism	.37	(.03)	< .001
Gender (girls/boys)	.26	(.04)	< .001
Parents marital status: divorced parents (no/yes)	−.11	(.03)	< .001
Family country background: one or two parents born outside Sweden (no/yes)	.02	(.03)	.49
R^2	21.9%		
Pessimism	−.36	(.08)	< .001
Gender (girls/boys)	.24	(.03)	< .001
Parents marital status: divorced parents (no/yes)	−.15	(.04)	.01
Family country background: one or two parents born outside Sweden (no/yes)	.01	(.09)	.78
R^2	21.5%		

Table 5
The Odds Ratio With 95% Confidence Intervals for High Health-Related Quality of Life (Above Mean) by Quartile of Optimism and Pessimism in Early Adolescence Group and Midadolescence Group

	Early adolescence group			Midadolescence group		
	OR[a]	95% CI	*p*	OR[a]	95% CI	*p*
Levels of optimism						
Crude						
Quartile 1—Low	1.0	—		1.0	—	
Quartile 2	1.59	(0.80, 3.16)	.19	1.21	(0.62, 2.37)	.57
Quartile 3	2.34	(1.27, 3.87)	.01	1.72	(1.02, 2.88)	.014
Quartile 4—High	4.02	(2.35, 6.88)	< .001	2.63	(1.50, 4.60)	< .001
Adjusted for gender						
Quartile 1—Low	1.0	—		1.0	—	
Quartile 2	1.54	(0.77, 3.07)	.22	1.28	(0.64, 2.55)	.48
Quartile 3	2.22	(1.27, 3.86)	.01	2.10	(1.22, 3.61)	.01
Quartile 4—High	3.97	(2.31, 6.83)	< .001	3.97	(1.76, 5.67)	< .001
Adjusted for gender, family country background, and divorced parents						
Quartile 1—Low	1.0	—		1.0	—	
Quartile 2	1.57	(0.77, 3.19)	.21	1.24	(0.61, 2.52)	.55
Quartile 3	2.09	(1.18, 3.70)	< .001	1.97	(1.18, 3.70)	.017
Quartile 4—High	3.80	(2.18, 6.60)	< .001	3.09	(2.18, 6.60)	< .001
Levels of pessimism						
Crude						
Quartile 1—Low	3.30	(1.73, 6.28)	< .001	4.69	(1.74, 5.44)	< .001
Quartile 2	1.84	(0.96, 3.52)	.07	5.35	(1.81, 6.23)	< .001
Quartile 3	2.28	(1.11, 4.66)	.02	1.97	(0.98, 4.00)	.06
Quartile 4—High	1.0	—		1.0	—	
Adjusted for gender						
Quartile 1—Low	3.36	(1.76, 6.44)	< .001	4.70	(2.23, 9.91)	< .001
Quartile 2	1.90	(0.98, 3.67)	.06	5.34	(2.44, 11.79)	< .001
Quartile 3	2.32	(1.13, 4.78)	.02	1.97	(0.97, 4.00)	.06
Quartile 4—High	1.0	—		1.0	—	
Adjusted for gender, family country background, and divorced parents						
Quartile 1—Low	3.36	(1.67, 6.65)	< .001	4.62	(2.07, 10.31)	< .001
Quartile 2	1.92	(0.98, 3.80)	.06	4.75	(2.05, 11.01)	< .001
Quartile 3	2.09	(0.99, 4.41)	.05	1.75	(0.82, 3.71)	.06
Quartile 4—High	1.0	—		1.0	—	

[a]Association were analyzed using logistic regression, $p < .05$.

level (Level 1) controlling for gender, parent's marital status, and family country background. This indicates that adolescents reporting high levels of pessimism were more likely to report a lower level of HRQOL than adolescents reporting lower levels of pessimism (Table 4). These results indicate that Hypothesis 1 was not rejected as there was an association between adolescent's self-rated optimism and pessimism and HRQOL.

Table 5 presents odds ratio with 95% confidence interval of the likelihood of rating high HRQOL in different levels of optimism and pessimism. The association between high levels of optimism and high self-rated HRQOL was significant in the early adolescent group (OR = 4.02, 95% CI [1.27, 3.87], $p = .01$) and in the midadolescent group (OR = 2.63, 95% CI [1.50, 4.60], $p \leq .001$) compared to low levels of optimism. This association was stable after adjusting for gender, parent's marital status, and family country background in both age groups. Adolescents with low pessimism were more likely to rate high HRQOL, in the early adolescent group (OR = 3.30, 95% CI [1.73, 6.28], $p \leq .001$) and in the midadolescent group (OR = 4.69, 95% CI [1.74, 5.44], $p \leq .001$). These associations remained significant when adjusting for gender, parent's marital status, and family country background both in the early adolescent group (OR = 3.36, 95% CI [1.67 6.65], $p \leq .001$) and in the midadolescent group (OR = 4.62, 95% CI [2.07,

10.31], $p \leq .001$). The second hypothesis was not rejected regarding gender in the midadolescence group, whereas in the early adolescence group this was not seen. However, the hypothesis was rejected when sociodemographic characteristics were taken into account.

Discussion

This study was set within the context of a health asset framework (Morgan, 2010), which aims to advance the work grown out of positive youth development, prevention, and resiliency (Benson, Scales, Hamilton, & Sesma, 2006; Lerner, Wertlieb, & Jacobs, 2003; Resnick et al., 1997). This framework aims to more systematically confirm those factors that are positively framed and can be defined, are measurable, can explain and predict positive health outcomes, and that can be translated into a set of actions that are implementable for promoting health. A core principle of the health asset framework is that health programs should be driven by theory. Assessing the measurability, explanatory, and predictive power of potential health assets through research can more easily facilitate their translation into practice (Garcia-Moya & Morgan, 2017).

The concept of optimism was identified as a potential "candidate" health asset as by definition it is positively framed and has been measured. Some evidence exists about its links to health-related outcomes, but little of this pertains to the field of adolescent well-being. Our study provides a starting point for understanding the readiness of optimism to be a health asset against the framework described above. The findings from the study will help identify the issues to be addressed by future research so that our knowledge about the utility of optimism as a health asset can be advanced.

Our study provides associational evidence that optimism is protective of HRQOL during adolescence among pupils from junior high schools in a medium-sized rural town in southwest Sweden. The sample included pupils from seven municipal schools based on a geographical distribution of these schools in the town environment and broad sociodemographic representation of the inhabitants. The pupils in this study can be seen as representative of those living in typical rural towns in Sweden. The intention of the study was to contribute to our understanding of the utility of optimism as a health asset for promoting well-being among adolescents. The process of doing so cannot be achieved in one study as the assessment of candidate assets needs to accumulate across studies in different contexts and population groups. However, this study has demonstrated that optimism is measurable. Our findings also suggest based on associations that optimism can be protective for low HRQOL, and the relationship is stable (in both age groups) even after controlling for gender and selected sociodemographic indicators (parent's marital status and family country background). In contrast, it is suggested that high levels of pessimism were a risk factor for rating low HRQOL and the relationship was similarly robust after taking confounding factors into account. Overall, the findings support our first hypothesis that there is an association between adolescent's self-rated optimism and pessimism and HRQOL (i.e., there is some evidence it has explanatory power). Some aspects of the health assets framework have therefore been achieved.

Early and Midadolescence

The findings from this study indicate a significant decrease in optimism and a significant increase in pessimism between early and midadolescence, which is consistent with other research (Patton et al., 2011). The changes seen in optimism and pessimism are interesting from a transitional and developmental perspective. There are multiple challenging transitions during the period of adolescence, for example, onset of puberty and change of schools. From a developmental perspective, we know that from the age of 7, children generally have a capability to use a range of coping strategies to deal with negative emotions (Bamford & Lagattuta, 2012; Holmbeck et al., 1995). Fischer and Leitenberg (1986) conclude that children in early adolescence are generally more optimistic than pessimistic about their long-term future. Patton et al. (2011) found that optimism generally decreases with age (12–14 years compared to 2 years later), and this was particularly pronounced among girls. However, interestingly, a study of preuniversity students (M_{age} = 18.2 years) found that by this age expectancy for success in the future had increased (Yong, 2010). A possible explanation for the findings in our research and in other studies might be that those at the stage of early adolescence may not have been exposed to life expectations, perceived life chances, and attaining goals and are therefore more likely to be optimistic. In contrast, those at the stage of midadolescence are more likely to be less optimistic about the future because of various transitions and accumulated stressful life events.

However, as already stated, it seems that as adolescents progress through this development period, they eventually regain a sense of optimism (Yong, 2010).

The resurgence of optimism could be the result of cumulative exposure to significant positive life experiences and the acquirement of good experiences of coping with new life events. Adolescents' opportunities of acquiring good experience of coping with new life events can be expected to play an important role in the development of an optimistic outlook about personal future (Carver et al., 2010; Wrosch & Scheier, 2003). Effective coping strategies among adolescents involve a capability of adjusting one's goals to certain demands. Individuals with higher levels of optimism have displayed greater flexibility in coping and goal pursuit (Carver et al., 2010; Hanssen et al., 2015; Wrosch & Scheier, 2003). In other words, being able to switch flexibly between different coping strategies might be a capacity, facilitated by an optimistic orientation, that separates, distinguishes, and influences the HRQOL of adolescents.

The changes in the levels of optimism across the adolescent development years highlight the need for more clarity about the definition of optimism, if it is to be put to use for practical purpose. For example, Carver and Scheier (2014) suggest that dispositional optimism is a personality trait that is relatively stable; however, they do concede that changing a person's outlook on life can be done but it is not a simple matter. One of the pre requisites of applying concepts using an asset approach is that they can be clearly defined. Further work to clarify these definitional issues in the context of adolescence is still required.

Gender and Sociodemographic Characteristics

This study indicates that gender had an impact on the relationship between optimism and HRQOL in midadolescence group, whereas the sociodemographic characteristics did not. Therefore, this study's results do not support our second hypothesis and is contradictory to earlier research (Biehl et al., 2014; Orejudo et al., 2012). However, the complexities of the relationships might require further work in different adolescent populations in Sweden and other countries in order to consolidate whether this is true or not.

Findings support wider literature in suggesting that gender has an impact on health-related outcomes (Deptula, Cohen, Phillipsen, & Ey, 2006; Orejudo et al., 2012; Patton et al., 2011). The role of gender and optimism at different ages should be further investigated to increase the understanding of the factors that contribute to the development of optimism. Contrary to expectations, our findings did not show that sociodemographic characteristics have an impact on the relationship between optimism and pessimism and HRQOL. Other research has proposed that optimism can act as a buffer for negative health outcomes associated with poor socioeconomic status (Adler, 2007; Carver et al., 2010; Finkelstein, Kubzansky, Capitman, & Goodman, 2007; Piko, Luszczynska, & Fitzpatrick, 2012). It has also been suggested that such a relationship might be explained by the adolescents' family environment. For example, an adolescents' capability of positive thinking may depend more on the levels of parental optimism (Bamford & Lagattuta, 2012), parents' ability to deliver an optimistic approach to their children (Bamford & Lagattuta, 2012; Orejudo et al., 2012), and a good relationship and communication with parents (Ben-Zur, 2003; Korkeila, Kivela, Suominen, & Batear, 2004; Orejudo et al., 2012). That is, an adolescent's general social environment may be at least as important as the actual socioeconomic status of the family. The relative impact that different dimensions of an adolescent's social environment can have on optimism, and its potential subsequent health benefits are worthy of further study.

Implications for Research, Policy, and Practice

This study was placed with a health asset framework as it aspired to provide a possibility of translating the research findings into practice. It demonstrated that the concept of optimism has the potential to be a health asset given the positive associations found between it and HRQOL. However, in order to put it to practical use in policy and practice, work is required to further understand how best to define and measure it. This will provide more clarity on how to gain more evidence about how optimism can link and explain a range of antecedents along the pathway to adolescent health and well-being. The health asset approach places emphasis on the building of theory in order to advance this understanding, as it is argued that theory-based programs are more likely to be effective (Garcia-Moya & Morgan, 2016; Morgan, 2014). In order to be useful to the asset approach, such theories need to be positively framed. It has already been suggested that the concept of optimism has this potential. (Lindstrom & Erikson. 2010) However, the idea of optimism needs to move from a concept with potential to a theoretically based

framework for action in health promotion orientated toward adolescents. There are a number of specific areas to explore that in the first instance are best suited to review level research. Such work would explore the theoretical underpinnings of optimism and the implications for its definition and measurement, synthesize the current knowledge about the links between optimism and a range of health-related outcomes, and identify the types of environmental factors that can encourage adolescents to be optimistic about the future. This would support the advancement of optimism as an explanatory theory for improving adolescent well-being so that it can be useful to both elements (described in the Introduction) of the health asset approach. Until this work is completed, we argue that the field of optimism research is insufficiently developed for utilization in intervention studies and its translation into policy and practice.

Strengths and Limitations

The obvious limitation of this cross-sectional study (inherent in all cross-sectional designs) is its weakness in establishing causal mechanisms, as this can only be inferred. Thus, it is difficult to rule out if adolescents with greater HRQOL tend to be more optimistic or the other way around. Therefore, our research questions are more ideally suited to longitudinal designs, which can explore the direction of relationships between variables. That said, cross-sectional analysis is important in helping to better formulate future research questions. An additional potential limitation relates to sampling. The seven schools were not randomly selected, instead the selections were based on the need to include sixth–ninth grades and to be large enough to avoid potential identification of individual adolescents in the data as well as to achieve representation of the town's various geographic and sociodemographic areas. The ICC indicated that the variance between school and HRQOL was negligible.

There are a number of strengths to the study. First, the response rate in both age groups of adolescents was high. In addition, the instruments used are internationally established, validated, and commonly used measures of optimism and pessimism and HRQOL. The versions of both the GESS instrument and HRQOL used were also adapted and fit for purpose among children and adolescents. The GESS instrument did, however, compel respondents to answer in a dichotomous way (forced), which could be argued as an additional weakness, contributing to small variations in ratings of optimism and pessimism and influence the statistical analysis. The study was based on self-reported data, which strengthens the results as it is based on an adolescents own perception of their HRQOL, optimism, and pessimism.

Conclusions

The study has allowed us to present associational evidence of the links between optimism and HRQOL in a context of a medium-sized rural town in Sweden. The findings indicate a significant decrease in optimism and a significant increase in pessimism between early and midadolescence. Gender had an impact on the relationship between optimism and pessimism and HRQOL, whereas the sociodemographic characteristics did not. The study infers some potential of an optimistic orientation about the future to function as a health asset during adolescence and by implication may provide additional intervention tool in the planning of health promotion. However, further work is required to articulate optimism as a health asset and to accumulate evidence in different populations and contexts.

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Article III

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Lost in space - an exploration of help-seeking among young people with mental health problems: a constructivist grounded theory study

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Abstract

Background: Mental health problems among young people is a worldwide public health concern. There has been an increase in mental health problems among young people in the Nordic countries in the last 25 years, particularly in Sweden. Despite this increase, international research has repeatedly shown that young people do not access or receive support when encountering mental health problems. The purpose of this study was to explore the process of help-seeking for professional support among young people with mental health problems.

Methods: The study used qualitative constructivist Grounded Theory and open-ended interviews. Thirteen young people between 15 and 23, recruited from two local support clinics, were interviewed.

Results: *Lost in space* emerged as the core category, capturing aspects of both the experience of self and mental health problems as well as the process of seeking and acquiring help from professional support systems. The study identified several prominent barriers for seeking and acquiring professional help for mental health problems. The young people expressed a lack of knowledge on mental health issues and support services and substantial efforts were made to try to cope with problems on one's own. *Lost in space* involved *Drifting - trying to make sense of own experiences and struggling to cope with problems*, *Navigating - searching for help through multiple attempts and contacts* and *Docking - finding support with something/somebody that feels right*.

Conclusions: The theoretical model sheds light on how young people with mental health problems were met with fragmented support services. Society needs to provide encompassing, youth-friendly and flexible support services, so that attempts at help-seeking are not missed.

Keywords: Sweden, Mental health, Young people, Help-seeking, Support services, Grounded theory

Background

Mental health problems among young people is a worldwide public health concern [1, 2]. International studies show that mental health problems in adulthood often originate in adolescence with half of all lifetime cases starting by 14 years of age and up to 75% of mental disorders in adulthood presenting before the age of 24 [3]. Interventions at an early stage may prevent a deterioration of symptoms and increased suffering for individuals as well as reduce further costs for society [4–6]. Previous research has repeatedly shown that young people do not access or receive support when facing mental health problems [7, 8]. There is no straightforward path from a debut of mental health problems to

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gaining access to support, and the process is instead characterized by complex and varied contacts as well as lengthy delays due to both attitudinal and structural barriers [5, 7–10]. Lack of support for mental health problems is troublesome since there is a strong relation between poor mental health and other negative health and developmental concerns [4, 5, 8].

Young people with emerging mental illness typically lack sufficient symptoms to meet the diagnostic criteria required for qualification for support or care despite considerable distress [5, 11, 12]. However, research on help-seeking has been geared towards young people with psychiatric illness and less towards those with milder forms of mental health problems [13]. This is contradictory, as young people with more severe forms of mental health problems are easier to identify and thus more often referred to appropriate care, whereas young people with milder forms of mental health problems often need to rely on their own resources for accessing help [13].

There has been an increase in mental health problems among young people in the last 25 years [2, 14]. Among the Nordic countries, Swedish 15-year-olds self-report the highest rate of psychosomatic health-complaints; pain, low mood, irritability, nervousness and sleeping problems, interpreted as signs of anxiety, depression and stress-related mental health problems [14]. Swedish studies of 16–18-year olds indicate that up to 1/3 of the young population report frequent symptoms such as pain, sadness, tiredness and anxiousness [15]. The increase in mental health problems among young people in Sweden is also evident in rates of suicidal attempts and suicides compared to other age groups [16]. Swedish data also show a clear increase in use of mental health services among young people between 13 and 24 [17, 18]. Despite this, young people express that they do not receive enough support or care [19]. They state that their problems are not taken sufficiently seriously and that they most often try to cope with their mental health problems themselves since support is not available and/or suited to their needs [19].

Inadequate resources, particularly for young people in need of care "in between" general psychosocial support and psychiatric treatment have been highlighted and efforts to improve young people's access to mental health care, evident in Sweden in recent years [20]. Establishment of a new level of care named "First line" started evolving in the beginning of 2000. The purpose was to facilitate access to care for parents, children and adolescents. However, it has not been specified through which structures this should be brought available, but both regional and local authorities such as regular health care, the school and the social services have a joint responsibility in ascertaining proper facilities. By definition, primary care is considered First Line, but this is also the case for voluntary youth health centres and in some instances paediatric psychiatric specialist care [20]. Youth health centres, although common throughout Sweden, are an optional commitment at local level, lacking clear and uniform guidelines from national authorities, common rules, regulations or requirements regarding accessibility, availability and quality of care [21].

Research on the issue of help-seeking for mental health problems among young people in Swedish context is scarce, particularly research focusing on the group "in between". Psychological distress in relation to psychiatric in – and out-patient service use has been measured over time through quantitative analyses, showing a decreasing threshold for psychological distress when seeking psychiatric care, particularly among young women [22]. Other studies have focused on aspects of young people's service experiences of mental health care, establishing preferences of young people when utilizing mental health services [23], and factors for improving accessibility of youth health centres for mental health problems through a questionnaire distributed to users [24]. However, no study seems to have focused on the particular pathway and process of seeking help, and little focus is also on the large group "in between", e.g. before specialist mental health services are needed. Therefore, this study focuses on the process of seeking help through the perspectives of young people, thereby deepening our understanding of their needs, enabling early intervention through support services suited to the needs of young people. The purpose of this study thus, was to explore the process of seeking professional support among young people due to mental health problems through a focus on their experiences.

Methods

This study used the qualitative design constructivist Grounded Theory (GT) [25]. GT is an inductive method, aiming at conceptualizing patterns of human behaviour. The focus is on processes and the context in which they take place. As seeking help is a process involving both the individual and the context where the individual is situated, it was deemed appropriate to use GT as method. Also, constructivist GT permits the existence of active interaction between researcher and participants and the emphasis is on co-construction and voice over conceptualization [25]. This suited the study since most data was collected during interviews where viewpoints were shared and interpretive understanding sought. The analysis and data collection were performed simultaneously and constant reflection and memo-taking were used to enhance analytical thinking. Furthermore, this study was done in line with the view of social constructionism that theory can only offer an interpretive portrayal of the world and not an exact picture [25].

Setting

Two local support services geared directly at young people in a city in southwest Sweden were used for the recruitment of participants; the general Youth Clinic run by the regional health care organization and the Ecclesiastic Youth Clinic run by the local Swedish church. Young people can initiate contact themselves with both services. The Youth Clinic is open for ages 13–23 and focuses on health promotion in the areas of reproductive and mental health, the latter through support and counselling. The Ecclesiastic Youth Clinic is open for young people aged 14–25 and they are welcome to seek support for any issues. Professional support through priest, deacon and behavioural advisor are available through support and counselling. Both support services are free of charge. Due to the variation of involved professionals and contexts in this study, the terms support and counselling have been used consistently through this article, encompassing both counselling, talk therapy, psychoeducation and general support.

Participants

This study was based on data from individual interviews with young people seeking support at the general Youth Clinic and/or Ecclesiastical Youth Clinic. Staff meeting the young persons at the two support services acted as recruiters, scanning inclusion- and exclusion criteria, and presenting the young people with the first written information about the study. The inclusion criteria were; being aged 15–24 and seeking support for mental health problems. In this study, the term 'young people' refers to the study population at hand with individuals aged 15–24. The World Health Organization (WHO) divides young people into adolescents, the age period 10–19, and youth 15–24, with the term young people covering the age range 10–24 [26], whereas the United Nations (UN) uses the term youth and young people interchangeably for ages between 15 and 24 (United Nations) [27]. No mental health assessment was done, which meant that the perspective and experience of the young person was enough for seeking help and being included in the study.

The exclusion criteria were; currently experiencing psychotic symptoms and/or active suicidal plans. The young people were asked to fill in a form stating their interest in participating and this form was passed on to the researcher. If an interest in participating in the study was expressed, the researcher tried to contact the young person. In most instances, contact was established, and a meeting was set up where the researcher gave an overview of the study and provided time for questions. It was carefully explained that participation was voluntary and could be terminated at any time. Informed consent was obtained in two copies and preceded interviewing. A total of 13 meetings and subsequent interviews were conducted. The interviewees were 12 females and 1 male ranging from the age of 15 to 23, with 8 interviewees being 15–19 years of age, and 5 being 20–24. They were primarily students. No sampling was possible, all who expressed a persistent interest in participating were interviewed.

Data collection

The interviews were scheduled soon after expressing willingness to participate. They were carried out at the premises of the clinic, or sometimes at a nearby psychiatric outpatient's clinic where the first author (KHW) also worked clinically. The interviewees were asked broad, open-ended questions and allowed to tell their stories [28]. In order to explore the processes concerning young people seeking and utilizing support, themes of interest were: perceived barriers and facilitators for seeking support, self-image and identity, resources and competence as well as views on organization and the support given. The interviews lasted between 45 and 90 min, and were audiotaped and transcribed by KHW. Sampling continued until similar themes kept re-emerging and saturation was reached, and no new leads or insights emerged, the properties of the categories and the core category were thus considered dense [25].

Data analysis

The constant comparative approach was used for analysing the data. The material was first sorted through initial coding by KHW, which entailed a close examination of the data line by line and subsequently, incident by incident [25]. Initial codes at this point were for example "wanting to be seen" and "needing somebody to talk freely to". KHW continued with focused coding, using the most significant and frequent initial codes. Constant comparison of codes and their content properties and dimensions allowed development of theoretical codes and tentative categories, i.e. the above codes were synthesized into a theoretical code of "feeling a need for help". Theoretical coding occurs as the researcher searches for the relationships between initial codes and describes how these relate to each other [28]. A selection of transcripts and coding was reviewed and discussed with the authors (JN, MN and PS), modifying the interview guide slightly to allow for further exploration. New interviews were compared to previous data and coding. An additional researcher (IMC) with expertise in grounded theory was involved in the analysis at this point and firstly performed an individual analysis in order to crosscheck findings, starting with line-by-line-coding, up to theoretical coding and formation of categories, which were then discussed with KHW, and subsequently the whole research team. The categories

were grouped together and conceptualized to a higher theoretical level, i.e. "Feeling a need for help" was raised to "Fumbling in Life". The three main categories and a core, encompassing category, emerged. A visual model was drafted from the main categories and the core. Memos were continuously kept and used in the constant comparative process, advancing the analysis of relationships between categories and enabling conceptualization. The authors all brought varying competencies and expertise coming from the areas nursing, health intervention and public health, thus constituting a multidisciplinary research team. The analysis was member-checked by the first interviewee at the final stage of the manuscript. The interviewee expressed recognition of the findings and had no objections to the analysis, thus no changes were done after this. The program NVivo was used to assist with data management. Participants' names were changed in order to protect participants' confidentiality.

Results

The core

Lost in space emerged as the core category, capturing aspects of both the experience of self and mental health problems as well as the process of seeking and acquiring help from professional support services. This involved three main categories; *Drifting* - the experience and unfamiliarity of mental health problems made young people drift whilst trying to make sense of own experiences. A struggle to cope with their problems was seen, using multiple strategies, eventually reaching a point of no return and seeking professional help. *Navigating* – the searching for help at various support services through multiple attempts and contacts. An inaccessibility and fragmentation of the support services made the young people navigate between different obstacles, trying to locate and access support. Encountering obstacles often meant going back to drifting before another attempt at navigating. A repetitive process of alternating between Drifting and Navigating was often seen during a prolonged period of time. *Docking* – finding support with somebody that felt right, often leading to an altered and more positive view of oneself (Fig. 1).

Drifting

Drifting was conceptualized as an abstract category, imbued in the young people's lives. This involved fumbling in life through unknown territory and identity forming. Drifting also contained substantial elements of struggling, trying hard to solve one's problems through a variation of strategies, eventually, ending with a point of no return where the young person sought help for mental health problems.

Fumbling in life

Fumbling in life encompassed aspects of both identity and knowledge of mental health problems. Thoughts on personal characteristics were compared to the feeling of having mental health problems and young people found it difficult to untangle the two, however, there was an increasing sense of not recognizing oneself. They maintained that their level of knowledge of mental health and mental health problems was too low. This was described in terms of having no idea of what was going on or

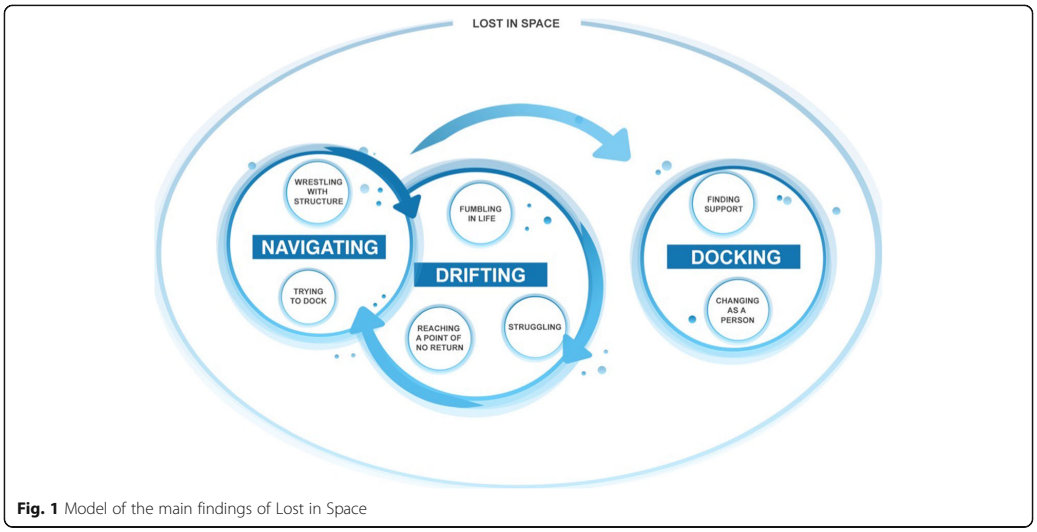

Fig. 1 Model of the main findings of Lost in Space

where to seek help. Difficulties in assessing signs of mental health problems and not being able to describe to others what the problem was, installed a sense of insecurity. One girl expressed:

> *"I suppose mental health problems are when you can't cope with every day things … I think. But there are variations in mental health problems too. I suppose I have had and am suffering from mental health problems but I don't know"* (female, 20).

The lack of knowledge resulted in thinking that the experienced mental health problems would not be "sufficient" for receiving support. Fumbling in life encapsulated a sense of loneliness with feelings of being different from peers. Expressions of not feeling whole and not present belonged to fumbling as well as not being able to think clearly and having part of the brain shut off. It also involved a yearning for somebody to truly see and confirm them, wanting somebody to tell them that they were ok, that they were not "too" different or sick, thus normalizing their experiences. Normalizing was done through expressing that mental health problems was a part of life, using this as rationale for the existence of one's own problems, sometimes comparing oneself to peers or celebrities with known mental health problems. Wishing there would be a tangible, physical issue was also expressed. It was thus important to be on the right side of sanity and young people disputed being labelled (mentally) ill.

Struggling

Struggling explained how the young people dealt with what was perceived as a reduced level of well-being and mental health problems, a challenging and ongoing situation. Strategies were more or less continual, with a constant scanning for relief and attempts at alleviating discomfort. Young people tried strategies for changing themselves, their activities, and surroundings. It meant trying to change attitude and thoughts as well as lifestyle, schools, workplace and friends. Young people tried to find a balance between deflection and finding peace within oneself. It was considered difficult, but not impossible, to impact your own feelings and state of mind. A common strategy was shutting off by limiting social interaction, leading to isolation and a feeling of loneliness. Shutting off also manifested itself as attempts to ignore feelings or postpone dealing with them. Sometimes suppressed emotions and mental health problems would resurface and cause emotional turmoil, bouts of crying or self-harm. This in turn increased the sense of drifting, with difficulties understanding one's own reactions. Trying different strategies resulted in a delay in seeking professional support.

Struggling encompassed a sense of ambivalence, both with regard to personal admittance of having mental health problems as well as seeking support. Talking about problems turned them into something tangible, whilst keeping the problems disclosed, made them less "real". Making the problems visible by seeking support entailed a fear that that there was no help to be had, thus fuelling ambivalence. One participant stated:

> *"I didn't want to seek help, because I didn't want to acknowledge that I had problems. If I say I feel bad, if I seek help and I talk about it, then it becomes something concrete"* (male, 18).

This subcategory entailed experiences of being stuck in a grey dense fog that made life unmanageable. The fog influenced their energy and ability to make decisions. All motivation was gone, there was a sadness and a feeling of lack of own worth. There was also a struggling with disappointment, not living up to own expectations on how to be as well as dealing with problems such as headaches, heartburn, anxiety and sleeping problems. A loss of function and being out of order was described in various settings such as school, work, and the household, often leading to a need for support of some kind. Struggling also contained an elevated sense of responsibility, manifesting itself as a demand to help oneself when experiencing mental health problems, finding the right help and making use of available support. Feeling better was perceived as one's own responsibility, adding to a sense of loneliness and struggle.

> *"Now I have to try and find yoga somewhere and that's not really what I want to do right now. Feeling better seems to be my own responsibility"* (female, 22).

The young people talked of wanting to be strong, to cope on their own and conveyed a pressure of succeeding in life. Sometimes this led to them not sharing information about their own problems, specifically with parents but also close friends were excluded from the difficult experiences. This put a greater strain on the young person.

Reaching a point of no return

After drifting and struggling, a point of no return was eventually reached. Deterioration of symptoms, a loss of, or decreased, function would be the cue to seeking help. This was in some instances described as clear and immediate, involving a sense of being overwhelmed, frozen, overcome with anxiety, panic or sadness.

"I felt bad the whole day. As soon as she had gone, when I came home, I collapsed and cried and had difficulties breathing and a pressure on my chest. And then I felt I'd had enough" (female, 22).

The decision to seek professional help was often dependent on input from somebody else. This was described as somebody else taking control, often family or friends. Other "catalysts" were supportive staff in schools, midwives or church staff, coaching, guiding and supporting the young person to seek professional support.

Navigating

Navigating was used as a depiction for the attempts of young people to seek support and what was encountered during this process. Navigating often lasted a prolonged period of time, and in some instances, years, partly due to a fluctuation of mental health problems but also due to wrestling with structural barriers, with multiple attempts of trying to dock with a functioning supporter.

Trying to dock

The subcategory Trying to dock described how a desire to get help led to recurring attempts at trying to gain support. Trying to dock entailed descriptions of hopes of being helped, being safe and expressions that finally, somebody would notice and help. A feeling of being engulfed in one's own life and context called for help from the outside, where a supporter could help with guidance and an outside perspective on problems. Not knowing what was wrong, increased the feeling of needing somebody to guide you. A longing for somebody outside the family to talk freely with was expressed and a longing for being understood.

"*It felt like I would be safe, like I would get help, things would get better. Somebody will see and understand my problems and will guide me"* (female, 20).

A desire for concrete tools was not uncommon. Sometimes, seeking support for primarily physical sensations, i.e. heart palpitations or pressure on chest constituted a desire to be "seen" as not feeling mentally well. Presented problems, both emotional and physical, were sometimes not taken seriously or picked up on, leading to a sense of sadness, disappointment and worry. Many instances of unhelpful support involving communication problems were described with feelings of not being listened to, but also having problems understanding the supporter. Pointless exercises, unhelpful tips and the supporter having the wrong focus were described. The result of support not being provided as desired or in a way that felt right, was a greater determination to try one's own strategies and/or further attempts of trying to dock elsewhere. A feeling of being unsupported or not cared for was described and the young person went back to drifting.

Wrestling with structure

The subcategory Wrestling with structure captured how obstacles were encountered during the process of seeking support. Waiting times, age limits or not being "sufficiently" ill were all major obstacles to seeking and obtaining support. Lack of resources and supporters recommending other support services due to waiting times was described as absurd. The notion of long queues and waiting times sometimes led to a sense of resignation. Regarding oneself as "too old", or "too young" sometimes constituted an obstacle in approaching certain support services. Being a minor meant occasionally refraining from seeking support, being afraid of guardians finding out. Not having supportive guardians was also sometimes an obstacle for accessing primary medical care.

Various support services were described, the most common being school-staff and the general youth clinic, but other health clinics were also involved in this trial-and-error-pattern of searching for supporters. Primary care was not generally considered an option for seeking support, being regarded as dealing with physical health. Although school staff, school nurses, mentors and counsellors, were valued because of their proximity, this was double-edged since getting support in school was connected with embarrassment and an undesirable show of weakness in front of peers.

When searching for a safe docking station/support service, wrestling with structure meant having to deal with dismissals and referrals with reference to a lack of symptom gravity (not having enough problems), being on an incorrect level of care (not being sick enough or being too sick) or not the right medical speciality. This led to a sense of resignation and an impression that there was no point in trying to seek support and sent young people back to a drifting state of feeling lost.

"I think I just felt very lost. They can't help me here, and they won't help me there. It was like, it was this I suspected would happen and why I didn't bother. No one will care" (female, 23).

Wrestling with structure meant dealing with an inadequate chain of support. Different needs were not accommodated in the same support service and this usually meant having to spread out contacts according to support type (e.g. medical advice at primary care, support and counselling at youth clinic, and physiotherapy, training, yoga etc. at private services). It also meant

having to spread out contacts according to the organization of medical specialities, (i.e. one place for treating eating disorder, one for treating ADD, and another for general support and counselling.) Being forced to seek support at different services, according to a classification of having simultaneous – but different – mental health problems was described as being complicated, too much to deal with, interfering in one's normal life and sometimes led to termination of support.

Young people expressed that they had believed that support would be more coordinated amongst different supporters and generally, tighter follow-up was asked for instead of the responsibility resting on themselves. It was sometimes described how, more or less suddenly, they found themselves without a supportive contact, due to supporter's illness, holiday, referrals not being sent etc. This led to a negative sense of drifting and being on one's own.

Wrestling with structure also surfaced in statements of not understanding why support structures were usually "hidden away". Clearly signposted and visible support services were perceived as helpful, signalling an openness.

> *"If the clinic had been in town, completely openly displayed, like H&M, and it says "Supportive clinic" or "This is a place for talking", then you notice every time you pass it. That will make you remember it. That would also decrease the shame"* (female, 19).

Facilitating factors for support services were identified, such as having an easy access to support, and support being free of charge. Anonymity was greatly valued, particularly in cases where parents had not been helpful or supportive.

Docking

Docking was the conceived space which referred to young people connecting with professional support and how the experience affected thoughts on self. This category contained information on what made contact with a supporter work in a beneficial way.

Finding support

The subcategory Finding support symbolized finding a seemingly safe station. This was described as ending up right but still continuing to struggle and having mental health problems. Finding support meant the feeling of loneliness decreased, simply by knowing there was somebody who cared. Young people described how they were recognized, accepted and listened to. Validation of their experiences made the drifting feeling diminish. Finding support was described as getting guidance, tools, reflections, having a place for venting and getting a perspective on what was going on. Having an outside supporter facilitated openness and constituted a place where feelings could be vented, problems disclosed and enabled feeling "pretty normal". *"Even though you feel bad when you seek support, it feels a little bit better afterwards, because you know you will get help. You are not as lonely as you think. Somebody is there and listens to you. And that feels good"* (female, 18).

A good supporter was described as having proper education and competence combined with personal engagement. It was somebody who could help sort things out through systematic reflection. It was important that the supporter did not judge but at the same time did not become a "new friend". There was also an issue in balancing the actual help. Young people sometimes claimed that their problems were not recognized or discarded as "usual teenage-behaviour", sometimes however, they felt their problems were blown-up and exaggerated, leading to unwanted consequences, i.e. social services were contacted. If the support was unsatisfactory, it was often attributed to the supporter not having enough competence or training. Being a behavioural specialist, primarily psychologists, installed confidence and made the young person feel safe and supported.

Changing as a person

Finding support contained the experience of personal change. Young people described how having mental health problems had changed them as a person. Only positive outcomes were mentioned, e.g. becoming stronger and more empathic. Stronger meant that they were not as easily affected by negativity and also that they had a possibility of helping themselves and others when encountering difficulties, expressed as:

> *"Even if it was really hard, I'm not happy that it happened, but it was still good and I have learnt a lot during this period of time, about myself. So I feel that it actually turned into something positive. But I never thought something like this would happen. Never ever"* (female, 23).

Being strong also meant daring to show weakness, accepting that difficulties and stress were part of life. Changing as a person entailed gaining knowledge, both on themselves but also on mental health and support services. Young people spoke about gaining an appreciation of themselves. Being well and healthy was defined as a matter of being able to deal with issues and having both good and bad days.

Discussion

This study interpreted help-seeking among young people for mental health problems as a process involving three interconnected categories; Drifting, Navigating and

Docking. Drifting entailed aspects of both not recognizing yourself, not being able to assess mental health problems and not knowing where to seek support. Defining aberrations from your usual self is particularly troublesome for young people since they are still in an identity-forming period of life [29] and a need for venting questions and concerns of both physical and psychological character is expressed [30]. An unfamiliarity of mental health problems and support services pushed young people into self-help strategies and delayed help-seeking. The lack of knowledge thus most likely functions as a barrier to seeking support, a predicament that has been indicated in other studies, claiming that awareness and knowledge of mental health is inadequate [31, 32]. However, because help-seeking is a complex process, interventions aimed at improving help-seeking rates through educational and informational initiatives may not suffice [33].

The young people in this study struggled to deal with mental health problems and were ambivalent about acknowledging having problems. Help-seeking made mental health problems public, which in itself constituted a barrier to seek help. This is in line with other research where a tendency to deny the troublesome reality on experiences was found [34]. Normalization has been seen as part of explanation for non-help-seeking, where a circle of avoidance was used for accommodating or denying illness rather than resolving it. The young people in our study regarded help-seeking as only one of many strategies, and focus was not on avoidance but rather activity towards helping one-self. This drive could be useful when looking at accommodating the needs of young people.

The turning point for seeking professional support often coincided with another person instigating or encouraging help-seeking. This might in some instances be very helpful, however, certain groups may run a risk of not benefiting from this such as minors without supportive or resourceful guardians. The importance of socio-economic background for access to healthcare has been repeatedly confirmed, for example in how young people with immigrant background or living in neighborhoods with high levels of socio-economic deprivation being are less likely to gain access to child and adolescent psychiatric clinics through family referrals [35]. Young people who have left school or do not attend school are another group at risk of not accessing support. School has been pointed out as an important arena and gateway for providing support for young people, however since most leave school at the age of 18–19, the influence of counsellors or teachers in improving access to appropriate services for mental health problems is limited [36, 37]. Only one male young person was interviewed. This mirrors real-life, and points to how certain groups of young people have a particularly low help-seeking rate [38, 39]. This is of great concert since boys/young men simultaneously have an increased risk of low mental health when exposed to multiple socio-economic risk-factors [40]. The possible vulnerability of certain groups makes it adequate to ask not how to change help-seeking behaviour but to look at how support systems can adjust to their needs [41].

Navigating as a category entailed noteworthy findings of the fragmentation of the Swedish support services. Young people with mental health problems faced several barriers, including being required to spread out their contacts as well as devoting time and effort to locating available support services. Primary care was not generally recognized by young people as being available or an appropriate support service for mental health problems, which is in line with international literature [7]. A lack of comprehensive care was conveyed, where support had to be sought in various locations and support services. Being referred due to diagnosis, symptom-load, age or simply lack of organizational resources was common. International findings also show major structural barriers for support-seeking are; low availability of care, restricted and/or delayed access, a non-youth-friendly environment and disconnectedness of settings, each operating in a separate silo [5, 39, 42]. There has been widespread acceptance in the last decade that traditional support services are not suited to the needs of young people [12]. Large reforms are evident in some western countries with considerable structural changes of health care systems according to the principle of 'one-stop' multidisciplinary, integrated youth-services [8, 43]. A common denominator in these changes is the "no-wrong-door"- approach and the ambition to move from a fragmented service to a holistic, single and youth friendly service. The integrated youth services often provide both primary care, care for mental health problems, drug and alcohol services, sexual health as well as social services support [43]. A network of around 300 specific youth centres exists in Sweden. They have no state directive and no permanent funding but operate on a voluntary community or regional level. The focus of these youth centres has traditionally been on reproductive and sexual health issues. These centres are generally positively perceived by young people, however, there are big differences between groups in terms of access and widespread differences between centres in resources, staffing and competence [24]. These centres can thus not be considered an integrated youth service. Despite the fact that several Swedish reports have repeatedly established the inequality in access to support between different groups, Swedish national recommendations still focus on expanding collaboration between support services [44].

Due to mental health being a complex area that often requires efforts of a varying nature, cooperation between actors and support services is even more vital – and vulnerable and ultimately puts the young person at risk of not getting adequate support. Looking at international research and the momentum towards integrated youth centres in other parts of the world, it is worth considering whether the fragmented nature of Swedish support services for young people with mental health problems should be subject to a more comprehensive change. The ambition and willingness of young people for self-help may be encouraged but structural factors such as availability and suitability of support services are prerequisites for help-seeking.

Implications

- Considering how young people express they have inadequate knowledge about mental health and where to seek support – initiatives for increasing knowledge on mental health and where to seek support are needed.
- Young people actively try to help themselves, a drive which may be capitalized upon – however, particular consideration for meeting the needs of groups that do not generally seek formal support is important.
- Because young people seeking support for mental health problems are met with a siloed and fragmented support system, it is worth considering a more comprehensive change of the Swedish support system.

Methodological considerations

Quality criteria for a constructivist grounded theory may be credibility, resonance, originality and usefulness [25]. Credibility was strengthened by interviewing young people of various ages during 2 years, 2017 and 2018 at two different support services, both general health care and ecclesiastical. However, a larger sample with more interviewees and clinics, might have offered a larger variation. Several researchers were involved, performing separate coding and analysis, adding to the trustworthiness of the method. The methodological approach was thoroughly described, thus making the research process available to the reader. The study was performed in a local context with two specific clinics and may not be transferable to any setting, however, we regard the processes of help-seeking as highly transferrable to other similar contexts. Findings were in line with research from other western states, indicating the usefulness of the findings. Resonance and analytic rigour were ascertained by member-checking the analysis with one interviewee. It is however important to note, that the perspectives of young people who do not seek formal help at all, were not captured through this study.

Conclusions

The theoretical model of this study sheds light on how young people with mental health problems were met with fragmented support services, making them Lost in space. A feeling of drifting, struggling on one's own and navigating whilst wrestling with structure for accessing adequate support emerged. Society needs to provide encompassing, youth-friendly and flexible support services, so attempts of help-seeking are not missed. Further research is needed on how best practice models for meeting the mental health problems of young people are delivered in the Swedish context, particularly on how to meet the needs of today's under-served groups of young people.

Abbreviation

GT: Grounded theory

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Authors' contributions

All authors (KWH, JMN, MN, IMC and PS) made significant contributions to the original paper. KWH, JMN, MN and PS together identified the research question and designed the study. Applications for funding and coproduction agreements were put in place by JMN. Data collection (the interviews) was carried out by (KWH). Data analysis was performed by (KWH, MN, IMC and PS) and then discussed with all authors (KWH, JMN, MN, IMC and PS). The manuscript was drafted by (KWH), and (JMN, MN, IMC and PS) provided critical revision of the paper in terms of important intellectual content. All authors (KWH, JMN, MN, IMC and PS) have read and approved the final submitted version.

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Availability of data and materials

The data generated and/or analysed during the current study are not publicly available due to participant privacy but are available from the corresponding author on reasonable request.

Ethics approval and consent to participate

The Regional Ethical Review Board in Lund, Sweden granted the formal approval for the study (Dnr 2017/29). The participants were all given oral and written information, first from the recruiting contacts at the clinic they had approached, and subsequently from the researcher. No contact or information was shared with the guardians because the participants had in some instances approached the clinics without their guardians' knowledge, even though the participants were sometimes under 18. Permission to interview minors is usually granted from the age of 15 in Sweden, which was also the case in this study.

Consent for publication

All participants provided their consent to publish findings by signing the informed consent form.

Competing interests
The authors declare that they have no competing interests.

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Publisher's Note

Article IV

Title

Seeking help for mental health problems among young people – a scoping review

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Abstract

Background: Few young people seek or successfully access support for mental health problems. This is a challenge also in countries with supposedly good availability to healthcare. Despite extensive research, there is a need for a nuanced understanding of young people's perspectives in relation to the help-seeking process. This scoping review aimed to examine literature on mental health help-seeking among young people, with a particular focus on exploring young people's own perspectives as well as to validate and further develop a

previously developed theoretical model describing help-seeking among young people for mental health problems.

Methods: The scoping review framework according to Arksey & O'Malley was utilized, including a qualitative elaboration suggested by Levac. The databases Medline/PubMed, CINAHL and PyscINFO were used to retrieve articles published between 2010-2020, investigating help-seeking among young people with a user perspective.

Results: From 1540 articles identified as potentially eligible for inclusion, 12 articles met both inclusion and exclusion criteria. Included articles were done in North America, Australia and Europe. There was a high level of conformity between the previously developed model on help-seeking and the analyzed articles. Findings showed that help-seeking was a dynamic and psychosocial process without sequentially fixed stages. Young people expressed an unfamiliarity of mental health-related issues rendering feelings of powerlessness. They did not apprehend the support structures as responsive nor available or accommodating the fluid and changeable nature of help-seeking. A strong wish for self-reliance and safe-guarding one's own health was expressed by the young people. More information is required on how to improve the support system and the help-seeking process by capitalizing on the young people's aspiration for self-reliance.

Background

The mental health of young people is a major public health issue, contributing to impaired physical and mental health, extending into adulthood (1-3). Promoting mental health of young people is an integral component in ensuring their development and improving health and social wellbeing across their lifespan (3). In light of the high rate of mental health problems among young people, a corresponding high rate of help-seeking and use of support resources could be assumed, but few young people actually seek and eventually access professional help. Such delays can be lengthy and are prevalent also in countries with good availability of healthcare (4-9). The delayed help-seeking process for young people with mental problems contains barriers relating to both individual and social context factors, such as mental health literacy and stigma (8, 10). This contributes to a complexity in offering interventions to support their help-seeking and highlights the necessity to understand the help-seeking process for young people with mental problems.

Help-seeking is usually described as a rational, agency-based process where the individual plans, decides and acts on symptoms (11). However, research also describes that help-seeking is not entirely an individual act, but influenced by social factors throughout the process. The societal organizational support structures also sets the limits and stipulates the possibilities for seeking help (Pescosolido & Olafsdottir, 2013). Help-seeking thus depend on both factors at individual level and structural resource for young people. Many studies examining help-seeking for mental health among young people, use a cross-sectional design on general community, or school populations (8, 12) with descriptive data, often based on surveys, focusing on attitudes not experiences (13). The main focus has been on individual factors, such as mental health literacy, and less information can be found on structural factors (8, 12). Due to this, a deeper and more nuanced understanding of young people's mental health help-seeking is needed, particularly regarding contextual factors, and from the experiences and perspectives of the young people. An understanding of the heterogeneity of help-seeking for mental health problems, may be used to improve the quality of service delivery and eventually the mental health of young people.

This was the starting point for a qualitative study with the purpose to understand the help-seeking process from the perspectives of young people with mental health problems in Sweden (14). The study showed that help-seeking was often a long, non-sequential, and dynamic process. Young people described a process where they moved in and out of the three phases

Drifting, Navigating and Docking that described the theoretical model; Lost in space. Drifting was characterized by insecurity and unfamiliarity with a lack of knowledge of mental health and the support system, Navigating was characterized by structural obstacles, a fragmented support system and desires for help, whereas Docking was characterized by experiences of finding help. For the purpose of usefulness, it is essential to validate and understand if the model can be applied to other settings and contexts, for example if the model is consistent with the experiences from help-seeking of young people from other countries. Therefore, the aim of this scoping review was to examine literature on mental health help-seeking among young people, with a particular focus on exploring young people's own perspectives as well as to validate and further develop a previously developed theoretical model describing help-seeking among young people for mental health problems.

Methods

A scoping review was deemed the most preferable approach for responding to this broad area of interest, rather than focusing on a specific research question or evaluation of clinical interventions (15). Scoping reviews maintain a broad window for inclusion of the kinds and quality of studies included (16). The methodological framework originally proposed by Arksey and O'Malley was used, entailing five framework stages, further developed by Levac with a qualitative elaboration of the material (16, 17). These stages provide a clear sequential order for identifying and collecting studies, charting the data and reporting results.

Stage 1; identifying the research question

A multidisciplinary research team with experience from health science research including public health, nursing, and youth research was assembled to discuss and clarify the scope of inquiry and identify research questions. The target population of interest was defined as young people with experience of mental health problems, and experience of help-seeking for mental health problems. Mental health problems were defined as referring to commonly experienced problems of depression or anxiety as well as behavioural and emotional problems. Considering the concept of help-seeking, the term is used for understanding the delay of care and to explore possible pathways for mental health promotion. Conceptually, help-seeking behaviour was regarded as a process influenced by social, psychological and contextual factors (18). The overall aim was to examine national and international literature on help-seeking for mental health problems among young people and their perspectives as help-seekers. Three specific

aims were formulated: 1) map general characteristics of published literature focusing on the perspectives of young people seeking help for mental health problems, 2) synthesize the knowledge of the help-seeking process from the perspectives of young people and 3) validate a previously developed theoretical model on help-seeking "Lost in space" based on published literature.

Stage 2; identifying relevant studies

A search strategy was developed together with a librarian to develop search terms using subject heading terms where possible, adapted to each of the three included databases; Medline/PubMed, PsycINFO and CINAHL. The search terms for the target population were i.e. adolescents and young, the search terms for the health outcome were i.e. mental health, depression, and anxiety, and the search term for the concept of interest was help-seeking. Other search limits were studies written in English between 2010 and 2020. The searches were conducted during summer 2020. See appendix A for full search strategy.

Inclusion and exclusion criteria

Studies were eligible for inclusion if they investigated help-seeking among young people with mental health problems between 11-25 years of age. Only studies that specifically investigated young people's own perspectives of experiencing or having experienced mental health problems and help-seeking were included. Since the intention was to understand help-seeking among young people with mental health problems, studies on particular target groups or populations were excluded, such as studies on specific treatment interventions. Likewise, studies where help-seeking attitudes or potential help-seeking intentions of a general population without personal experience of the issues of interest were excluded. Studies not specifically focusing on adolescents or young people, thus studies with a more population-based perspective, or encompassing wider age groups, were excluded. Theses, comments, editorials, consensus statements and other opinion-based papers were excluded as well as studies solely exploring the perspectives of others than the help-seekers themselves (families, helpers, professionals etc).

Stage 3; study selection

All identified studies from the searches were imported to EndNote and duplicates removed. Screening was carried out with a sequential, stepped approach, and an iterative process

between the authors of the study (17). In the first step of study selection, titles and periodically abstracts, were screened by KHW who discarded obviously irrelevant studies based on the exclusion criteria. In the second step of study selection, abstracts of the remaining studies were screened independently by three of the authors (KHW, PS, MN) to determine eligibility based on the defined inclusion and exclusion criteria. Disagreements between the authors were discussed with a fourth author (JN). The third step of study selection required KHW to examine the full-text of the remaining articles to determine eligibility. This full-text examination was discussed with all authors. A PRISMA diagram (figure 1) details the screening process with number of papers retrieved and selection of the included studies.

Stage 4; charting the data

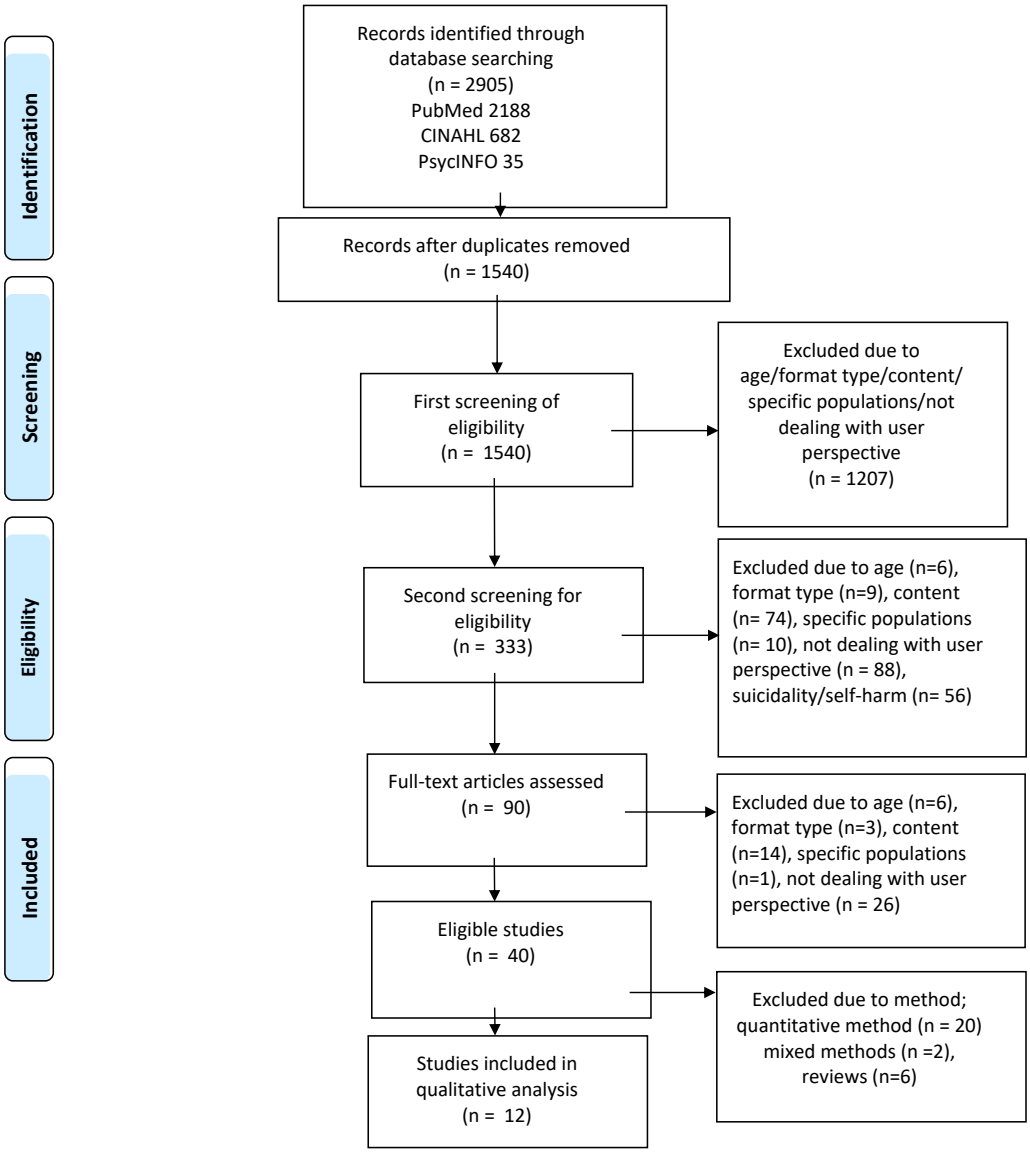
Data charting was done in accordance with scoping review standards, using a developed form for extracting information from each study on; authorship, year of publication, journal, source of origin, design, population and age group, aims of the study, methodology, and important results (16). A descriptive, numerical summarization presenting the extent, nature and scope of included studies was done (17), see table 1 for full bibliographic information of included studies.

Stage 5; collating, summarizing, and reporting results

The intention of the scoping review was to synthesize the knowledge and aggregate findings from the included studies, thus a qualitative thematic analysis was used (17). For the thematic analysis, an abductive approach was used (19). The theoretical model "Lost in Space" describing help-seeking among young people for mental health problems in a Swedish context (14) was used for the deductive process in the analysis. A categorization matrix was developed from the theoretical model, emanating from properties of themes in original subcategories and categories. The analysis began with reading the findings in the included articles several times, then identifying and inductively coding text and quotes in relation to the research questions of the study (20). In this phase, data was inductively scrutinized to discover patterns, experiences, expressions and perspectives with codes being close to the data (20). Then, the deductive process involved going back to the data and placing the inductively derived codes into themes and subcategories of the theoretical model. Codes that

did not match the theoretical model subcategories, contributed with new aspects to existing themes of the model and in some cases, generated new themes, broadening the understanding of help-seeking for young people with mental health problems. KWH performed the data analysis and to enhance the quality and validity of the analysis, the data analysis was discussed continuously with all authors.

Figure 1. Prisma diagram of study selection process.



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *P*referred *R*eporting *I*tems for *S*ystematic Reviews and *M*eta-*A*nalyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit www.prisma-statement.org.

Results

Mapping the characteristics of published literature

In total, 1540 articles were identified as potentially relevant records through the database searches. After the first screening of title and abstract, 1207 articles were excluded on the basis of age, format type, content (as in not dealing with help-seeking), focusing on specific populations or not being based on a user perspective. In the second round of screening, another 243 articles were excluded due to the eligibility criteria. In the third round of screening, the remaining 90 articles were reviewed in full-text and of these 12 articles met the full set of eligibility criteria.

The characteristics of the included studies are described in table 1. Seven articles were published between 2010-2015, and 5 articles were published after 2016. The design was mostly qualitative with individual interviews (n=9) and focus groups (n=7). Seven articles utilized a combination of methods (for example mixed methods), two articles included information from surveys. The focus of articles covered; social and organizational factors impacting help-seeking, functional concerns, attitudes towards computerized mental health support, attitudes to consulting primary care, perceptions and help-seeking behaviours in schools, exploration and identification of barriers and facilitators in general populations with and without previous experience of mental health support, barriers and facilitators in male groups specifically, connections of masculinities and help-seeking, comparing groups' help-seeking strategies and descriptions of experiences, self-management and help-seeking. The recruitment for participants varied from educational settings (n=4), youth mental health services (n=2), community websites (n=1), primary care (n=1), youth services (n=2), previous participation in longitudinal studies (n=2) and community samples (n=3). Four articles focused on young males, and four specifically on barriers to help-seeking. Three articles were set in USA, one in Canada, three in Australia and five in Europe. No studies covered Scandinavia or Sweden specifically. Ages between 11-25 were included with a variation of age clusters, the smallest age group being 2 years (ages 20-22) and the largest being 13 years (ages 12-25), mean age group covered was 6 years.

Table 1. Characteristics of the articles included in the review

Author	Title	Journal	Year	Country	Aim	Design	Sample (study population and age)	Main results
Anyon, Y. et al.	Help-Seeking in the School Context: Understanding Chinese American Adolescents' Underutilization of School Health Services	Journal of School Health 2013 Vol. 83 Issue 8 Pages 562-572	2013	USA	To identify and investigate social and organizational factors unique to Chinese American students' help-seeking process in a school context	Sequential mixed methods; cross-sectional survey followed by a grounded theory approach with focus groups and individual interviews. Recruited in schools.	Stated according to high school grades 9-12, equivalent of ages 14-18. Survey N= 1744 Qualitative part N=51	Contextual influences shaped students' help-seeking trajectories in schools more than attitudinal and behavioural barriers. Chinese American students' constrained self-identification hinder help-seeking in schools.
Cairns, A. et al.	Exploring functional concerns in help-seeking youth: a qualitative study	Early Interv Psychiatry 2015 Vol. 9 Issue 3 Pages 228-33	2015	Australia	To explore functional concerns of help-seeking young people	Qualitative, semi-structured interviews, content analysis. Recruited at youth mental health clinic.	Age 14-25 N=10	Identified four themes for seeking help; relationships, emotional problems, risk-taking behaviour and employment concerns. Themes differed somewhat according to age.
Clark, L. H. et al.	Capturing the Attitudes of Adolescent Males' Towards Computerised Mental Health Help-Seeking	Australian Psychologist 2018 Vol. 53 Issue 5 Pages 416-426	2018	Australia	To explore the attitudes of young males towards computerized mental health support and treatment	Qualitative, semi-structured interviews and focus groups, content analysis. Recruited at child and adolescent mental health services, schools and community website.	Age 12-18 N=29	Barriers for computerized mental health interventions were unfamiliarity, control over decision-making, effort involved and confidentiality. Barriers were found to be much the same as barriers for accessing other kinds of support, however, it was still suggested that computerized mental health support was more accessible.
Corry, D. A., Leavey, G.	Adolescent trust and primary care: Help-seeking for emotional and psychological difficulties	J Adolesc 2017 Vol. 54 Pages 1-8	2017	N Ireland	To explore adolescents' attitudes to consulting their GP for psychological problems.	Qualitative, focus groups, thematic analysis. Recruited in schools.	Age 13-16 N=54	A general reluctance to engage with the GP was noted, primarily due to a pervasive lack of trust. Girls expressed being more anxious about seeking help from GPs whereas older boys were particularly concerned about confidentiality.
Lindsey, M. A. et al.	Understanding the Behavioral Determinants of Mental Health Service Use by Urban, Under-Resourced Black Youth: Adolescent and Caregiver Perspectives	J Child Fam Stud 2013 Vol. 22 Issue 1 Pages 107-121	2013	USA	To explore mental health help-seeking behaviours and perceptions of mental health services in schools among urban, under-resourced Black youth, applying the Unified Theory of Behaviour as theoretical construct.	Qualitative, focus groups. Recruited in schools by a school mental health clinician.	Age 11-14 N=16 (+11 caregivers)	Negative expectancies and social norms regarding mental health treatment were seen to influence service use negatively.
Lynch, L. et al.	Young Men, Help-Seeking, and Mental Health Services: Exploring Barriers and Solutions	Am J Mens Health 2018 Vol. 12 Issue 1 Pages 138-149	2018	Ireland	To explore barriers to, and solutions for, professional help-seeking for mental health problems amongst young men.	Qualitative, individual interviews and focus groups, thematic analysis. Recruited at local youth service.	Age 18-24 N=17	Key themes of barriers touched on both personal and environmental factors. Important findings were that young men fear psychiatric medication and homophobic responses from professionals, and highlights the need for implementing mental health education.
Martinez-Hamaez, A. et al.	Non-professional-help-seeking among young people with depression: a qualitative study	BMC Psychiatry 2014 Vol. 14 Pages 124	2014	Spain	To explore reasons for non-professional help-seeking and obtain recommendations for improving access to mental health care services.	Qualitative, individual interviews and focus groups Recruited through previous participation in a longitudinal study.	Age 17-21 N=105	Reasons for not seeking help were strongly conditioned by gender. A three-phase model was proposed of the help-seeking process; normalization, problematization and evaluation of consequences.
Rice, S.M.et al.	Young men's access to community-based mental health care: qualitative analysis of barriers and facilitators	J Ment Health 2018 Vol. 27 Issue 1 Pages 59-65	2018	Australia	To identify barriers and facilitators to mental health care as identified by young men with a recent history of help-seeking.	Qualitative, individual interviews and focus groups, thematic analysis.	Age 12-25 N=25 (25 young men + professional supporters)	Identified barriers to seeking help were; male role expectations, unfamiliarity with talk therapy, difficulties navigating the system, intake processes. Facilitators were; positive initial contact, effective

						Recruited at youth-specific early intervention centres.		cross-sector partnerships, availability of male supporters and use of targeted messaging.
Salaheddin, K. and Mason, B.	Identifying barriers to mental health help-seeking among young adults in the UK: a cross-sectional survey	Br J Gen Pract 2016 Vol. 66 Issue 651 Pages e686-92	2016	UK	To explore barriers in accessing mental health support among young people.	Quantitative, cross-sectional survey + open ended question with thematic analysis. Community sample.	Age 18-25 N=203	More than 1/3 of participants did not seek help despite having emotional or mental health problems. Major barriers to help were; stigmatising beliefs, difficulties identifying or articulating concerns, a preference for self-reliance and difficulties accessing help.
Spence, R. et al.	Help-seeking in emerging adults with and without a history of mental health referral: a qualitative study	BMC Res Notes 2016 Vol. 9 Issue 1 Pages 415	2016	UK	To explore help-seeking strategies in young adults with or without a history of referrals, compare differences between groups and explore barriers to care.	Qualitative, semi-structured interviews, thematic analysis. Recruited from a longitudinal study.	Age 20-22 N=29	Young people used a combination of approach and avoidant techniques for dealing with mental health problems. Those with a history of referral to support services suffered more from stigma and were more likely to rely on avoidant or suppression techniques which was interpreted as having consequences for choice of help-seeking strategies.
Stafford, A.M. et al.	Getting a Grip on My Depression: How Latina Adolescents Experience, Self-Manage, and Seek Treatment for Depressive Symptoms	Qualitative Health Research 2019 Vol. 29 Issue 12 Pages 1725-1738	2019	USA	To develop a framework that describe experience, self-management and treatment-seeking for depressive symptoms by Latina adolescents	Qualitative, semi-structured interviews, grounded theory. Recruited from primary care and community settings.	Age 13-20 N=25	A five-phase psychosocial process was found to depict the process of experiencing, self-managing and seeking help.
Tang, M.O. et al.	College men's depression-related help-seeking: a gender analysis	J Ment Health 2014 Vol. 23 Issue 5 Pages 219-24	2014	Canada	To describe connections between masculinities and help-seeking of college men with depression.	Qualitative, semi-structured interviews, interpretive description. Recruited at university.	Age 19-25 N=21	Three themes were identified; denying weakness, limiting self-disclosure and mastering autonomy, redefining strength

Synthesis of knowledge of the help-seeking process from the perspectives of young people

The findings from this synthesis showed a high level of agreement with the theoretical model Lost in Space. Overall, the results showed that help-seeking was a dynamic and psychosocial process without sequentially fixed stages, where young people expressed an unfamiliarity and insecurity, lack of knowledge of mental health issues, a longing for self-reliance and in some contexts, a presence of stigma. Young people did not apprehend the support structures as responsive nor available. Some elements that emerged in the analysis were not readily encompassed within the subcategories in the original model; stigma and trust. Other elements that emerged showed further dimensions of experiences that contribute to an in-depth understanding and new perspectives of established subcategories in the model (see table 2).

Table 2. Synthesis of knowledge of the help-seeking process from the perspectives of young people

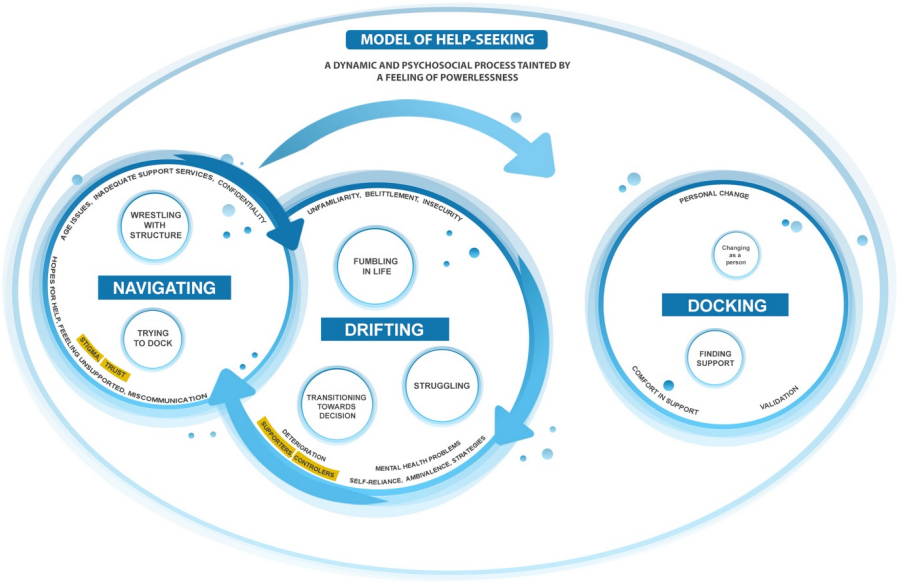
Category	Subcategory		Theme				
	Original/NEW	Comments	Original/NEW	Number of meaning units in the analysis	Confirmed content	New content	Comments
Drifting	Fumbling in life		Unfamiliarity	23	✓		
			Belittlement	7	✓	✓	Also presented as a rational strategy whereas in the original model primarily related to a sense of insecurity
			Insecurity	2	✓		
	Struggling		Ambivalence	7	✓		
			Endavouring strategies	23	✓	✓	Strategies also emerged to character as avoidant/approach and destructive/constructive. The particular strategy Denial was also presented as relating to embarrassment and protection of others, besides a wish for self-reliance in the original model.
			Self-reliance	20	✓		
			Mental health problems	2	✓	✓	Also referred to relating to external factors, whereas in the original model primarily related to internal factors
	Reaching a point of no return/ TRANSITIONING TOWARDS DECISION	Title of subcategory changed to reflect the prolonged process of reching a decision to seek help	Deterioriation	4	✓		
			Important others /SUPPORTERS & CONTROLLERS	23	✓	✓ ✓	Divided into Supporters (16) and Controllers (7) due to function in relation to help-seeker.
Navigating	Trying to dock	A clearer conceptual division between subcategories Trying to dock and Wrestling with structure done to reflect the personal experiences of the former and the structural aspect of the latter	Hopes for help	3	✓		
			Feeling unsupported	11	✓	✓	New negative references to professionalism perceived as impersonal
			Miscommunication	7	✓	✓	Relays of the importance of reframing negative and medical terminology to positive and informal terms.
			TRUST	5		✓	Trust added as new theme after finding material on lack of confidence in treatment, and familiarity facilitating help-seeking.
			STIGMA	39		✓	Stigma added as new theme with many references in articles relating to shame, fear of ridicule and longing to fit in. Similar expressions found in the original material, however the term stigma was never incorporated into the model.
	Wrestling with structure		Confidentiality	7	✓	✓	Powerlessness was evident in the included articles, in relation to the dimensions Confidentiality, Age issues, Inadequate support services and Sense of resignation.
			Age issues	6	✓	✓	
			Inadequate support services	20	✓	✓	
			Sense of resignation	1	✓	✓	
Docking	Finding support		Comfort in support	5	✓		
			Validation	2	✓		
			Consequences	4	✓		
	Changing as a person		Personal change	1	✓	✓	Personal change described as finding a more positive outlook of life through own determination and decisiveness

Presentation of developed theoretical model based on “Lost in space” describing help-seeking among young people for mental health problems

The original theoretical model ‘Lost in space’, depicted the process of help-seeking as consisting of three categories; Drifting, Navigating and Docking. The findings from the analysis, aided in developing an elaborated model of help-seeking, figure 2. The overall notion of help-seeking as a fluid and dynamic process with the three categories Drifting,

Navigating and Docking were reinforced. The further developments of the model are described in detail below.

Figure 2. Elaborated and further developed theoretical model of help-seeking among young people for mental health problems



Drifting

Drifting as the initial category of the Lost in Space model, encompassed a general feeling of unfamiliarity, often coupled with a sense of insecurity and phenomena such as normalizing one's experiences and minimizing due to insecurity and lack of knowledge. Young people's voices in the analysed articles corroborated Drifting well, through similar expressions and experiences.

Fumbling in Life

In the original model, "Fumbling in life" encompassed themes of *unfamiliarity, insecurity* and *belittlement*. Young people, in the analysed articles, also expressed *unfamiliarity* with both mental health problems and not recognizing oneself. Lack of knowledge was frequently described both in regards to communicating, distinguishing and assessing emotions but also regarding where and when to seek help leading to a sense of *insecurity*. Due to this *insecurity*,

young people practiced *belittlement*, trying to make their problems smaller or unimportant. They expressed that their problems were not sufficient to receive support. In some of the analysed articles, *belittlement* was presented as a rational strategy, enabling young people to downplay their problems and rationalizing not actively dealing with them or approaching others for help whereas in the original model, *belittlement* was carried out due to a sense of *insecurity*.

Struggling

In the original model, "Struggling" was characterized by simultaneous descriptions of *mental health problems* and incessant attempts and *strategies* to feel better, *ambivalence* and a strong longing for *self-reliance*. These themes re-appeared in the included articles. *Mental health problems* were described by the young as i.e emotional problems, panic attacks, sadness, self-harm, anxiety and lack of motivation. Within Struggling in the original model, young people usually referred to *mental health problems* as being something "within" (internal) rather than originating "outside" (global). However, in several of the analysed articles, the *mental health problems* were attributed to something 'outside', and young people related mental health problems to relationships, stress, and risk-taking behaviour.

Themes on *endeavouring strategies* trying to deal with mental health problems were common in the included studies, as in the Lost in Space model, pointing to the more or less continual and relentless attempts and strategies young people performed in order to deal with their problems. One of the included articles pointed out that seeking help requires effort, however, lack of effort was not a dominating issue for young people in either the original model, nor in most analysed articles, rather a strong wish for *self-reliance* permeated most of the material. In some articles, an in-depth exploration of the used strategies was done, according to having an 'approach' or 'avoidant' character, or gendered differences. In the Lost in Space model, an abundance of strategies was ascertained, however, the type of strategy was not explored. Denial was a common strategy in both the original model as well as in the included articles. In the Lost in Space model, this was described as "shutting off", with the intent of ignoring feelings and problems. This strategy was directed to oneself, wanting to handle things, being strong and coping. In some of the analysed articles, denial was presented as relating to a sense of embarrassment, as well as being done in order to protect others. Several reasons were attributed to this phenomenon; that young people did not want to trouble others, did not want to burden or alarm, and did not trust others. In the Lost in Space model, reasons for denial

were differentiated by a sense of responsibility, enacted by for example not sharing information with family and friends, but withholding information thus seemed to relate to further aspects than a sense of responsibility and self-reliance.

Another frequent theme in both the original model as well as in the findings from the included articles was *self-reliance*. Statements of wanting to be strong, trying to cope on their own, not sharing information and an elevated sense of responsibility to manage one's life and mental health problems were evident. *Ambivalence* as a theme recurred throughout the material in both the included studies and the original model. Young people expressed simultaneous and contradictory feelings and thoughts towards both themselves and their problems, others and help-seeking per se. They were often hesitant to seeking help, whilst at the same time expressing a need and a longing for help.

Reaching a point of no return

Within *Reaching a point of no return* in the original model, young people expressed deterioration and reaching out for support, often with the help of others. In Lost in Space, others were named 'catalysts', showcasing their importance for actually initiating a help-seeking process. Within the analysed articles, important others were consistently brought up by the young people, with examples of others coaching, supporting, guiding and in some instances taking control over the help-seeking process. A new perspective in the included articles was a negative perception of control, and how others exerted control on the young to seek help. Whilst this negative control did not emerge in the original model, an elaboration of the Lost in Space model may expand on the various functions of the important others, aka dividing them into *controllers* vs *supporters*, thus elaborating one them, into two themes. The other theme in this subcategory, *deteriorating*, was brought up in several articles, as in the Lost in Space model. This indicated worsening experience of symptoms and decreased ability to function. Young people described not leaving the house, escalated behavioural problems, self-harm and suicide attempts, 'having a melt-down' or having their problems revealed as trigger for seeking help. The prolonged time-span and process leading up to seeking help, suggests a change of title of this subcategory.

Navigating

The category Navigating depicted attempts of trying to find support, personal reflections hopes and longings and wrestling with structural barriers. Expressions from young people

appearing in the analysed articles conformed well with subcategories “Trying to dock” and “Wrestling with structure”, adding themes *Trust* and *Stigma*.

Trying to dock

This subcategory in the Lost in Space model entailed descriptions of personal reflections, hopes, longings and disappointment when trying to seek support. All themes from the original model were exemplified in the included articles. *Hopes for help*, being safe, noticed and understood were common in the articles, as were accounts of the opposite; *feeling unsupported*, and *miscommunication* with not being understood or listened to. Both the original model and the new material contained accounts of being treated like a child and not taken seriously. Several analysed articles brought up how support was perceived as impersonal and instrumental rather than person-centred, adding new aspects of negative references to professionalism and reliance on medication. Young people expressed the importance of reframing negative and medical terminology to positive and informal terms. In all, young people expressed a *feeling of being unsupported* with continued efforts of seeking support elsewhere. A new theme, *trust*, was identified in the thematic analysis from descriptions of lack of confidence in treatment, and how familiarity facilitated help-seeking. A lack of *trust* was depicted as arising from limited prior contact, from anxiety about seeking help, from concerns about professional competence and negative perceptions of professionals. Within *trust* in the articles, were also concerns about confidentiality and parental involvement, however, according to the original model, this was interpreted as a structural obstacle.

Wrestling with structure

In both the original model and the analysed articles, there were multiple references to practical and structural obstacles such as access, waiting times, resources, inadequate chain of support, and lack of coordination between supporters. Young people voiced feelings of not being met by professionals in an appropriate and timely manner, how they were passed on whilst being referred to other support structures and how there was a perceived lack of resources making access difficult. Support use was described as inconsistent, with repeated attempts at initiating and discontinuing help. Young people in several articles expressed primary care as not being an option for seeking support. The theme *Inadequate support services* was thus corroborated by young people in other contexts.

Confidentiality and age issues were a concern of the young people both within the original model and the thematic analysis, primarily relating to parental control and insight. Young people voiced that being a minor was as an obstacle both in independently accessing help, and also in assumptions and apprehensiveness that confidential information would be communicated to parents. In some articles, as mentioned above, this was said to relate to the theme *trust*, however, in both the Lost in Space model and in analysed articles, *confidentiality* was a prominent feature. Age was also an issue in not feeling at place at some support services.

A common theme in the articles were references to *stigma* and shame. Articles relayed young people having a strong sense of shame about seeking help, perceiving it as a display of weakness. Fear of social consequences, ridicule and a longing to fit in made young people describe a feeling of shame, embarrassment, thoughts of what others would think and say and efforts to conceal both mental health problems and help-seeking. Several articles focusing exclusively on males stressed the gendered aspect of this, claiming that this group was particularly affected by masculine ideals of strength and autonomy hindering displays of weakness and preventing help-seeking. Within the original model, the findings relating to this theme were evident, described in the subcategory 'Wrestling with structure' in relation to seeking support in school, embarrassment and an undesirable show of weakness in front of peers. However, the term *stigma* was never used. Due to the overwhelming presence of codes from the analysed articles relating to stigma, it is prudent to incorporate *stigma* by making it a unique theme.

Docking

Docking in the original model, contained references from young people on subcategories "Finding support" and "Changing as a person".

Finding support

All themes of the subcategory "Finding support" were found in the thematic analysis. In both the original model and the analysed articles, young people described experiences of being *validated*, accepted, recognized and listened to and the importance of *comfort of support* and initial positive contact was stressed. Descriptions of good and bad supporters and preferences regarding for example gender and profession were evident. Both also contained descriptions of negative outcomes and unwanted *consequences* from having sought help, for example in

the original model this was described as problems being exaggerated and social services getting involved, and in the analysed articles, there were descriptions of referrals to support services appearing as punitive rather than helpful. This subcategory also contained accounts of young people being discarded and not being taken seriously.

Changing as a person

In the original model, this subcategory described the consequences of successful help-seeking in the form of gaining knowledge and positive *personal change*. Young people in the original model, stressed the positive aspects and changes after having experienced mental health problems. Very little material was found in the articles in regards to this subcategory. Primarily, the aspect of *personal change* was depicted in the thematic analysis as finding a more positive outlook of life through own determination and decisiveness.

Discussion

This scoping review aimed to examine literature on help-seeking among young people with mental health problems, with a particular focus on exploring young people's own perspectives as well as to validate and present a further developed theoretical Lost in space model. A high level of conformity was found between the original Lost in Space model and the analysed articles in this study. The analysis reinforced that help-seeking is to be regarded as a fluid process, often experienced by users as unfamiliar and obstacle-laden, tainted by feelings of powerlessness (21-24).

Discussion and implications in relation to the original model "Lost in space"

After reviewing up-to-date literature on user perspectives of help-seeking for mental health problems among young people, it is clear that the depiction of the initial stage of help-seeking, as being characterized by a sense of drifting, was to a large extent corroborated from young people's experiences described in the reviewed articles. Regardless of context, young people expressed a general feeling of unfamiliarity and a lack of knowledge, often coupled with a sense of insecurity, and belittlement of experiences (21-23, 25-30). This was also supported by a large number of codes and expressions relating to the theme endeavouring strategies in an effort to be self-reliant (22, 23, 25-31). This points to the more or less continual and relentless pursue of young people to deal with their problems. A strong wish for

self-reliance was consistently stressed by young people in the reviewed articles. An additional perspective would be elaboration of characteristic and type of strategy used, whether, positive/negative, destructive/constructive, or approach/avoidant. The reviewed articles confirmed that reaching a decision to seek help, often takes place with the aid of others (21-25, 29, 31, 32). A distinction between 'controllers' and 'supporters' in this regard may further elaborate the model and a re-naming of the subcategory 'Reaching a point of no return' from the original model into 'Transitioning towards decision' would reflect the transitional nature of this process.

The category Navigating, capturing both personal experiences and structural barriers, was well confirmed by the review. Stigma and trust surfaced as new themes, and particularly stigma appeared with a large number of codes in the analysed articles. Young people described a feeling of shame, embarrassment, thoughts of what others would think and say and various efforts to conceal both mental health problems and their help-seeking (21-23, 25-28, 31). The same phenomenon was described in the original model but not named, as stigma was not a prominent feature in that empirical material. Potential cultural differences might lie behind this difference in describing the phenomenon. Both reflections of not being met by professionals in an appropriate and timely manner, and observations of a perceived lack of resources making access difficult surfaced in both the original model and the included articles (23, 26, 29). Accounts of not being taken seriously, being treated like a child, not listened to and discarded as well as descriptions of inconsistent use of support, repeatedly initiating and discontinuing help, appeared in the original model as well as the included articles (22, 26, 28, 29). In the original model, a *sense of resignation*, often related to difficulties accessing support and *feeling unsupported was at hand*, whereas through the review analysis, 'powerlessness' surfaced as a permeating theme, based on themes primarily in the Navigating category, capturing young people's experience of seeking help.

The model might benefit from a clearer conceptual division between 'Wrestling with structure', and 'Trying to dock' with the latter entailing primarily personal accounts and experiences, expressions of hopes, disappointments and recounts of feelings, and the former referring to structural conditions.

The latter part of the original model, Docking, was not as well corroborated through the analysis. There were few descriptions of actually finding support and even fewer of personal

reflections on the effects of finding help (21, 22, 31). It may be that research on the help-seeking process does not focus on, and is discontinued as soon as support is established and aspects of this may be found in other literature on service utilization or treatment satisfaction. The results imply removing this subcategory from the model; however, by dividing the help-seeking journey into smaller isolated fractions a whole-process-focus could be missed.

Discussion and implications in practice

In contrast to most of the recent review articles on help-seeking for mental health problems, this review included young people from the age of 11 to 25, thus also including young adults. The studies described in the included articles were based a varied recruitment and contextual sample. The concerns voiced in the studies were generally in line with previous reviews, including themes on confidentiality, structural barriers, unfamiliarity and lack of knowledge. No specific patterns according to age or context could be discerned (4, 8). However, several articles dealt exclusively with young men and boys proposing that the reasons for not seeking help were strongly conditioned by gender. Masculine ideals of strength and autonomy were said to hinder help-seeking (21, 23, 28, 31). Issues of gendered traits were conveyed, however, the same findings emerged in the Lost in Space model where issues of self-reliance, wanting to be strong, shunning displays of weakness, were not male-specific, but rather shared between participants, regardless of gender. Cultural variations may account for this difference between studies and findings. This said, most participants in studies on help-seeking are female and the findings may translate poorly to other populations and contexts. Help-seeking is exceptionally low among boys and young men which in itself calls for a focus on specific populations, with particular consideration in meeting the needs of groups of for example boys and young men.

Previous reviews have shown past positive experiences and outcomes of help-seeking and positive contacts with support professionals to be facilitators for seeking help (4, 8). At the same time, a preference for self-reliance when facing mental health problems is consistently reported, particularly prominent in studies with participants having previous experience of mental health problems and mental health support, contradicting the findings of past experiences facilitating help-seeking (8, 23). Particularly young women seem to have poor expectations regarding therapeutic outcomes, signalling a lack of trust in professional supporters, perceiving treatment as impersonal and protocol-driven (23). The results also

identified the importance of supporters' ability to meet young people responsively, using a person-centred approach. Young people felt more comfortable when the supporters did not use a medical language and emphasized the importance of using positive and informal terms for improving communication between the young person and the supporter. Other studies have confirmed this finding, underlining the importance of having young staff who are skilled, respectful, welcoming and allow shared decision-making (33).
Structural factors, and how young people experience the support system, seems to play an important role in the help-seeking process. This was exemplified by young people's experiences of lack or resources, problems with accessibility, waiting times etc. (4, 8). Despite different contexts, young people seemed to voice similar concerns in regards to help-seeking. Other research has shown that structural problems do not seem to vary across contexts but rather stretch over different geographical and socio-economic backgrounds at macro-level, with high-income countries still showing substantial delays and poor help-seeking rates for young people (13, 34). Universal interventions and further resource allocation may not solve the dilemma with help-seeking since the increases in the use of healthcare services are mainly driven by young people with low levels of psychological distress (35). This is also in accordance with studies indicating that more severe depressive symptoms decrease the help-seeking intention (36). This is particularly troublesome, in light of the negative perceptions from earlier contacts with support (23) and calls for scrutinization of how the support system can meet the needs of young people with mental health problems.

This review showed that young people consistently expressed experiences and feelings of powerlessness with a lack of ability, knowledge or means. Support services do not to seem to meet young people according to their needs, with an unfortunate incapability of support services to accommodate the fluid and changeable nature of help-seeking and meeting young people in a person-centred and flexible manner. Research on shared decision-making has pointed out the importance for personalized support and the potential benefits of involvement in mental health decisions (37). Thus, even in favourable circumstances, young people perceive structural barriers, pointing to a need of further research on how to meet the needs of mental health support among young people. Perhaps, this is where the greatest effort is needed, reducing unequal power-structures, improving the possibility to exert influence, decision-making and a personalized support.

Methodological considerations

This review has some limitations. The choice of databases and keywords was developed in accordance with an experienced health literature librarian, however, making a choice always entails the possibility that some information may have been missed. Other databases and different keywords may have produced different results. We aimed to include studies focusing on groups wide enough to be defined as population-based, nevertheless, these still often utilized an ethnocentric perspective such as having a particular ethnic descent. This automatically raises the issue of generalizability and transferability. It was evident that studies consistently focused on particular populations, stressing the vulnerability and poor help-seeking of this particular group. However, similar claims kept reappearing regardless of which particular group was being studied. This claim of attributing stigma and cultural norms for non-help-seeking amongst both Black, Latino and Chinese American youth, has been observed by others (32).

Criteria for including articles was that they should dealt with the direct perspectives of young people who had experienced mental health problems and help-seeking. Whilst excluding those who had no experience of help-seeking (thus all articles dealing with intentions to seek help only) might have been a clear-cut and easy choice, however, that would also have meant that we excluded those with experience of mental health problems who had not sought help for various reasons, thus the avoidance is also a perspective worth taking into consideration.

In order to limit bias, the work was done alternating methods of individual and joint reviews respectively. However, subjectivity is a relevant issue that the authors of this review cannot completely waiver.

Conclusion and implication

The field of help-seeking among young people for mental health problems is an area receiving growing attention in research and academic literature. However, this review shows that there is substantial heterogeneity among studies, both in regards to methods, populations and how help-seeking is investigated. In qualitative literature exploring user perspectives, help-seeking is depicted as a fluid and dynamic process, corroborating the theoretical model of Lost in Space. Important findings are the presence of stigma, lack of knowledge of mental health issues, a longing for self-reliance and a sense of powerlessness expressed by young people in

various contexts and countries. Paying attention to these findings would imply acknowledging young people's sense of feeling lost, making support services more flexible and person-centred.

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Appendix A Search strategy

	Cinahl	MedLine/PubMed	PsycINFO
Date	2020-08-13	2020-07-08	2020-09-03
Mental health (MESH) + adolescence/adolescent (MESH) + help-seeking behavior (MESH)	88	26	
Behavioral Symptoms [Mesh]) AND Help-Seeking Behavior [Mesh]) AND Adolescence/adolescent[Mesh]	389	99	
Psychological distress (MESH) + help-seeking behavior AND Adolescence/adolescent(MESH)	1		

Mental health (MESH) + young adult (MESH) help-seeking behavior (MESH)	26	31	
Behavioral Symptoms[Mesh]) AND Help-Seeking Behavior[Mesh]) AND Young Adult [Mesh]	177	103	
Psychological distress (MESH) + help-seeking behavior AND Young adult (MESH)	1		
Psychological distress (MESH) + help-seeking behavior (MESH)		3	
Depression [Mesh]) AND "Help-Seeking Behavior"[Mesh]) AND "Adolescent"[Mesh]		35	
Depression [Mesh] AND ”Help-Seeking Behavior"[Mesh] AND "Young Adult”[Mesh]		47	
Anxiety [Mesh]) AND "Help-Seeking Behavior"[Mesh]) AND "Adolescent"[Mesh]		14	
Anxiety [Mesh] AND "Help-Seeking Behavior" AND “Young Adult"[Mesh]		17	
Suicidal Ideation"[Mesh]) AND "Help-Seeking Behavior"[Mesh]) AND "Adolescent"[Mesh]		24	
Suicidal Ideation"[Mesh]) AND "Help-Seeking Behavior"[Mesh]) AND "Young Adult"[Mesh]		19	
Self-Injurious Behavior"[Mesh]) AND "Help-Seeking Behavior"[Mesh]) AND "Adolescent"[Mesh]		50	
Self-Injurious Behavior"[Mesh]) AND "Help-Seeking Behavior"[Mesh]) AND "Young Adult"[Mesh]		45	
“Mental health” AND “help-seeking” AND adolescen* fritextsökning		819	
“Mental health” AND “help-seeking” AND young fritextsökning		856	
Mental health (MESH) + help-seeking behavior (MESH) + adolescent attitudes [MESH]			13
Mental health (MESH) + help-seeking behavior (MESH) + adolescent behavior (MESH)			3
Mental health (MESH) +help-seeking behavior (MESH)+adolescent characteristics (MESH)			1
Mental health (MESH) + help-seeking behavior (MESH) + adolescent health (MESH)			2
Mental health (MESH) + help-seeking behavior (MESH) + emerging adulthood (MESH)			3
Depression, emotion (MESH) + help-seeking behavior (MESH) adolescent attitudes (MESH)			1
Depression, emotion (MESH) + help-seeking behavior (MESH) adolescent behavior (MESH)			1
Depression, emotion (MESH) + help-seeking behavior (MESH) adolescent characteristics (MESH)			0
Depression, emotion (MESH) +help-seeking behavior (MESH)+adolescent health (MESH)			0
Depression, emotion (MESH) +help-seeking behavior(MESH)+emerging adulthood (MESH)			1
Anxiety (MESH) + help-seeking behavior (MESH) + adolescent attitudes (MESH)			1

Anxiety (MESH) + help-seeking behavior (MESH) + adolescent behavior (MESH)			0
Anxiety (MESH) + help-seeking behavior (MESH) + adolescent characteristics (MESH)			1
Anxiety (MESH) + help-seeking behavior (MESH) + adolescent health (MESH)			1
Anxiety (MESH) + help-seeking behavior (MESH) + emerging adulthood (MESH)			0
Self-destructive behavior (MESH) + help-seeking behavior (MESH) + adolescent attitudes (MESH)			3
Self-destructive behavior (MESH) + help-seeking behavior (MESH) + adolescent behavior (MESH)			1
Self-destructive behavior (MESH) + help-seeking behavior (MESH) + adolescent characteristics(MESH)			2
Self-destructive behavior (MESH) + help-seeking behavior (MESH) + adolescent health (MESH)			0
Self-destructive behavior (MESH) + help-seeking behavior (MESH) + emerging adulthood (MESH)			1
Combined search **Limits:** 2010 -2020, English	682	2188	35
Total	2905		
Total minus duplicates	1540		

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Katrin Häggström Westberg is a registered specialist nurse in psychiatry with a MA in Nursing and a BA in political science. Her doctoral thesis is in the field of Health and Lifestyle, Halmstad University.

The thesis focuses on exploring health assets in relation to the mental health of young people in order to gain further knowledge about how to facilitate help-seeking and enhance the mental health of young people. Socio-economic status, demographic characteristics, dispositional optimism, and individual and structural resources related to help-seeking and mental health have been investigated

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