

**EXPLORING CHILDREN'S UNDERSTANDING OF ANXIETY**

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I would like to dedicate my Masters by Research to my late father, George Day, who never got to see me graduate but always believed in me and would be proud beyond belief if he could see me now.

## **Abstract**

### **Background**

The prevalence of anxiety disorders is a recognised worldwide problem. The number of referrals to the Child and Adolescent Mental Health Service in the United Kingdom (UK) has increased by 26% over the last five years. The UK government have issued several policies to shape the future of children's mental health services. To ensure this is done effectively, it is crucial to assess young people's perceptions and understanding of mental health. As such, the aim of this research was to explore children's understanding of anxiety.

### **Methods**

A literature review was conducted to determine existing knowledge in relation to children's anxiety and the methodologies employed to inform the current study design. A qualitative exploratory approach was utilised using the Leventhal's Common-Sense Model to explore the five dimensions of anxiety (identity (appearance), cause, consequence, duration and treatments). The current research employed innovative creative methods and techniques, namely the 'Draw and Write Technique' in three individual focus groups, creating group drawings and answering cue card questions based on vignettes. Thematic analysis was used to analyse the transcribed verbal and visual data.

### **Results**

The current research demonstrates that children as young as eight years have some understanding about the five dimensions of anxiety. It was observed that children are more likely to seek support from their family as opposed to staff in school and have a limited knowledge about professionals who provide support for those with mental health problems. Furthermore, the children in the research had a limited understanding about the consequences and duration of anxiety.

### **Conclusions**

The research broadens our knowledge of children's understanding of anxiety and highlights some of the gaps in their understanding. The findings are significant in highlighting where developments in policy and practice could most usefully be focused. Future research directions and consequences for clinical practice are discussed.

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## **1. Introduction and Background**

There is a growing concern that the prevalence of mental health problems in young people has increased in the past decade. The number of referrals to CAMHS (Child and Adolescent Mental Health Service) has increased by 26% over the last five years (Crenna-Jennings & Hutchinson, 2018). Recent NHS (National Health Service) statistics have found that 1 in 8 young people, aged between five to 19 years old, experience at least one mental health disorder (Government Statistical Service, 2018). Consequently, children's mental health has become a national concern. The government has responded by issuing a number of policies in an attempt to shape the future of children's mental health services. To ensure that appropriate interventions are developed to prevent mental health problems, it is crucial to assess young people's understanding of the identity (appearance), causes, consequences, duration and treatment of mental health problems.

Anxiety disorders are one of the most common mental health problems experienced by children with an estimated 241 million young people around the world receiving a diagnosis (Polanczyk, Salum, Sugaya, Caye, & Rohde, 2015) with the median age of onset during the primary school years at around 11 years old (Kessler, 2005). However, poor treatment rates for childhood mental health problems have been observed with less than one in three young people with a diagnosable mental health condition accessing appropriate NHS care and treatment (National Audit Office, 2018). The lack of treatment may be due to limited service provision (National Audit Office, 2018), long waiting lists (Crenna-Jennings & Hutchinson, 2018) or barriers to seeking



help such as stigma and a lack of understanding about the disorder (MacLean, Hunt, & Sweeting, 2013).

Anxiety is characterised as excessive worry that is difficult to control and is commonly associated with somatic symptoms such as stomach cramps in children (Sayal, 2006). When the worry begins to interfere with the child's everyday life, these fears are termed anxiety disorders (Beidel & Turner, 2005). There are several different types of anxiety disorder including social anxiety (SA), generalised anxiety disorder (GAD) and separation anxiety disorder (SAD) amongst other types of the disorder (American Psychiatric Association [APA], 2013). The assessment and treatment type differ depending on the type of anxiety that is experienced (American Psychiatric Association [APA], 2013). According to the Diagnostic and Statistical Manual of Mental Disorders (DSM), SA is classified as "*a marked, or intense, fear or anxiety of social situations in which the individual may be scrutinized by others*" (APA, 2013, pg. 203). Symptoms of SA include fear and avoidance of social situations such as meeting unfamiliar people or situations where the individual has to perform in front of others (APA, 2013). GAD is characterised by "*persistent and excessive anxiety and worry about various domains that the individual finds difficult to control*" (APA, 2013, pg. 190). Symptoms associated with GAD include excessive worry as well as a number of physical symptoms including restlessness, difficulty concentrating and sleep disturbance which cause significant clinical impairments in important areas of functioning (APA, 2013). According to a survey conducted by the National Health Service [NHS] (2017), GAD is the most common type of anxiety disorder, with 1.5% of children and young people aged five to 19 experiencing the disorder. In contrast, SAD is less common than GAD, with 0.7% of five to 19 year olds diagnosed with the disorder (NHS, 2017b). According to the DSM, the main feature of SAD is defined as

*“developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached”* (APA, 2013, pg.190) In addition, SAD can impact on a child’s daily life and may interfere with activities such as going out with friends and attending school due to a persistent reluctance or refusal to leave home. This is potentially due to a fear of separation and manifests in symptoms such as nightmares (APA, 2013). Presenting with physical complaints may make it difficult to identify when a child is suffering with a mental health problem such as anxiety. Anxiety disorders can have clinical impairments including issues relating to the child’s academic performance and social interactions; thus, preventing the child from completing typical daily activities, otherwise viewed as ‘normal’ (APA, 2013).

Assessment and intervention types for anxiety differ depending on the presentation and diagnosis (APA, 2013). Formal instruments such as the Liebowitz Social Anxiety Scale (LSAS) (Liebowitz & Klein, 1991) and The Strengths and Difficulties Questionnaire (SDQ) can be used to aid an assessment for SAD in children (Goodman, 1997b; National Institute for Health and Care Excellence [NICE], 2013). The LSAS (Liebowitz & Klein, 1991) requires the individual to self-assess their anxiety from ‘0’ (‘none’) to ‘3’ (‘severe’) and level of avoidance from ‘0’ (never i.e., 0% of the time) to ‘3’ (‘usually’ i.e., 67-100% of the time) in 24 different situations such as ‘telephoning in public’ and ‘going to a party’ based on the experiences of the past week. The SDQ is an emotional and behavioural screening tool which is used as a self-rating tool with children aged 11 years and above (Goodman, 1997a). The Questionnaire is not used as a self-rating tool for children under 11 years but has several variations for completion by the child’s parents and teachers (Goodman, 1997a). The questionnaire consists of 42 items including ‘I worry a lot’ and ‘I am often unhappy, depressed or tearful’ which requires one of three responses (‘true’,

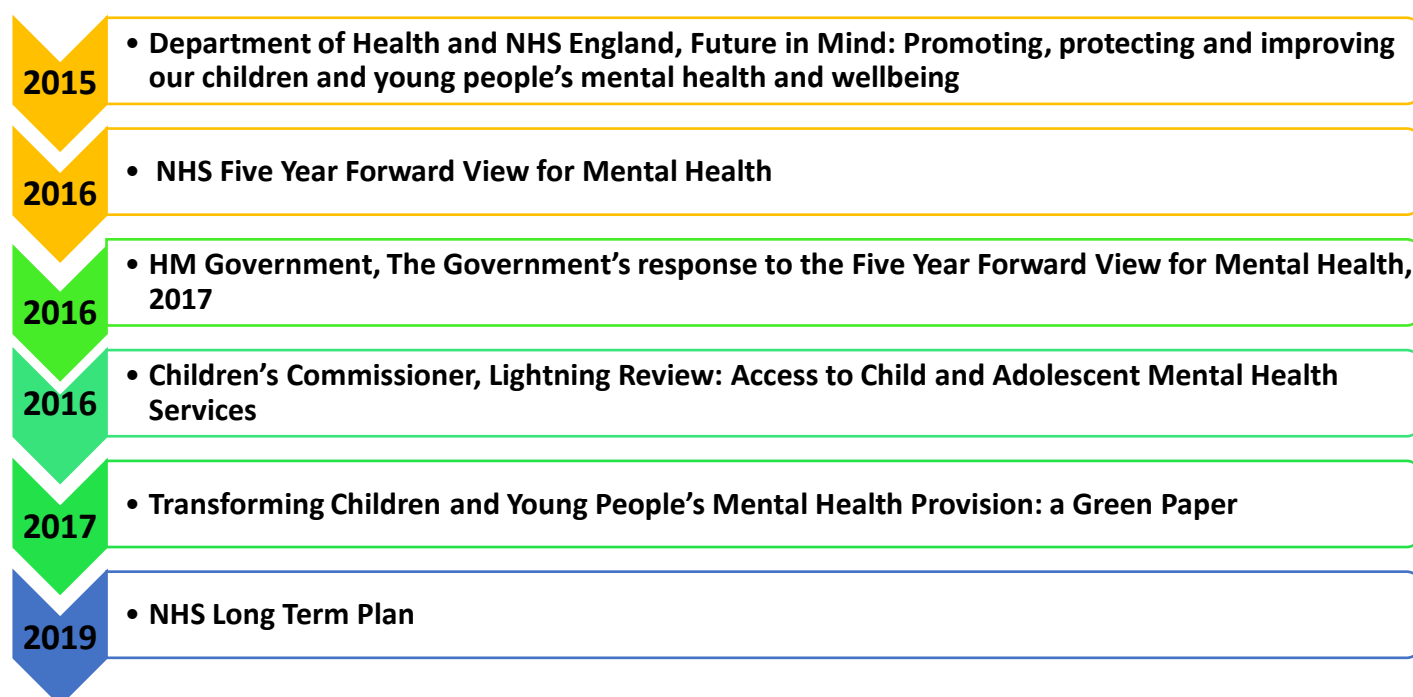
'somewhat true' and 'certainly true') (Goodman, 1997a). The recommended treatment for SA disorder in children is individual or group Cognitive Behavioural Therapy (CBT) whereas pharmacological and mindful based interventions are not recommended (NICE, 2013)

Predominantly GAD is diagnosed by a trained clinician who will conduct a clinical interview with the child (and often their parent) in an attempt to determine the duration, nature and the severity of the disorder and the subsequent impact this has on their functional impairment (National Institute for Health and Care Excellence, 2011). The treatment type for GAD depends on the age of the patient and the cause of the anxiety. Common treatment types for GAD include counselling, talking therapies such as CBT and anxiety medication may be prescribed depending on the severity of the case (NHS, 2017a). To build a comprehensive picture of the child's problems, a multiple informant approach is usually adopted during the diagnostic process for anxiety in children, which can include the child, their parents or carer and often professionals such as school staff (Reardon, Harvey, Young, O'Brien, & Creswell, 2018).

In the absence of treatment, anxiety disorders can have long term effects with the possibility of leading to the development of other mental health problems in adulthood (Pahl & Barrett, 2010), impacting on education and work prospects (National Audit Office, 2018) and economic impacts on society and the NHS (Fineberg *et al.*, 2013).

## 1.1 Policy Context

Given the consequences of anxiety disorders and the economic impacts of potential lifelong involvement of mental health services (Fineberg *et al.*, 2013), the government has responded to the problem by releasing a number of key documents outlining their action for child mental health services moving forward in order to address the problem. The figure below provides a five-year timeline of the key publications (policies and programmes) regarding children's mental health services. The key objectives and proposals for each document are outlined below.



**Figure 1.** Timeline showing initiatives set out to improve children's mental health services

The Department of Health and NHS England (2015) published the Future in Mind: Promoting, protecting and improving our children and young people's mental health

and wellbeing report outlining several objectives which would be met by 2020. The report had several main objectives which include improving public awareness and understanding about mental health problems in children and young people in order to improve attitudes towards and reduce the stigma around mental health problems (The Department of Health and NHS England, 2015). The report outlines the importance of promoting good mental health, prevention of mental health problems through early intervention and the importance of early identification in order to prevent more serious problems from arising (The Department of Health and NHS England, 2015). Improving access to mental health services, particularly for those who are deemed most vulnerable, was also a key proposal (The Department of Health and NHS England, 2015). Another key objective of the paper is improving communication through different services and appointing specialist points of contact in schools as well as integrating mental health services in schools and GP practices (The Department of Health and NHS England, 2015).

The National Health Service [NHS] (2016) released The 'Five Year Forward View for Mental Health' which outlines the strategy taken to increase access to mental health services for children and young people by 2020/21. This document states by 2020/21, the NHS funded community services will meet the needs of at least 35% of children and young people with diagnosable mental health conditions (NHS, 2016). The Government responded to the 'Five Year Forward View for Mental Health' by accepting all of the 58 recommendations in the report in full (HM Government, 2017).

The Lightning Review was published by the Children's Commissioner for England (2016) and highlighted potential issues with children and young people's mental health services. The aim of the report was to support commissioners and policy makers, by highlighting the areas where improvement is required using the views of young people,

who had previously used CAMHS (Children's Commissioner for England, 2016). The report discussed several issues including lengthy waiting times for children to be seen by mental health services, problems with being turned away from CAMHS, problems with missed appointments and re-referrals and variations in practice across the country (Children's Commissioner for England, 2016). The report captured the views of young people who asked for shorter waiting times, a reduction of stigma and a 'drop in' service to discuss their worries (Children's Commissioner for England, 2016).

As a response to the increasing prevalence of mental health problems in the United Kingdom, the Department of Health and Department of Education (2017) published Transforming Children and Young People's Mental Health Provision: A Green Paper which outlines their plans to improve support for children and young people's mental health services by setting out proposals to meet the 58 objectives and recommendations outlined in the Five Year Forward View (NHS, 2016). The paper states the Department for Education will provide funding to ensure that all schools and colleges can train a designated senior lead for mental health (Department of Health and Department of Education, 2017). By 2022/23, new mental health support teams will be trialled in up to a quarter of the country, to link to schools and colleges to provide support for children experiencing mental health problems, and to professionals who work with children and make referrals to specialist services (Department of Health and Department of Education, 2017). The final proposal in relation to waiting times, states that a new four week waiting time will be tested throughout the country by 2022/23, which will reduce the wait for accessing specialist NHS and mental health services for young people (Department of Health and Department of Education, 2017).

The National Health Service [NHS] (2019) Long Term Plan states the priorities of the NHS over the next 10 years and extends the commitments outlined in the Five Year

Forward View for Mental Health (NHS, 2016) in order to secure funding. This document stated that access to mental health services would be expanded in order to meet the needs of an additional 345,000 children and young people (NHS, 2019). According to the plan this objective will be achieved through a growing investment into children and young people's mental health provisions embedding support into educational settings and community mental health services and through creation of mental health services for children and young people with complex needs (NHS, 2019). The document outlines a new approach to supporting young people aged 18-25 through transition to adult services and a boost in investment to eating disorder services for young people to ensure that more young people receive help in a shorter time period (NHS, 2019).

In the documents discussed above, the government have outlined their strategy to tackle the current problem with children and young people's mental health. By improving the understanding and awareness of the public about mental health problems in children and young people, this will improve the attitude towards such problems and reduce the stigma associated with them. This will be achieved through the promotion of good mental health, early intervention and early identification which together will help to prevent mental health problems developing into more serious problems. In order to achieve the objectives proposed in the above documents, it is crucial to elicit the views of young people to find out what young people understand about the identity (appearance), causes, consequences, duration and treatment of mental health problems.

## **Children and Anxiety: A Review of the Literature**

A systematic search of the literature was conducted utilising a search strategy, for details of this see Appendix A. A table of study characteristics was also created to present a synthesis of the literature (Appendix B).

### **2.1 Children's Understanding About the Identity of Mental Health Problems**

It is fundamental to understand the extent of children's knowledge about mental health problems to locate the gaps in their knowledge in order to target educational interventions.

Children's lack of understanding about mental health problems has been observed in a naturally occurring sample of patients at CAMHS. Stafford, Hutchby, Karim, and O'Reilly (2016) explored children's understanding about their first-time assessment at CAMHS. The research found that the naturally occurring sample of six to 17 year olds responded to the question about their understanding of their attendance at the service in three different ways - using medical terminology, using lay terminology (vaguely explaining their difficulties) or responses such as "I don't know" suggesting a limited understanding (Stafford *et al.*, 2016). Some of the children were able to place a medical label on their difficulty such as attention deficit hyperactivity disorder (ADHD) and follow this up with a correct explanation of what this meant while others simply repeated terms which had originated from third parties e.g. teachers with the absence of understanding of the term (Stafford *et al.*, 2016). Other children were able to offer responses which showed some understanding about the reason for their attendance such as describing their problems in their own words (Stafford *et al.*, 2016). The most common response was found to be children claiming a lack of understanding about



their visit to CAMHS but this may be due to resistance and a lack of willingness to engage (Stafford *et al.*, 2016). This suggests that in some cases, children are not aware of why they are attending services such as CAMHS for assessments or use medical terminology without a full understanding of the underlying meaning (Stafford *et al.*, 2016).(Walsh, Scaife, Notley, Dodsworth, & Schofield, 2011) It may be the case that children do have some understanding about their presentation to CAMHS but feel unable to articulate this in the child mental health assessment, which typically requires verbal communication between child and professional. By asking the child to explain the problems they are experiencing in their own words and using more creative methods which require less verbal communication may promote engagement and increased understanding on how they view their difficulties. Such information could be useful for professionals working with the child to gain an insight into the child's perception of their problems and communicate to the child using language they can relate to. The researchers acknowledge that CAMHS referrals and assessments can lead to increased anxiety in children and a need to provide children with a better understanding of the reasons for referral and information about what the assessment entails is required (Stafford *et al.*, 2016).

Walsh et al. (2011)Although this research extends our current knowledge of children's understanding of their presentation to CAMHS, it has certain limitations in terms of methodology. Interviews between the child and the practitioner may have made the children feel nervous and uncomfortable due to the clear difference in status between themselves and the professional. Therefore, the children in the study may not have answered truthfully and could have provided socially desirable answers using medical labels such as "ADHD" and "OCD" to please the practitioner or may not have felt confident to respond truthfully out of fear of saying the wrong thing. Furthermore, the

presence of parents in some of the interviews may have led to the child withholding information that they did not want to disclose with their caregiver in the room.

## **2.2 Children's Understanding About the Causes of Mental Health Problems**

A series of recent studies have explored children's understanding of emotional difficulties (Dixon et al., 2013; Hennessy & Heary, 2009; Roose & John, 2003; Stafford et al., 2016) involving children as young as eight years old highlighting the extent to which children understand the causes of mental health problems. (Dixon et al., 2013); Fox et al. (2008); (Hennessy & Heary, 2009)

Previous research has found that when presented with a vignette describing symptoms of the behavioural difficulties, children aged between eight and 14 years old made reference to both external and internal causes for the description of the character's behaviour (Hennessy & Heary, 2009). Research conducted by Hennessy and Heary (2009) found that children are more likely to endorse external explanations such as issues in the school environment, problems with peers and poor parental relationships for psychological problems such as conduct disorder, depression and ADHD. This finding was observed in three separate focus groups containing children aged eight, ten and 14 years old (Hennessy & Heary, 2009). In all three groups, internal causes such as brain damage due to head injury and emotional responses and feelings such as jealousy, anger and loneliness were less common than external causes (Hennessy & Heary, 2009). Whilst internal causes were discussed by all three age groups for all psychological problems, qualitative analysis revealed that the oldest children (14 years old) discussed more internal causes of behaviour than the other two age groups (Dixon et al., 2013; Hennessy & Heary, 2009).

Although the above study conducted by Hennessy and Heary (2009) demonstrates that children as young as eight years old are able to suggest both internal and external explanations for psychological problems, it has certain limitations. The target character presented for conduct disorder was male, for ADHD was male and for depression was female (Hennessy & Heary, 2009). Therefore, it could be suggested that gender is a potential confounding variable as the children's responses may have been different had they been presented with the same vignette of the opposite sex. Notwithstanding this limitation, the study clearly reveals that children as young as eight years old are able to offer some insight into the causes of mental health problems and how their understanding about the causes of such behaviour may change as they age (Hennessy & Heary, 2009).

Similar findings were demonstrated in Dixon *et al's* (2013) study which found that children aged between eight and 13 years focused mainly on external and social causes in the external environment to explain emotional difficulties that the characters were experiencing. The children were more likely to discuss social causes such as family and falling out with a friend, and educational factors including struggling with school work (Dixon *et al.*, 2013). Some of the participants in the research interpreted physical symptoms and literal explanations such as lack of sleep or appetite as causes of the characters behaviour (Dixon *et al.*, 2013).

Although the study is based on a small sample of 25 participants, Dixon *et al's* (2013) research extends our knowledge of young children's beliefs about the causes of mental health problems. The study demonstrates that children as young as eight years old are able to identify social, educational and environmental causes and located the causes of emotional difficulties in the external environment rather than using biological or internal causes (Dixon *et al.*, 2013). Such findings suggest that young people may

be unaware of the internal and biological causes for mental health problems such as genetic predisposition. Given the children's ability to communicate about such problems, Dixon *et al.* (2013) suggest that it may be appropriate to consider children's perspectives in the development of education programmes such as Social and Emotional Aspects of Learning and Healthy Schools Programmes (Dixon *et al.*, 2013) which encourage child participation.

### **2.3 Children's Understanding About the Treatment Available for Mental Health Problems**

Young people's knowledge about the sources of help available demonstrates an important part of their general understanding about mental health problems. For children with psychological problems, help seeking can be difficult as they often rely on adults such as parents and teachers to identify the problem, direct them to appropriate services and seek help on their behalf (Hennessy & Heary, 2009). A small number of studies have explored children's beliefs about the support available for those experiencing mental health problems (Armstrong, Hill, & Secker, 2000; Hennessy & Heary, 2009).

(Armstrong et al., 2000; Dixon et al., 2013; Walsh et al., 2011; Wisdom & Green, 2004)(Armstrong et al., 2000; Hetherington & Stoppard, 2002)(Walsh et al., 2011)(Walsh et al., 2011)(Hetherington & Stoppard, 2002)(McAndrew & Warne, 2014)(Walsh et al., 2011)(Walsh et al., 2011)(Armstrong et al., 2000)(Hennessy & Heary, 2009)(Armstrong et al., 2000; Hennessy & Heary, 2009; Hetherington & Stoppard, 2002; McAndrew & Warne, 2014; Walsh et al., 2011)(Walsh et al., 2011)(McAndrew & Warne, 2014)(McAndrew & Warne, 2014)(Armstrong et al., 2000; McAndrew & Warne, 2014)(McAndrew & Warne, 2014)(Hetherington & Stoppard,

2002)(Hetherington & Stoppard, 2002; McAndrew & Warne, 2014)(McAndrew & Warne, 2014)(Armstrong et al., 2000)(Hetherington & Stoppard, 2002)

(Armstrong et al., 2000)Research conducted by Armstrong *et al.* (2000) found that young people aged 12 to 14 years viewed friends and family (both immediate and extended) as an important source to share problems and talk to (Armstrong et al., 2000)with girls suggesting this as their preferred way to discuss issues. In comparison, boys discussed avoidance tactics such as sleeping and eating to cope with the negative feelings and said they were more likely to bottle up and internalise their feelings (Armstrong *et al.*, 2000). The children often believed that their problem was less important than adults problems which could have a detrimental effect resulting in children keeping their worries to their self, preventing early help and causing problems to worsen (Armstrong *et al.*, 2000). Focus groups revealed that whilst some participants felt that teachers were an appropriate source of help for school related problems such as bullying, the children were worried about trusting professionals due to fears that information would be shared with others without prior warning (Armstrong *et al.*, 2000). Despite the children believing that they had no access to professionals, the role of a counsellor was discussed by some participants (Armstrong *et al.*, 2000). The willingness to seek help from a counsellor was based on prior personal experience and the stigma towards this type of professional with one participant suggesting that they give out “pills” (Armstrong *et al.*, 2000). Similarly, whilst the children were aware of support services such as ChildLine, the children reported worries about speaking to an unknown confidant who would not take their problems seriously or barriers to contacting the service such as a lack of money to use the phone (Armstrong *et al.*, 2000). These findings suggest there is a need for work to be done around the issue of confidentiality and that young people will only seek help for mental health problems

from people who they believe they can confide in and can trust. Armstrong *et al.* (2000) emphasise the importance of taking young people's problems seriously even when they do not seem important and making it explicit to young people the boundaries about information sharing and confidentiality.

Similar findings have also been demonstrated by Hennessy and Heary (2009). Focus group and interview analysis revealed that young people aged between eight and 14 years old referred to three main independent groups for support; family (both immediate and extended), peers and professionals (including psychologists, psychotherapists, psychiatrists, counsellors and teachers) (Hennessy & Heary, 2009). Across all age groups, family were viewed as the most important source of support for individuals experiencing psychological problems, with only a few participants in each age group referring to the support of professionals (Hennessy & Heary, 2009). Such research implies that children are able to identify the sources of support available for psychological problems but may require more information about the role of professionals. This has important implications for clinical practice and Hennessy and Heary (2009) suggest that children who are referred to mental health professionals may require more information about the role of the professional which may help to increase engagement. It may be that young people are more likely to seek the support of their parents/carers as they are less familiar with the role of professionals in supporting people with mental health problems.

The research above shows that family and peers are seen as the most trustworthy sources of support, that children have a lack of knowledge about professional help and highlights some of the worries that young people have about disclosing personal information particularly within school (Armstrong *et al.*, 2000; Hennessy & Heary, 2009). Such findings are concerning considering that in school, teachers may be the

only support available to students who have a duty in loco parentis. Taken together, these findings do not support recommendations from recent government guidelines which are placing increasing emphasis on the role of the school to provide mental health support, signposting young people to help and providing resources for teachers (Department of Health and Department of Education, 2017). Further research should be conducted to find out which staff members/groups children are more likely to confide in and how they are likely to confide in them, to ensure these individuals have sufficient training and resources to support young people.

This section has highlighted the central role of family and friends in young children's help seeking and support and indicates that parents and carers play a key role in accessing support, advice and intervention on behalf of their children (Armstrong et al., 2000; Hennessy & Heary, 2009). This may be due to the fact that children have a lack of awareness about sources of support outside of the family as in the study by Armstrong et al. (2000) some participants believed that parents were not always the right source of support, but were unaware of who else to talk to or did not want to discuss their problems outside of the family environment.

The subsequent section will discuss the barriers that parents face when seeking support for their child including stigma and a lack of knowledge about support available for mental health problems.

## **2.4 Parental barriers to accessing help**

### **2.4.1 Uncertainty**

The literature review highlighted the worries and concerns experienced by parents, who are often the main source of support for their children (Armstrong et al., 2000; Hennessy & Heary, 2009). The barriers faced by parents when accessing support for their child include uncertainty about their child's issues, difficulty in distinguishing (Reardon et al., 2018) between anxiety disorders and other behavioural or psychological issues, a lack of confidence in their judgement, poor knowledge about how to seek help for their child and uncertainty about who to contact for help and advice (Crouch et al., 2019; Reardon et al., 2018).

In the study conducted by Reardon et al. (2018), parents reported difficulties in recognising whether their child's symptoms or behaviour were due to anxiety and determining whether the behaviour was a difficulty or not. Some parents appeared to have false perceptions, viewing anxiety as a common childhood problem and a personality trait, deterring them from help seeking as they did not consider anxiety as a problem which required professional help (Reardon *et al.*, 2018). Parents reported fears about seeking help for their child's problems as they were concerned about being an overprotective parent (Reardon *et al.*, 2018). Parental uncertainty about the symptoms associated with anxiety were also observed with parents relating behaviour such as feeling nervous and being clingy with anxiety more readily than symptoms such as temper tantrums and angry outbursts (Reardon *et al.*, 2018). Therefore, due to a lack of parental understanding and uncertainty about anxiety and the symptoms, children may not receive appropriate intervention for their problems and may mean that children do not receive the help they require.

Research conducted by Crouch et al. (2019) explored parents experiences of reaching CAMHS for childhood anxiety problems and confirmed the findings of Reardon *et al.* (2018) that parents face many barriers when seeking help for their child's anxiety.



Parents reported feeling uncertain about when to seek professional help for their child and uncertainty about the services available (Reardon et al., 2018). Such factors lead to delays in support, with parents waiting until they could no longer cope with the problem before deciding that help was needed. Similarly to the study conducted by Reardon *et al.* (2018), it was found that parents faced problems when attempting to distinguish between anxiety and other behavioural and psychological problems which was made increasingly difficult due to the presence of comorbidity from medical conditions such as brain injury (Crouch et al., 2019).

Although the study conducted by Crouch et al. (2019) is based on a small sample of parents of 16 children, it provides an in-depth experience of the uncertainty that is experienced by parents who are seeking help for their child. The research emphasises the need to promote awareness of childhood anxiety problems targeted at parents to educate them about symptoms of anxiety and information about where and when to seek help (Crouch *et al.*, 2019). Such intervention may encourage parents to reach out for help at an early stage and increase the likelihood of the child receiving early intervention.

#### 2.4.2 Communication with professionals

In the diagnosis of anxiety in children, a multi informant approach is often adopted and can involve, the child, their parents and other professionals such as teachers in order to gain a comprehensive view of the problems the child is experiencing (Grills & Ollendick, 2003). Whilst communication with professionals including teachers, GP's and clinical staff was reported largely as a positive experience, some parents in the research conducted by Crouch *et al.* (2019) reported problems. Parents reported

difficulties working with teachers especially in cases where the anxiety did not present in school, delaying treatment for some children where the referral was made through school due to contrasting observations between parent and teacher (Crouch et al., 2019). Parents anticipated how professionals such as the GP and teachers would respond to information about their child's problems and were concerned that they would be met with negative or stigmatising responses (Crouch *et al.*, 2019). Postal information received including appointment letters and information letters were difficult to understand for one parent, which may lead to further problems such as not attending appointments (Crouch *et al.*, 2019). The researchers highlight the need for professionals who work with the child to have the understanding and knowledge to recognise childhood anxiety difficulties and information to refer families to services and professionals (Crouch *et al.*, 2019).

Whilst the research conducted by Crouch *et al.* (2019) extends our knowledge about the barriers that parents face, it is important to consider that the sample was recruited from one UK service. Therefore, the research may not represent families who are from a diverse range of ethnic backgrounds and socio-economic status, who may have had differing experiences.

As outlined above, parents can experience a range of barriers when seeking help for their child. The next section will explore previous research which has explored inconsistencies between parent and child agreement about symptoms and treatment outcomes.

## **2.5 Parent and child agreement**

In many cases, adults provide a significant part of the diagnostic process to build up a picture of the child's everyday functioning (National Institute for Health and Care Excellence, 2011). The literature review conducted in the current study, highlighted inconsistencies between parent and child agreement in the disclosure of symptoms (Benjamin, Puleo, & Kendall, 2011; Persson, Hagquist, & Michelson, 2017).

Social desirability refers to a response bias where participants have a "*tendency to look good' and provide socially acceptable answers*" (Coolican, 2014, pg. 118). Children who are anxious may worry about how they are perceived by other people which could prompt them to give socially desirable responses when questioned about their symptoms. This has been observed in a naturally occurring sample in research conducted by Persson et al. (2017). The research explored the service experiences of ten to 18-year olds where children reported feeling pressure from parents and school professionals to attend the service and felt like the views of their parents were considered more significant than their own (Persson et al., 2017). Furthermore, the young people reported feeling afraid of giving the wrong answer and that the conversation was restricted as they did not want to speak about certain topics in front of their parents (Persson *et al.*, 2017). It could be suggested that the observed levels of poor parent and child agreement for symptoms of mental health problems is due to the fear of upsetting the parent or professional by saying the wrong thing or a desire to minimise symptoms to appear in a more favourable manner.

Parents and carers are often involved in a child's diagnosis of anxiety in clinical settings to build up a thorough picture of the problem the child is experiencing. Agreement between parent and child for treatment outcomes and symptom reporting is poor (Benjamin et al., 2011; Persson et al., 2017). Research conducted by Benjamin et al. (2011) explored the efficacy of CBT for young people aged seven to 14 years

based on the perspectives of the child, their parents and school teacher. The findings from this study found a higher parent and child agreement for externalising symptoms compared to internalising symptoms, with parents reporting more improvement post treatment than their children (Benjamin *et al.*, 2011). This finding may be because observable physical symptoms such as crying and tummy aches may have improved but the child is reluctant, or has a limited understanding of the interview questions (Benjamin *et al.*, 2011), to express their internal symptoms such as worry. It may be difficult to rely on the perception of parents and teachers as the distress the child experiences may not be readily observable, especially from teachers who have a number of other children who demand attention at the same time (Benjamin *et al.*, 2011). Whilst the child's anxiety appears to have improved from an observer's point of view, it is possible that children and young people will lack the vocabulary or ability to discuss the complex symptoms they are experiencing.

Therefore, parents may have to infer meaning and describe symptoms the child is experiencing on their behalf based on physical symptoms and behaviours which are readily observable. It could be suggested that the views of external observers, such as parents, involved in the multi informant approach do not necessarily reflect those of children, which could account for the lack of parent and child agreement. A lack of agreement between parent and child can be problematic, leading to the development of inappropriate services and treatment, which could have a negative impact on the child.

The above demonstrates that it is difficult to build up a true picture of what the child is experiencing from the points of view of many informants including the child. The following section will explore the literature around stigma which is experienced by both children and parents.

## 2.6 Stigma

The previous research identified stigma as a barrier experienced by parents who are help seeking on behalf of their children and also by children who are experiencing mental health problems. Stigma refers to “*a negative stereotype or sign of disgrace that sets people apart from others*” (Byrne, 2000, pg. 65).

Though recent efforts have been made to increase the support and understanding of mental health problems, the literature revealed that stigmatising attitudes are evident in children as young as ten years old (MacLean et al., 2013). Participants aged between ten and 15 years old viewed symptoms of mental health problems as ‘weird’ and ‘voluntary’ and ‘within the person’s control’ (MacLean et al., 2013). Most of the children and young people exhibited beliefs that psychological symptoms are less prominent than physical symptoms and described psychological symptoms such as ‘crying in class’ as ‘weird’, ‘rare’ and ‘taboo’ and reported such symptoms as ‘babyish’ and ‘silly’ (MacLean et al., 2013). In comparison physical symptoms such as having a cold or headache were viewed as ‘normalised’ and ‘common’ and “symptoms that happen to everybody” (MacLean et al., 2013, pg. 168). The children’s negative perception about psychological symptoms influenced the degree to which they reported help seeking behaviours due to worries about how their parents, teachers and peers would respond to a disclosure and the impact of disclosure on their social identity, as they feared they would be treated differently (MacLean et al., 2013). This was observed more so in boys who said they were more likely to conceal their psychological symptoms than females (MacLean et al., 2013).

The findings showed that both males and females would be likely to conceal the psychological symptoms they experienced to avoid potential stigma (MacLean, Sweeting, & Hunt, 2010)(MacLean et al., 2010). An implication of these findings is that children would be less likely to seek help for psychological symptoms due to the belief that they are uncommon and are worried about the stigmatising responses they would receive from others.

Such findings were echoed in research by MacLean et al. (2010) which revealed that boys were more likely to conceal symptoms of mental health problems due to increased pressure to be viewed as 'masculine' (MacLean *et al.*, 2010). Such findings indicate that due to stereotypical expectations and a lack of understanding about mental health problems, boys would not seek help for their problems leading to negative impacts long term. It is clear that there is a definite need to break down the gender stereotype and educate young people about mental health in order to change the attitudes towards psychological symptoms and promote help seeking in boys and girls.

This research extends our knowledge of the stigma associated with mental health problems suggesting that psychological problems are viewed as a sign of weakness that can be controlled by the individual, which would prevent young people from reaching out for help (MacLean *et al.*, 2010). An implication of these findings is that there is a desperate need to address these misconceptions through mental health education and promotion, to educate young people about mental health and reduce the stigma, which may lead to an increased willingness to seek help for their mental health problems. Moreover, mental health education and promotion should begin in primary school and should be readily available to those who support children, given

that children as young as 10 years old believe that psychological symptoms are rare and embarrassing (MacLean et al., 2013).

## **2.7 Summary of the Literature**

The review has highlighted research which has focused on identity (symptoms), causes and treatment (including barriers) and a lack of research in the duration and consequences of the disorder. Children and young people explain the mental health problems they are experiencing through the symptoms and behaviour that they experience (Stafford et al., 2016). Previous research exploring children's understanding about the causes of mental health problems has found that children are more likely to endorse external explanations, e.g. environmental factors compared with internal causes (Hennessy & Heary, 2009). A developmental trend has also been found, with older children suggesting more internal causes than younger children (Hennessy & Heary, 2009). The review revealed that whilst children are able to name the sources of support available to them, they rely heavily on the support of family and friends (Armstrong et al., 2000). Children and young people are less likely to seek the support of professionals such as teachers and counsellors due to worries about confidentiality and the barriers, such as lack of resources, they may face (Armstrong et al., 2000; Hennessy & Heary, 2009). A number of parental barriers were found, with parents facing problems around finding, accessing and receiving support for their child (Reardon et al., 2018).

The previous research outlined in the literature review, has not explored children's understanding about how long anxiety disorder persists and the onset (duration) or the

consequences of the disorder. There is also limited research around children's understanding of the identity, cause and treatment of anxiety disorders.

This study will utilise the five dimensions of the Common Sense Model proposed by Leventhal, Meyer, and Nerenz (1980) to explore children's understanding of anxiety using visual and interactive methods to address the gaps in the research. The next chapter will introduce the framework which will be used to guide the key stages of this research and will present a discussion about conducting research with children, followed a detailed outline of the methods used in this study.



## 3. Methodology

### 3.1 Aims/Objectives

The aim of this study is to explore children's understanding of anxiety. The objectives are to explore the five dimensions of the Common Sense Model proposed by Leventhal et al. (1980):

- To explore children's understanding about the identity of anxiety
- To explore children's understanding about the causes of anxiety
- To explore children's understanding about the consequences of anxiety
- To explore children's understanding about the duration of anxiety

To explore children's understanding about the treatments available for anxiety

### 3.2 The Common Sense Model of Illness

The Common Sense Model of Illness (CSM) (Leventhal et al., 1980) was originally developed to explore patients' perceptions and response to their physical illness. According to Leventhal *et al.* (1980) perceptions of illness are guided by three different sources of information (1) lay information from social communication or cultural knowledge (2) information from perceived significant others or those in authority and (3) current or personal experience with the illness. The CSM is broken down into 5 separate domains of cognitive illness representations which combine to form a person's individual perception of an illness (Leventhal *et al.*, 1980). The five domains are (1) identity (the labels and symptoms associated with the illness) (2) cause (beliefs about the underlying causes of the behaviour) (3) timeline (the perceived duration of the illness and timescale of symptoms) (4) consequence (the impact that the illness

can have) and (5) treatment (the perceived curability of the illness) (Leventhal, Phillips, & Burns, 2016).

The CSM has been proven to be a useful model for exploring adult's illness perceptions for a variety of physical health problems and illnesses (Kaptein et al., 2010; Knowles, Wilson, Connell, & Kamm, 2011; Paddison, Alpass, & Stephens, 2010). In previous research, the model has been applied to explore children and young people's perceptions of physical health problems such as obesity (Babooram, Mullan, & Sharpe, 2011) and in research exploring children's beliefs and how they cope with their ADHD (Ringer, 2020). The previous research by Babooram et al. (2011) indicates that the CSM is a useful model as it provides a broader insight into children's perceptions of health problems compared to alternative models such as the Piagetian Model which places a focus on causative factors (Eiser & health, 1989) and has been developed directly to be used in a health context (Leventhal et al., 2016). Ringer (2020) concluded that whilst the CSM was useful for categorising the beliefs about children's perceptions of their disorder, the model may need to be adapted for conditions such as ADHD due to overlaps between some dimensions.

However, despite the usefulness of this model, it has not been extensively researched with children. Fox et al. (2008) used the five domains in the CSM to explore children's understanding of mental illness using a vignette and discussion card task. In this study, young people were exposed to vignettes with depression, schizophrenia, anorexia nervosa or dementia and were required to respond to cue cards following each (Fox et al., 2008). The researchers concluded that the framework proposed by the CSM was useful for investigating the developmental trends in children's knowledge and understanding of mental health problems as the children appeared to form ideas about mental health problems based on the components of the CSM (Fox *et al.*, 2008).

Given that the CSM has been heavily researched with adults and has previously been found to be useful when used with children to explore their perceptions and understanding (Fox *et al.*, 2008), the model was used to guide the current research to explore children's understanding about the identity, causes, duration, consequence and duration of anxiety.

### **3.3 Conducting Research with Children**

Until recent times, research aimed at understanding children's experiences has placed children as objects rather than subjects, as participants in research (Greene & Hogan, 2005). More recently, research has 'involved children' as active participants to gain an insight into the child's experience to provide a more comprehensive view on how children see the world (Grills & Ollendick, 2003). However, conducting research with children presents researchers with a range of challenges including conceptual, methodological and ethical issues (Kirk, 2007). It is important to provide children with information about what the research entails using child friendly vocabulary and provide opportunities to discuss and answer queries before they can provide informed assent. Research with children exploring socially sensitive topics should also be approached with caution as it can cause distress and emotional harm which may cause the child to become upset during the research. Therefore, it is important for researchers to be prepared to deal with different eventualities and provide details of support such as the contact details of charities for the children to seek information and support (Greene & Hogan, 2005).

Grills and Ollendick (2003) suggested that children may not be able to accurately report their own symptoms and experiences due to limited cognitive and linguistic capacities. Therefore, self-report methods such as the Revised Children's Manifest

Anxiety Scale (Reynolds & Richmond, 2008) used in research by Corrigan, Druss, and Perlick (2014) which consists of items such as “*I have too many headaches*” and “*other people are happier than I am*” require young people to have the ability to read and understand abstract concepts and evaluate their own behaviour in comparison to others. According to the theory of Cognitive Development proposed by Piaget (1964) children do not develop the cognitive ability to fully think about abstract ideas until they reach the Formal Operational Stage at the age of twelve and above. Therefore, it could be suggested that misunderstanding of such questions may lead to children providing false responses or under reporting symptoms if they do not have the vocabulary to accurately report the private distress that they are experiencing, thus questioning the validity of such research. When using questionnaires with children it is important to avoid ambiguity by using appropriate language for the age group to ensure that they have an understanding of the words used (Grills & Ollendick, 2003). Whilst questionnaires allow for a large amount of data to be gathered efficiently, they restrict the exploration of meanings and experiences as they are understood by children (Kirby, 2004). It was argued that visual and verbal methods that are more child friendly and require less cognitive demand may be more suited to assessments and research with children and young people (Kirby, 2004).

In society, adults often have authority over children, which is instilled into them from a young age. Children are often directed by the adults around them to do what they are told and what is expected of them. Such difference in status could lead to a child finding it difficult to dissent, disagree or say things which they deem to be unacceptable by providing socially desirable responses (Greene & Hogan, 2005). In addition, Mayall (2000) argues that the subordinate position of the child must be considered by the researcher. When conducting qualitative research with children, Waterman, Blades,

and Spencer (2001) highlighted the need to be cautious when interpreting children's responses to closed questions, and to use open questions as much as possible. However, one-to-one semi-structured interviews between researcher and child may be problematic due to emphasising the difference in status between the researcher and participant leading to young people feeling uncomfortable to discuss certain (sensitive) topics. In an attempt to reduce this difference in status, focus groups with children of a similar age range, and the use of vignettes may help children to feel more comfortable and open to discuss topics (Dixon et al., 2013; Liamputtong, 2011). When researching with children aged ten and above, a group size of up to eight children is recommended (Horner & Health, 2000). It is important to consider the setting when conducting focus groups with young people, for example, ensuring that a setting which is familiar is important as new environments and adults may cause anxiety (Kennedy, Kools, & Krueger, 2001). The structure of the focus group is also crucial with children who may have a low attention span (Morgan, Gibbs, Maxwell, & Britten, 2002). Therefore, the inclusion of various activities and techniques such as drawing and visual prompts may be beneficial, particularly for topics concerning sensitive areas (Thomas & O'Kane, 2000). Whilst sensitive topics may be difficult to discuss in a group setting due to worries about embarrassment and humiliation, focus groups may provide a less threatening environment for children to discuss their views, particularly where they have something in common or are familiar with others in the group (Liamputtong, 2011). Familiarity with group members could encourage the discussion of topics and may prompt ideas or comments from other participants and allow participants to comment on and develop ideas about the topic of discussion (Greene & Hogan, 2005).

### 3.4 Creative Research Methods

Greene and Hogan (2005) argue that it is important for the researcher to be open minded with the nature of methods utilised in research with children and to ensure that these methods are suited to their knowledge, understanding and interest. Visual and creative methods may provide a more child friendly alternative to traditional methods when conducting research with children. The Draw and Write Technique (Wetton, 1999) is becoming an increasingly popular method of gaining children's views. Using this method, children are invited to draw and write about an issue in question (McWhirter, 2014). This method is an innovative method used to find out about children's understanding and the language they use to communicate their own experiences in a unique way (Driessnack, 2006) whilst helping to break down the barriers between researcher and children (McWhirter, 2014). This method has previously been used successfully with children in physical health research (Horstman, Aldiss, Richardson, & Gibson, 2008; Smith & Callery, 2005) and has been used by Dixon et al. (2013) in their research on mental health. Asking children to produce the drawing takes the focus away from the adult researcher who may be asking direct questions and provides a child centred approach for them to reveal their understanding and lived experiences. Drawing is a less threatening, child friendly method which allows people to express things that they struggle to convey verbally (Angell, Alexander, & Hunt, 2015). Using this method in a group setting to create group drawings may reduce the spotlight on those children who feel less confident to draw.

The literature review has shown that children have some ability to communicate about mental health. However, the evidence also suggests that children's understanding about mental health is limited. This study will therefore adopt a child friendly, visual

approach to explore with children their perspectives and understanding of mental health, with a particular focus on anxiety.

### **3.5 Study Design**

This exploratory study adopted a qualitative approach using focus groups and creative methods such as the draw and write technique to explore children's understanding of anxiety. Using focus groups and cue cards allowed the researcher to direct the discussion whilst maintaining the flexibility for the children to change the direction of conversation and to develop and expand on each other's answers.

#### **3.5.1 Vignettes**

Two vignettes were created for the research, a male character, Harry, and a female character named Jenny (written versions of the vignettes can be found in Figure 2). Both vignettes displayed symptoms of childhood anxiety based on the DSM-IV diagnostic criteria (American Psychiatric Association, 2000) such as excessive worry and difficulty sleeping whilst relating to the child's own life by including experiences in settings that they may have experienced (e.g. forgetting to take a lunch box to school or feeling nervous before attending a party). The vignettes were presented as short animations (see Appendix C) with a voiceover created using Microsoft PowerPoint and were shown to participants using a laptop. The animations did not include any real-life images of people as the researcher did not want to influence the children's thoughts about the vignettes. The description of the vignettes was adapted to ensure that the language used was appropriate for the participants. The suitability of the vocabulary

used in the vignette was checked with a young person of the target age range, prior to the research.

**Vignette 1 – “Jenny”**

*Jenny is 10 years old. She finds it hard to get out of bed before school and has a funny feeling in her tummy. She thinks that she is not doing very well at school and thinks that she will fail in tests. She checks again and again to make sure that she has not forgotten things such as her lunchbox and coat, so it sometimes takes her a long time before she leaves the house. Jenny thinks that something bad will happen to her when she is away from home.*

**Vignette 2 – “Harry”**

*Harry is 10 years old. Harry says he can't get thoughts out of his head. Harry often says he feels sick and his heart beats fast. Harry has stopped going to friends' parties as he says he doesn't find anything fun anymore. Harry finds it hard to be around people who he doesn't know very well and finds it hard to talk to them. He finds it hard to sleep at night and wakes up in the middle of the night.*

**Figure 2.** Written character vignettes which were displayed to the children in the form of an animation

The vignettes were created based on their use in previous research surrounding sensitive topics such as behavioural problems (Dixon et al., 2013; Hennessy & Heary, 2009) and allow participants to discuss their understanding of such topics in front of their peers, without having to refer to any personal experiences (Liamputtong, 2011). The vignettes were used as the basis for the draw and write exercise and for the focus group discussions which followed. Unlike traditional quantitative methods such as questionnaires, vignettes are useful for research involving children as they allow for participation regardless of reading ability. Vignettes are engaging and relevant to



children (Dixon *et al.*, 2013) and have a story telling nature (Liamputtong, 2011) which may help to reduce the pressures which can arise from questionnaire and interview methods and can encourage a child to talk about their own experience through the behaviour of a character.

### 3.5.2 Sample

Convenience sampling involves seeking out participants from the target population, who are accessible and who can easily take part in the study (Howitt & Cramer, 2017)., In the current research, to the aim was to gain access to a convenience sample of school aged children to conduct focus groups at a familiar and convenient location.

It is important to consider the size of a focus group and a group size of six to ten participants is recommended (Liamputtong, 2011). A small group size may make it difficult to maintain an active discussion, whilst a large group size can be difficult to manage and may make others feel less confident to speak up and share their views (Liamputtong, 2011). A smaller group may allow time for each participant to have a turn to speak and discuss in greater detail than in larger groups (Liamputtong, 2011) which was a key consideration for exploring children's understanding of anxiety. Considering these factors, the research aimed to recruit three separate groups of between four and eight children, aged between ten and 14 years old. This age group was selected due to a lack of research about children's understanding of mental health problems and the government objectives which aim to improve children's and young people's access and implement support within educational settings. The age group also includes the overlap between the final years of primary school and the first few

years of secondary school, which also covers the age 11, the mean onset of mental health problems (Kessler, 2005).

For participants to take part in the current research they were required to be aged between ten and 14 years old, male or female, able to understand and speak English, and a member of a community group in the United Kingdom. Participants were only able to take part in the research if their parents/guardian had given consent.

### **3.6 Procedure:**

#### 3.6.1 Access and recruitment

The researcher contacted a local Scouts leader and discussed what the research entailed. Due to the difference in status between adults and children in schools, the researcher wanted to create a more relaxed environment in contrast to the conventional unequal power relationship between 'teacher and student' where children are expected to do what they are told. Children are often told to listen carefully and not speak while others are speaking in school and given that the current research is more interactive, this would not have been appropriate. In order to provide a more child friendly, informal setting (Mayall, 2000), a community Scouts group was chosen in favour of a school. Information sheets for parents were attached to a consent form and handed out at the Scouts group several weeks in advance of the focus groups. This ensured that parents/guardians had time to contact the researcher directly with any questions or for clarification prior to the research taking place. Verbal assent from the children was gained prior to their engagement in the research through an explanation of what the research entailed and were told that they could withdraw from the research at any point to take part in the activities with the rest of the group.

### 3.6.2 Materials

The materials used in the current research are listed below:

- Laptop
- Coloured felt tip pens
- Written debrief
- Large sheets of paper
- Cue cards
- Blank name stickers
- Vignette videos

### 3.7 Data collection

The focus groups took place in a spare classroom in the Scouts base during the normal hours that the children would attend the group. Those who did not have consent to take part in the session were involved in alternative activities arranged by the scout's leader. The participants and researcher were seated around a table which had a variety of coloured felt tip pens and a large sheet of paper in the middle. The researcher handed out blank stickers and asked the children to write their name and age, the researcher had her own sticker on to provide the children with an example and to minimise the status between them. The researcher explained to the participants what the research entailed - that they were going to watch two videos of characters and that questions would be asked after each video was shown. The children were told that they did not have to take part and could join in with the remainder of the group's activities. In both groups, children were shown the first animation which introduced the character 'Jenny' (Figure 2 shows the written version of the vignettes).

Each vignette was followed by identical open-ended questions on cue cards which each explored the children's understanding of anxiety in one of the 5 dimensions of the Common Sense Model proposed by Leventhal et al. (1980). Examples of the cue cards and the area of the model that was targeted by each question can be found in Figure 3. For the question "*What do you think Jenny/Harry looks like?*", participants were encouraged to draw and each character to produce a group image. Similarly, for the question "*How long do you think Jenny/Harry will feel like this?*" the participants were handed a sticky note and asked to write their response and stick it on a large timeline which had been placed on the wall. Questions were followed by prompts to encourage the children to expand on their answers to meet the research aims and explore children's understanding of anxiety. After all cue cards had been discussed, participants were then presented with the second vignette Harry, and the same cue questions were asked. On completion of the session, participants were provided with a verbal and written debrief. The focus groups were recorded using an encrypted audio recorder and were later transcribed and analysed by the researcher.

**Instructions for draw and write task:**

- *What do you think Jenny/Harry looks like? (identity)*
- *Can you think of any words to describe Jenny/Harry? (identity)*

**Focus group discussion questions/prompts:**

- *How long do you think Jenny/Harry will feel like this? (duration)*
- *What should Jenny/Harry do? (treatment)*
- *What would you do if you felt like this? (treatment)*
- *Would you be friends with Jenny/Harry? (identity)*
- *What do you think Jenny/Harry feels like this? (coping)*

**Figure 3.** Draw and write instructions and focus group questions/prompts

### **3.8 Data storage**

All data collected during the research was securely stored on the University server. All documents including transcripts and visual data were stored on the researcher's personal university drive in password protected files which only the researchers could access. An encrypted audio recording device which required password access was used to record the focus group data and was uploaded on to the researcher's university drive in a password protected file.

All data collected for the research will be stored at the University for 10 years following the completion of the research. All parents were made aware of this and were provided with information on how their child's data would be stored in the information sheet.

### **3.9 Approach to analysis**

Thematic analysis was deemed an appropriate method as this method is a commonly used method for describing, analysing and reporting themes and patterns within qualitative data (Braun & Clarke, 2006). A step by step process was conducted by following the guide outlined by Braun and Clarke (2006). The data collected from the three focus groups, including the words that the children had written on the visual data, were manually transcribed by the researcher. The transcribed data was then checked

against the original audio recording and re-read several times in order to ensure the accuracy of the transcription against the recorded data. The first phase of the thematic analysis is familiarisation with the data (Braun & Clarke, 2006). This phase involves '*repeated reading*' of the data to familiarise yourself with the content of the data set whilst making initial notes about any thoughts or ideas (Braun & Clarke, 2006). The second stage of Thematic Analysis includes working through the data set and giving equal attention to each part of the data generating initial codes from the data which "*identify a feature of the data that appears interesting to the analyst*" (Braun & Clarke, 2006, pg. 18). The transcribed data was printed onto large A3 sheets and notes and interesting points were made in the margin. When the data had been coded, the next stage of the analysis involves searching for themes from the codes which have been identified from the data and analysing where the codes can be sorted into potential main themes and subthemes (Braun & Clarke, 2006). The next phase involves reviewing the themes that have been identified in the previous phase to refine the themes, reviewing the coded data and deciding whether the data extracts fit or whether the theme is too small and discarding them from the analysis (Braun & Clarke, 2006). The codes were checked through by the researcher and the supervisory team to ensure that there was agreement that the themes were an accurate reflection of the codes. The final phase includes defining what the theme is about and naming the themes and looking at how the themes fit in with the research questions (Braun & Clarke, 2006).

### **3.10 Ethical approval and procedures**

Ethical approval was gained from the Human and Health Sciences Research Ethics Panel (SREP) prior to the research taking place. The information sheet (Appendix D) and consent form (please see, Appendix E for a blank copy) was sent home to parents/guardians describing what the research entailed. The information sheet contained information for parents/guardians about how to withdraw their child or their child's data from the research at any point until the cut-off date (time the analysis had been conducted). Informed consent was obtained from parents in the form of a consent form which was returned to the Scout group prior to the research taking place. A signed consent form was mandatory for the children to take part in the research. At the beginning of the research all children gave verbal assent, following a description of what the research would involve and an offer to withdraw from the research and join in with the remainder of the group to do the alternative activities.

To ensure anonymity, during transcription, participant's names were replaced with a unique identification number in order to protect the identities of the participants (e.g. B1/G2). A list of the participant's names and unique identification numbers were stored in a password protected file accessible only by the researcher and research supervisors. Participants names will not be published and will remain anonymous throughout the research. Protocols were put in place for dealing with any participants whereby a member of the Scouts staff stayed in the session and were on hand to look after any children who needed to leave the room for any reason whilst the research was taking place and provide emotional support if required. At the end of the session, all participants were provided with a verbal and written debrief which contained information about charities which could provide further information and support (e.g. Young Minds and MIND) and explained the aim of the research in a child appropriate way.

The researcher adhered to The Data Protection Act (2018) and the University's policy ensuring that all the collected data was stored in a password protected file on a computer at the University of Huddersfield, for which only the researcher and research supervisors had access to. Information containing personal details of participants, such as paper copies of consent forms, were scanned and stored as files on the University network and hard copies were stored in a locked drawer at the University. The data will be stored at the university for a minimum of 10 years.

### **Reflexivity**

Etherington (2004) refers to reflexivity in research as "*the capacity of the researcher to acknowledge how their own experiences and contexts inform the process and outcomes of inquiry*" (pg. 32). When undertaking qualitative research, it is important to consider the role of the researcher and reflect on how certain aspects including our thoughts, feelings, environment, cultural influences, social influences and personal history have influenced the research (Etherington, 2004). In the current study, there are several things to consider which could have influenced my role as a researcher and facilitator during the focus groups.

My lack of experience as an interviewee and lack of interviewing skills may have impacted on the quality of the questions and the way they were asked in the focus groups. Having never conducted a focus group before, I was nervous when doing the first focus group, meaning that I did not probe on some interesting responses, which may have hindered the quality of the group and the richness of the data. On reflection of the first focus group I felt more confident and I was able to recognise where



responses could have been probed to gather more in-depth data to gain a deeper insight into children's understanding of anxiety.

At the time of conducting the research my full-time occupation was an educational teaching assistant, supporting those with special educational needs, in a secondary school. I work with children who are the same age as the target age group in a school environment which may have meant that my thoughts and perceptions about children of this age was influenced by the children I work with.

It was important to consider my own views and opinions and my own interest in the area and be aware of these in order to prevent them from distorting the research data. One way I overcame this is to create a semi-structured focus group plan by creating cue cards to ensure that each focus group followed the same direction and was not directed by my own thoughts. It was crucial to revisit the data upon transcription and beyond to ensure that the children's understanding was from their perspective and reflected what they were saying. The data was sent to the supervision team in order to check the analysis and ensure that the same ideas were agreed by the three of us.

A further factor which may have had an impact is the setting and environment. The research took place at the Scouts headquarters, a place where all the participants were familiar with and had been many times previously. I aimed to ensure that the focus groups felt informal and relaxed through the use of the creative research methods and familiar environment which may have increased the children's engagement to take part. Similarly, this could have had a negative effect as the children felt comfortable and may have led to silly behaviour with participants making responses to make their peers laugh.

## **4. Findings**

#### 4.1 Participant characteristics

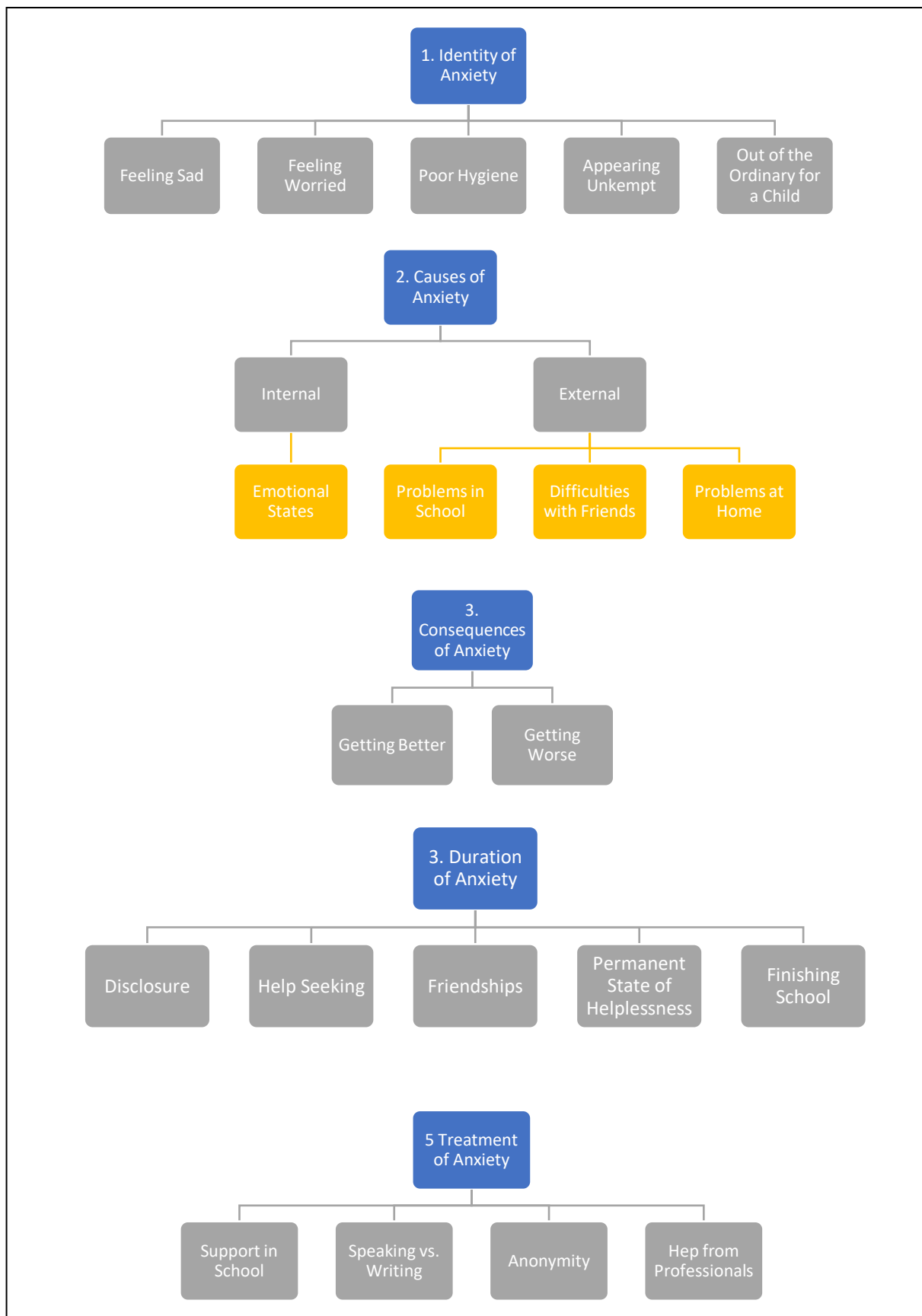
In total, three independent focus groups were conducted with children aged ten to 14 years. The participants were all members of the same Scouts group. The table below demonstrates the characteristics of the participants in the three focus groups. Participants were randomly assigned to each group by the Scouts leader.

**Table 1**

*No. mean age and gender of participants for all focus groups.*

<b>Focus Group</b>	<b>N</b>	<b>Male</b>	<b>Female</b>
1	6	2	4
2	8	6	2
3	5	2	3

The research aim was to explore children's understanding of anxiety by looking at the identity (presentation), causes, consequences, duration and treatment of anxiety. A deductive approach to the analysis was employed and in this section a discussion of main themes and subthemes will be presented. The main themes which will be discussed are Identity of Anxiety, Causes of Anxiety, Duration of Anxiety, Consequences of Anxiety and Treatment Available for Anxiety (see Figure 4). The data will be presented across all three groups as all of the groups followed the same procedure.



**Figure 4.** Thematic map showing all themes and subthemes

Overall, the data suggested that children's general understanding of anxiety was limited. Whilst the children were able to articulate their thoughts and ideas, participants appeared to know more about the potential causes of anxiety but their understanding about the sources of support and the duration of the disorder were less developed. A negative perception of the characters was evident across all three groups through their drawings and written and verbal descriptions.

## **4.2 Identity of anxiety**

Children's responses to the vignettes about Jenny and Harry provided an indication of children's perception of anxiety and understanding of how this might be manifest in symptoms and physical appearance. This section discusses children's views according to five subthemes: Feeling Sad, Feeling Worried, Poor Hygiene, Unkempt/Messy and Out of the Ordinary for a Child.

### **4.2.1 Feeling Sad**

Participants described the characters by referring to physical representations of their emotions and feelings. There was a united consensus that both characters were "sad", this was observed through the drawings and the words used to describe them. Participants in all three groups described Jenny's facial expression using the words "sad" and "worried". This was reinforced by the images they produced as part of the 'Draw and Write' task with the drawings from all three groups picturing Jenny with a frown or sad face.

Researcher: So, what are we thinking, what does she look like?

Female 2 (11yrs): no no a sad face

Researcher: a sad face? Why has she got a sad face?

Female 2 (11yrs): because she seems sad

Researcher: what do you think she's sad about?

Male 2 (11yrs): she's got a moustache

Female 2 (11yrs): been scared

Researcher: she's sad about been scared? Of what?

Female 1 (14yrs): going to school

Female 2 (11yrs): life

Across all three groups, the joint images produced by the participants showed the character Jenny with either an upside-down semi-circle shaped mouth or a squiggled line and participants described this as a "sad" or "worried" face. Through their illustrations of the character of Jenny, the children describe that when someone is experiencing the symptoms of anxiety this shows physically on the person and is apparent to an external observer through a person's facial expression. When questioned about this, the participants in group 3 suggested that Jenny's sadness was as a result of problems in the external environment such as school and everyday life. Participants in group 2 emphasised the extent of Jenny's sadness in their group drawing as they added tears to her face and described her character by writing the word "upset".

Gray

Nervous.

Doesn't care  
about what  
he looks  
like

Upset  
Pretzel

Jenny

Rugged  
Manly

Know

Anxiety

Know

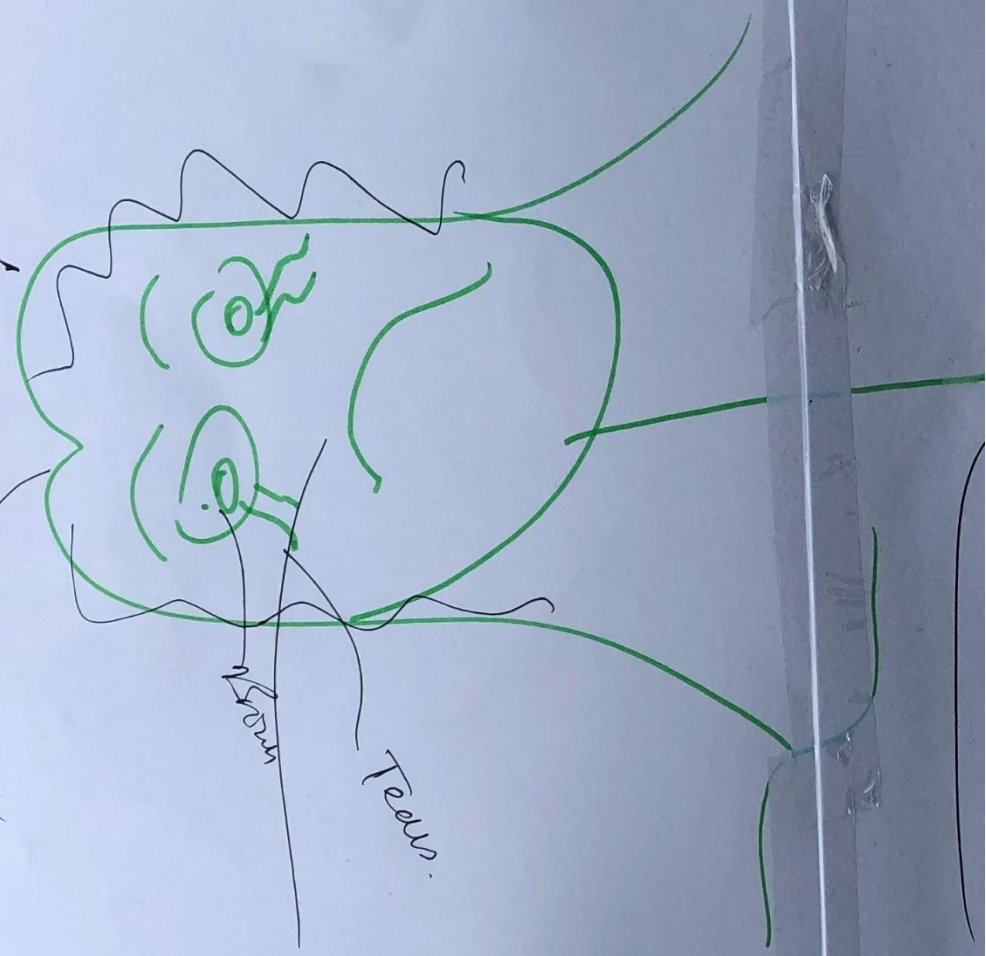
Tears.

Worrying  
about other  
things.

Doesn't want to  
get hurt

Nervous

Sad face



Participants in group 2 described how they would avoid being friends with Jenny due to a fear that the sadness she is experiencing would be passed on to themselves:

Female1 (12yrs): yeah if she's always sad then you don't want to be with her because she'll just make you feel

Male 5 (13yrs): she might pull you down but like you'd try and help her

Female 1 (12yrs): you'd feel bad for her so you'd try and help her

Researcher: so you'd feel bad for her and you'd try help her but if she was bringing you down then maybe it's not a good idea to be friends with her?

Collective: yeah

Male 6 (10yrs): if she's making you sad

Social distance from the character Jenny was influenced by her emotions and the participants in this group believe that Jenny's behaviour could make other people around her sad, which would be a reason to avoid her friendship.

The children do not appear to understand that people do not always show how they are feeling through their facial expressions, as often people who present with symptoms of anxiety are able to conceal and mask how they are feeling to people around them. This appears to be a common misunderstanding with participants in all three groups describing and drawing Jenny this way.

#### 4.2.2 Feeling worried

Similarly, participants in group 1 described Jenny using physical descriptions of her emotions and discussing some of the physical symptoms that they were experiencing. The participants drew Jenny with squiggled lines on her forehead which they labelled as 'worry lines', this was also observed for Harry in group 2. Worry was viewed as

something which could impact on many different areas of the character's life including their physical appearance:

Researcher: so her hair then, what do we think her hair looks like?

Female 2 (12yrs): brown

Female 1 (12yrs): probably brown

Researcher: so what do you think its long or short?

Male 6 (10yrs): rugged

Male 5 (13yrs): not long but not short

Researcher: so what do you mean by rugged? a bit messy?

Male 5 (13yrs): yeah

Researcher: why do you think she's got messy hair?

Male 6 (10yrs): because she takes so long

Male 5 (13yrs): she takes too long looking for her lunch box rather than her straighteners

Male 6 (10yrs): worried about other things

In all groups, the drawings produced of both characters displayed their hair as untidy and in some images quite unruly. During group 1, when asked their opinion of why Jenny's hair was 'rugged' they suggested that this was due to her mind being preoccupied and 'worried' about other things and the participants showed some awareness that Jenny's feelings are impacting on her physical appearance. Standing out and looking different to others was viewed negatively. The participants appear to believe that looking nice will help people to fit in with others and that someone who is experiencing these symptoms may stand out due to their appearance.



Jenny

unsociable

worry lines

Deep creases

Dark

bags under eyes

friendless

messy

hair

smelly



When asked about Jenny's physique, the same participants also discussed the negative impact that worry is having on Jenny's eating behaviour.

Researcher: so do we think she's hungry?

Male 5 (13yrs): yeah, because she she forgot her lunch box

Researcher: okay

Male 2 (12yrs): how big are her arms are they like the sticks in the picture?

Researcher: so is she slim? Do we think she's quite slim?

Collective: yeah

Male 5 (13yrs): because she forgets to eat

Male 6 (10yrs): she might be poor as well

Male 5 (13yrs): because she's too she's too busy worrying about everything else

Male 6 (10yrs): about everything else

The participants in this group suggest that worry is a major part of Jenny's life which preoccupies her mind and impacts on her cognition, making her forget about basic needs such as eating. Some participants were able to make links between how Jenny thinks and the impact this has on her behaviour. The children express a belief that the symptoms of anxiety are quite visible and obvious on the person experiencing the symptoms and do not seem to understand that many people who suffer with anxiety manage to function and live normal everyday lives.

The idea that Jenny's thoughts were impacting on her behaviour was also observed in group 3:

Researcher: so, what do you think her clothes are like?

Female 2 (11yrs): they are quite dark because because she she wants to fit in and not be seen

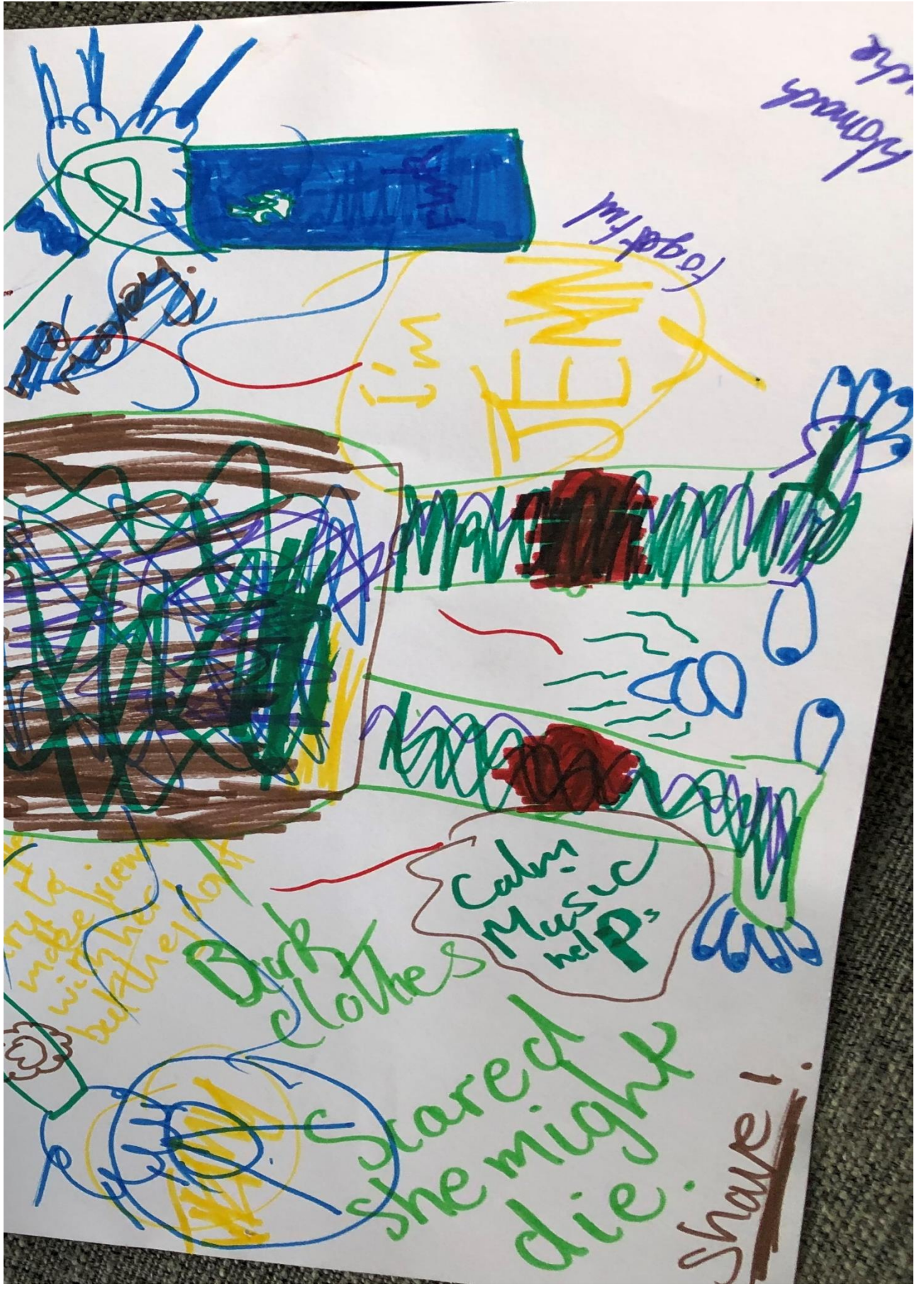
Researcher: so, she wants to blend in with everyone else?

Male 2 (11yrs): she has purple and green shoes because she can't read because she can't, she can't see what colour her shoes are, so she gets them mixed up because she's worried about everything else

Researcher: so, she's wearing odd shoes?

Female 2 (11yrs): yes, one shoe one colour

When asked about the clothes that Jenny is wearing Female 2 implies that Jenny wears clothes that are dark in colour to blend in with her peers as she 'wants to fit in'. This idea links to the Cognitive Behavioural Therapy models, and this participant is making links between how Jenny feels and how she behaves. Female 2 suggests that due to the fear of standing out, Jenny wears clothes which will help to her to fit in with others. Peer acceptance is seen as a major point and standing out is seen as a negative thing and negative evaluation due to not fitting in with others. Conversely, this belief is challenged by male 2 who holds a negative view of Jenny suggesting that due to her worry she has difficulties with her eyesight and reading which makes a simple task such as putting shoes on very difficult for Jenny. This participant shows a misunderstanding by implying that it is easy to spot someone who is experiencing anxiety as they will stand out quite clearly. Such comments are made consistently by Male 2 in this group suggesting that he may find it uncomfortable to discuss the sensitive topics.



Stomach

Forgetful

JEM

...ing to  
with her  
but she's not

Dark clothes

Calm Music

Scared she might die

Shave!

Female 2 in the same group described how negative experiences such as a lack of sleep were the result of the worry Harry was experiencing:

Researcher: and whys he got bags under his eyes?

Female 2 (11yrs): because he's tired and he didn't sleep properly

Researcher: why do you think he doesn't sleep properly?

Female 2 (11yrs): because he's worrying about that he doesn't have a childhood

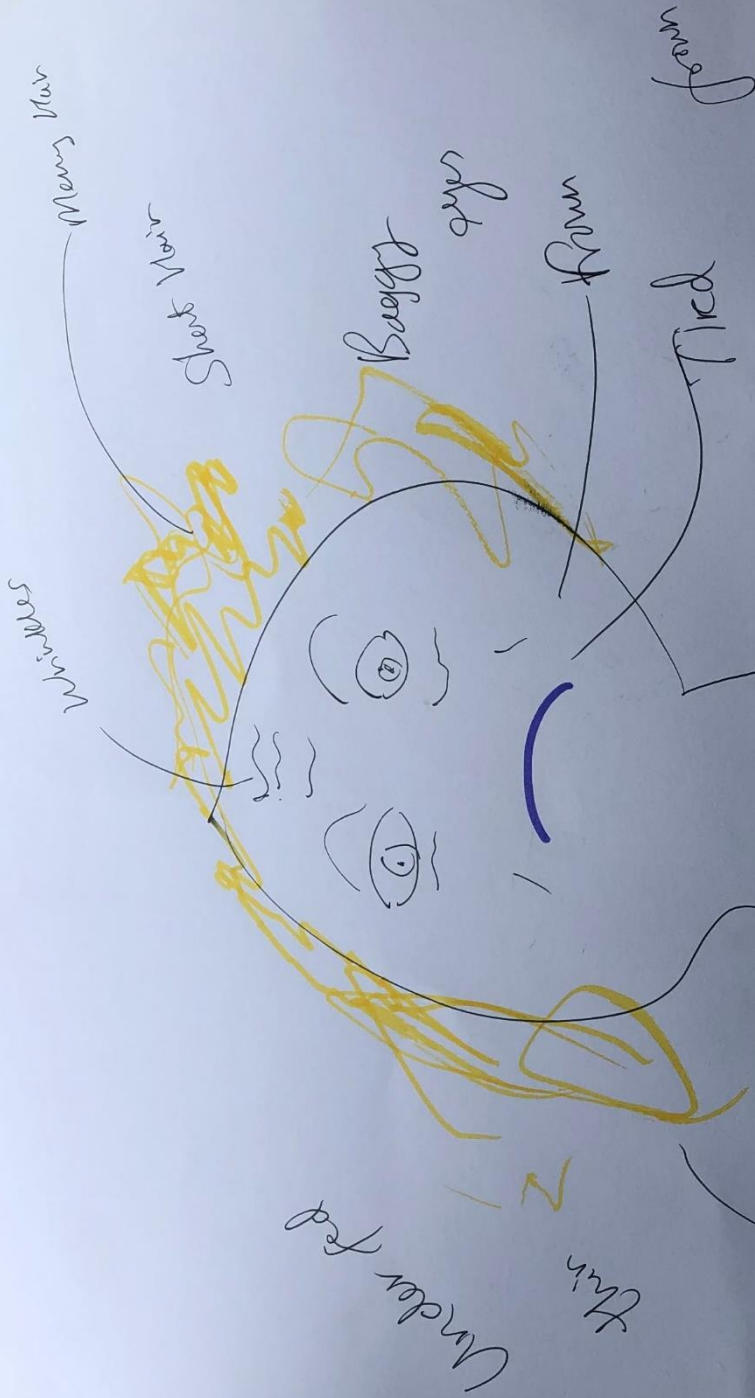
Researcher: he doesn't have a?

Female 2 (11yrs): a childhood

This participant describes how worry is affecting Harry's sleep, which in turn affects his appearance due to looking tired.

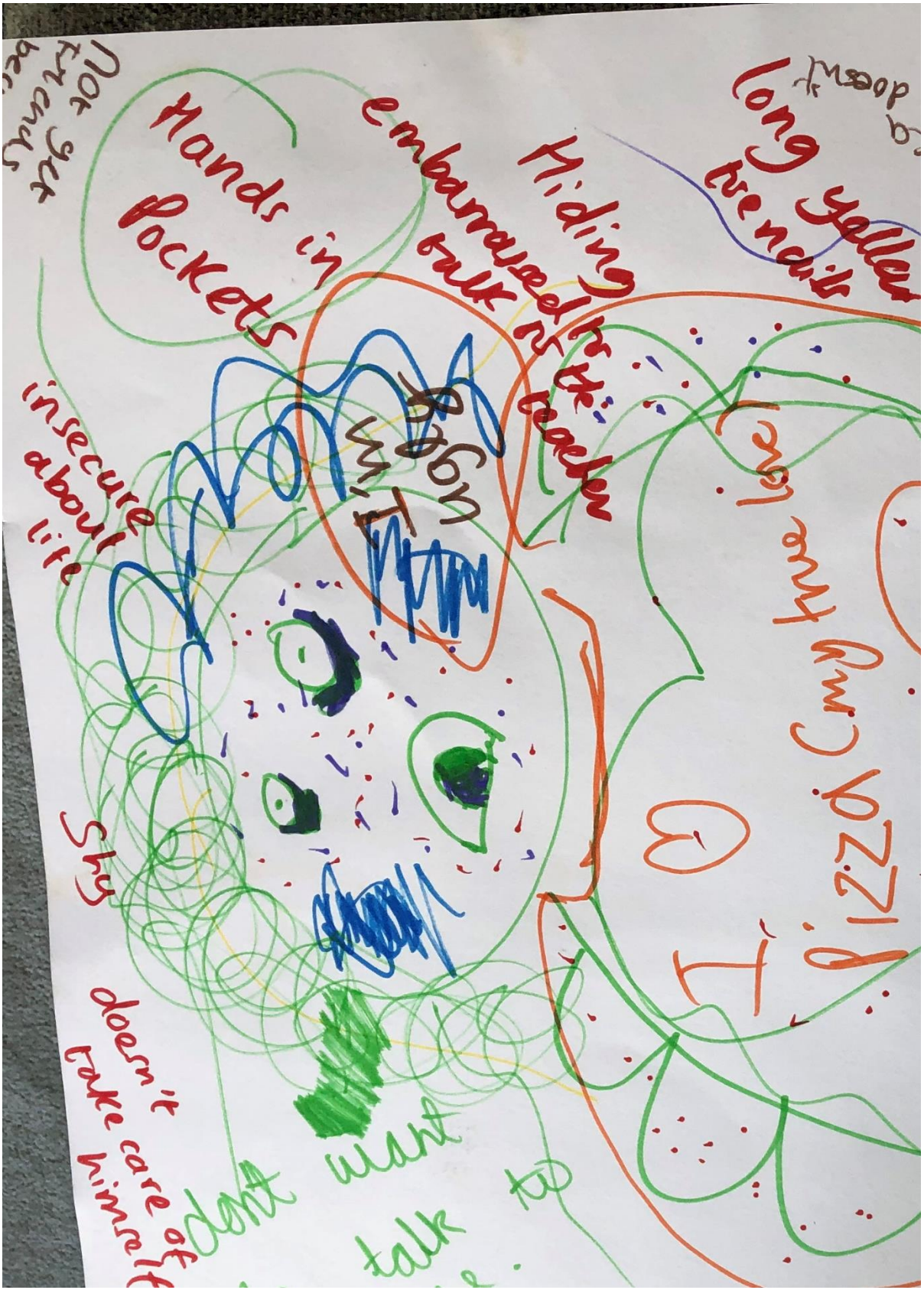
(group 2)

Harry



Long hair  
because  
doesn't  
grow





Not yet friends

Hands in Pockets

embarrassed to talk to teacher  
Hiding

long yellow freckles

insecure about life

shy

doesn't care if people like him

want to talk

I love my pizza

### 4.2.3 Poor Hygiene

Participants in all three groups hinted that both characters have a negative appearance and poor hygiene through their visual drawings and descriptions of the characters:

Male 1 (13yrs): she might not have time to have a shower

Researcher: ok, alright, so do you think she smells?

Female 4 (10yrs) yes

Male 1 (13yrs): she might

Female 1 (12yrs): if she finds it hard to get up in the morning then she won't have time to do much

Female 4 (10yrs): she stinks, look

Through their drawings and descriptions of Jenny, participants describe a negative image of Jenny as they indicated that she is not clean and suggested she was 'smelly' as she did not have enough time to have a shower. This was emphasised through their drawings as they drew lines around their drawing of Jenny's character which they described as "*smell lines*".

Similar comments were also observed for Harry by Male 2 in group 3 who suggested that Harry did not often have a shower and went on to emphasise the extent of this by mocking him - "*never showers you know when you go to birthday parties and have sprinklers in the garden that's the only time he ever showers*".

The participants also appear to have developed unrealistic ideas about people who suffer with symptoms of anxiety which can be seen from the group's discussion about Harry below:



Female 2 (11yrs): his toenails are long and yellow because he can't clip them

Male 2 (11yrs): from 18 years ago

Researcher: so, are you saying that his new shoes are not very trendy?

Female 2 (11yrs): I think 18 years ago was cool

Researcher: so, he's got long yellow toenails

Female 2 (11yrs): cos he can't trim them brown around the edges

Male 2 (11yrs): brown on the whole thing and he wears the same socks everyday

This group provided quite a graphic description of Harry's lack of hygiene by suggesting that he rarely changes his socks or maintains good hygiene by clipping his toenails. This is quite a horrific description of Harry and demonstrates the stigma attached to mental health problems as these participants show a negative view of Harry.

#### 4.2.4 Appearing Unkempt

Participants described Harry's character as a messy individual who is not well dressed and does not take care of his appearance:

Researcher: split ends? So what kind of things do we think he's wearing?

Male 6 (10yrS): like pale clothes

Male 4 (12yrs): they look quite used

Researcher: okay so a bit tatty? Or a bit dirty?

Collective: yeah

Male 6 (10yrs): wrinkled

Male 5 (13yrs): like stained or somet or got like little rips in

Female 2 (12yrs): a bit too small for him

In this discussion, the participants describe Harry's clothing as used, stained and too small for him. They appear to try and distance themselves from the male character by describing his clothes as undesirable by suggesting that Harry is not very well dressed. The children appear to believe that someone who has anxiety will appear in a certain way and will stand out from their peers.

Female 3 (13yrs): he's got fuzzy eyebrows

Researcher: why's he got fuzzy eyebrows?

Female 4 (10yrs): because when he gets stressed he gets eyebrows

Researcher: oh right ok, so were saying he's quite stressed then if he's got quite fuzzy eyebrows?

Female 4 (10yrs): yeah

Female 3 (12yrs): he's got a monobrow

When asked to describe what Harry looks like, the Females in group 1 sketched Harry with 'fuzzy' eyebrows which they then joined into a single monobrow. Female 4 described how Harry grows hair when he is stressed indicating that he experiences this a lot due to his excess hair. This demonstrates a negative view of Harry as being tidy and well-kept is something that is viewed as desirable by most males and females. Participants linking Harry's feeling and behaviour to the amount of hair he has on his eyebrows shows that they do not understand that some people with anxiety do not demonstrate symptoms which are external.

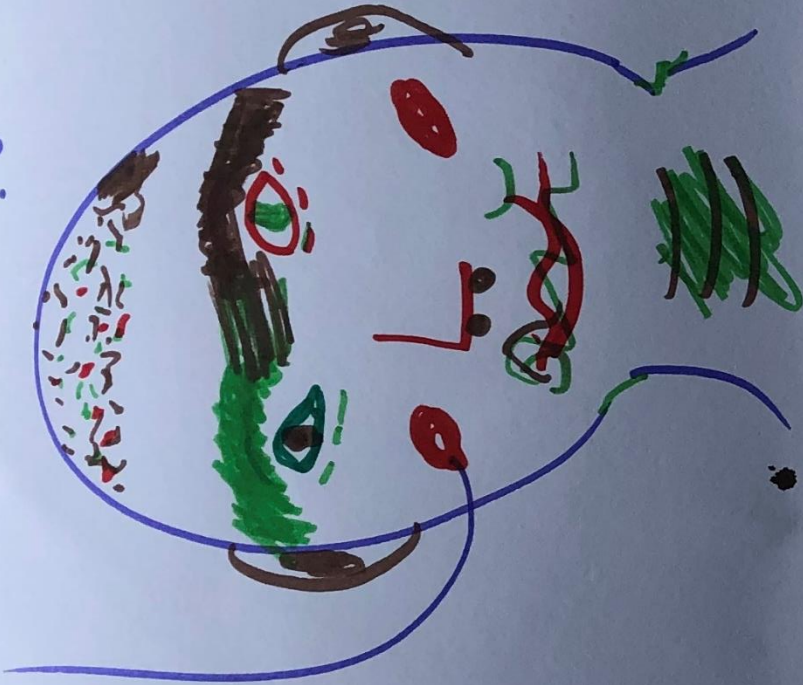
Harry

Poor hygiene.  
double chin

Embarrassed  
Doesn't care  
Bald  
under

Specialist

Paranoid



Lack sleep  
Worried

pulled his hair out

Female 2 (12yrs): short hair

Male 5 (13yrs): quite pale because he never goes outside in the sun

Male 6 (10yrs): oh no he might have long hair because he doesn't like going to the hairdressers

Female 1 (12yrs): he's got quite a big frown

Researcher: so a frown, long hair because he doesn't like going to the hairdressers

Male 5 (13yrs): make it longer

Researcher: do we think his hair is messy or?

Collective: yeah

Female 2 (12yrs): lots of split ends

The participants in this group imply that Harry's feelings are impacting on his behaviour, preventing him from going outside and getting a haircut which is impacting on his appearance. The children appear to be referring to extreme cases of mental health problems which prevents people from leaving the house and do not appear to have the awareness that anxiety can affect people who manage to cope with life's everyday tasks and appear no different to the people around them.

#### 4.2.5 Out of the ordinary for a child

Participants in all groups created images containing features which you would not associate with a typical child. Participants in some groups used a lack of colour while others used distinct colours such as green and brown in their illustrations. Many of the drawings do not reflect the image of a human and appear more cartoon or monster like. In the discussion below, the participants describe some of the features of Harry's face:

Researcher: so same again. I want to know what you think Harry looks like.

Female 3 (12yrs): he's got bags under his eyes because he's

Researcher: why, do you think he's tired?

Male 2 (11yrs): he has a blue face

Researcher: why's he got a blue face?

Male 2 (11yrs): because you know when someone's ill and because he wakes up in the middle of the night

Researcher: is he ill?

Male 2 (11yrs): yeah, he's ill

Participants in group three appear to misunderstand the symptoms that Harry is experiencing and attribute this to a physical illness describing his physical appearance by suggesting he has "*bags under his eyes*" and "*a blue face*". The participants in this group do not appear to recognise that the symptoms Harry is experiencing are linked to his mental health which may make it difficult to recognise problems such as anxiety in themselves and others. This was also observed in group 1 when participants attempted to label Harry's problem by suggesting "*it might be cancer*".

Similar unpleasant descriptions of Harry's character were also observed in group 1:

Researcher: ok, same as what we did for Jenny. I'm looking for what does Harry look like?

Female 4 (10yrs): he's bald. He's green and bald

Researcher: so he's bald. Feel free to pick up the pens and draw

Female 4 (10yrs): he's got bags under his eyes again.

Male 2 (10yrs): he's got dandruff

Female 1 (12yrs): I'm trying to draw bags under his eyes and falling

Participants described Harry in a horror like manor which was followed up by their illustrations of him as green and bald, with a monobrow, bags under his eyes and dandruff in his hair showing undesired aesthetical features. Such findings suggest that the children have a negative view of people who experience the effects of mental health problems. When questioned further about their illustrations, some participants used their own experiences to make sense of Harry's behaviour:

Researcher: so we've said he's got no hair; why do we think he's bald?

Female 1 (13yrs): because he's stressed

Researcher: ok because he's stressed

Female 4 (10yrs): he's pulled all his hair out

Researcher: so he's pulled his hair out?

Female 1 (12 yrs): yeah because you know when you get annoyed

Female 4 (10yrs): that's what I did when I was younger

Female 1 (12yrs): I still do that yeah

The participants show a link here between Harry's feelings and his behaviour, suggesting that his lack of hair is due to feeling stressed and pulling his own hair out. One of the youngest participants in this focus group related this to her own life suggesting that she too did this when experiencing the same feelings.

### **4.3 Causes of Anxiety**

This theme explores the children's understanding about the causes of the character's behaviours. Participants were asked "why do you think Jenny/Harry feels like this?" in order to gain an insight into their understanding of the causes of anxiety. Many of the

children's explanations about the cause of the behaviours were focused on external explanations, with less focus on internal or biological explanations.

#### 4.3.1 External Causes of Anxiety

The first sub-theme which will be discussed is external causes of anxiety. Participants described some of the causes of anxiety that are external to the characters relating to things in the external environment that have caused Jenny/Harry to feel this way. This section has been broken down into four sections that will be discussed below, Lack of Friendships, Problems in School, Lack of Support and Abuse/Neglect. The main external cause of anxiety discussed by the children was around family issues in the home environment.

##### Problems at Home

Problems within the home environment was mentioned at least once by some participants in all three focus groups. Abuse and neglect experienced in the home environment was another potential external cause of the character's behaviour discussed by participants in group 2:

Male 6 (10yrs): maybe her parents don't treat her very well

Researcher: so her parents are neglecting her?

Male 6 (10yrs): yeah

Male 5 (13yrs): she might have been adopted from a young age and had quite an aggressive childhood and then changed into a positive one

The participants used ideas about parental neglect and adoption to explain why Jenny was behaving this way and suggested that some of the problems could be rooted in early childhood due to experiencing a difficult home life. Male 5 suggests that these issues are no longer present but the problems still persist. This shows some participants understand about how major life events can impact on our behaviour in the future. These ideas about abuse and neglect were also evident in group 3 "*she might have been bullied at home*" Male 2 (12yrs) by "*older siblings or younger siblings*" Male 5 (13yrs). Interestingly this point was raised more frequently by male participants:

Researcher: so, who do you think he lives with now?

Female 3 (12yrs): his mum

Female 1 (14yrs): his foster mother

Male 2 (11yrs): his drug mum

Researcher: ok so do you think his mum is on drugs?

Male 2 (11yrs): yes

Researcher: so, he's not got a very nice home life then?

Male 2 (11yrs): no

Researcher: and is that why he's feeling like this?

Male 2 (11yrs): yes

The participants drew upon elements of drug use and the care system as reasons to explain the cause of Harry's behaviour implying that the character has a complicated and difficult home life. Similar ideas about a lack of support from Jenny's parents was observed in group 1 "*her parents might not be supportive*" Male 1 (13 yrs) and a lack of trust in group 3 "*and trust issues (between) her family and then she might not trust anyone else*" Male 1 (11yrs). This implies that whilst a negative home life can be detrimental, having a good, stable home life is important to these young people as



participants suggested parents and the family as the most frequent source of support for the characters and themselves.

### Difficulties with Friends

Friendships were viewed as having a pivotal role in anxiety with a lack of friendships and peer rejection suggested as a potential cause and making friends been viewed as a solution for the disorder. Female 4 in group 1 suggested that the direct cause of Jenny's behaviour was "*because she hasn't got any friends*". Standing out and not fitting in with peers was viewed as a negative thing which could have negative consequences such as peer rejection:

Researcher: do you think she has friends in school?

Collective: no

Male 2 (11yrs): not looking like this she doesn't

Researcher: why not?

Female 3 (12yrs): because she's shy and she's scared she's got erm social anxiety yeah

The male in this group describes how Jenny's negative physical appearance leads to peer avoidance. In contrast, the Female participant explains this lack of friendship due to her personality describing Jenny as "shy" and hinted towards her having an underlying mental health problem such as 'social anxiety'. This participant appears to have some understanding that a condition such as social anxiety may impact on someone's ability to form relationships due to difficulties communicating with others:

Researcher: so, do you think she speaks to people?

Female 2 (11yrs): I'm shy

Researcher: so, you've drawn her saying I'm shy. Do you think people try and make friends with her?

Male 2 (11yrs): no

Female 3 (12yrs): maybe. Well they probably do but she's like I'm shy bye

Researcher: so, they just avoid her?

Female 3 (12yrs): yeah

The same male participant demonstrates a negative view of Jenny as he implies that people do not attempt to befriend Jenny. A contrasting view is shown by the Female participant who suggests that people try to make friends with Jenny but she struggles to communicate with them. This shows a misunderstanding about young people who suffer with anxiety who may struggle to communicate with others rather than not wanting to communicate as suggested by Female 3. The current study suggests that the young people do not know how to communicate with people who present in this way and are unsure about how to interact with those who may be experiencing social anxiety or shyness which could lead to social avoidance. There is an element of confusion as they interpret Jenny's shy behaviour as ignorance and demonstrate an inability to communicate with people who respond in this way. This is also observed below when the participants are discussing Harry's character:

Female 4 (10yrs): he's feeling like erm like feeling very alone in the world

Researcher: so he doesn't have any friends?

Male 1 (13yrs): but it says that he doesn't like going to friend's birthday parties so that means he has friends

Male 2: but doesn't like his friends

Male 1 (13yrs): so he doesn't really see them anymore

In this excerpt, the participants misinterpret Harry's behaviour and suggest that the reason he does not attend social events such as birthday parties is due to a dislike of his friends rather than due to problems that he is experiencing. The older children in this group struggle to understand the implications of anxiety in young people and that those who experience anxiety may not take part in social events due to feeling too anxious rather than due to a dislike of their friends. This gives an insight how such behaviour can be misinterpreted by young people and in turn lead to further friendship problems.

### Problems in school

Interestingly problems within the school environment were only suggested for the Female character, Jenny. School was suggested as a reason for Jenny's behaviour in each group due to trouble in school and specific areas such as bullying or a lack of support:

Female 3 (12yrs): school

Researcher: what about school is making her feel like this?

Female 3 (12yrs): err she doesn't have any support

Participants in group 3 suggested school as a direct cause of the way Jenny was feeling and suggested that she might be scared of going to school:

Researcher: what do you think she's sad about?

G2 (11yrs): been scared

Researcher: she's sad about been scared? Of what?

G1 (14yrs): going to school

School is an important place where children spend much of their time. Problems in school was viewed as a negative thing but on the other hand school was viewed as a place of help and support.

#### 4.3.2 Internal causes

Throughout the focus groups, internal causes of the character's behaviour were referred to less frequently. Participants referred to three main emotional states - feeling paranoid, feeling sad and feeling scared.

#### Emotional states

These emotional states were described by participants as impacting on the character's everyday life, preventing them from going outside, taking part in social events and feeling conscious about the way they look. The children discussed how negative thoughts such as being paranoid about the way Harry looks may be the cause of his behaviour. Standing out was viewed as a negative thing and participants show an understanding about how you look can impact how you feel and emphasise the importance of fitting in with their peers.

B2 (11yrs): depression

B1 (11yrs): it's because he keeps thinking about his dad and he can't fall asleep

G1 (14yrs): he has nightmares

Researcher: what do you think he has nightmares about?

G1 (14yrs): erm death he keeps seeing his father dying

Researcher: ok so he keeps seeing it over and over again in his head? Okay any other reasons why he's feeling like this?

B2 (11yrs): because he's had chickenpox twice

Researcher: ok so he's physically ill? So that's making him feel the way he's feeling?

B2 (11yrs): scared he might die

Feeling worried and the experience of negative life events such as the bereavement of a close family member was viewed as something which could impact on the way Harry was feeling and cause his behaviour.

The participants described how Harry's behaviour is a result of feeling paranoid:

Female 1 (13yrs): he's paranoid

Researcher: He's paranoid? What's he paranoid about?

Researcher: what's he paranoid about?

Male 1 (13yrs): he's scared of like loads of stuff and he gets worried he's always thinking someone is watching him and stuff like that

The participants suggest that feelings of paranoia and worry about being watched and evaluated by others contributed to Harry feel the way he is feeling. This is an insecurity and implies that social acceptance and peer rejection is an important factor.

The participants attempt to label the causes of Harry's behaviour by suggesting that his feelings are due to him feeling depressed and "*not finding anything fun*" – Male 6 (10yrs).

B2 (12yrs): he might stay in his room all the time which makes him feel sad

Researcher: he might what?

B2 (12yrs): stay inside he might not get enough sunshine?

Researcher: ok yeah so we think he stays inside a lot? So maybe that's made him feel how he's feeling?

Collective: yeah

The males in this discussion explain the cause of Harry's behaviour due to him staying inside of his room and not going out which is making him feel sad and as a result has a lack of sun. The children seem to recognise that an unhealthy lifestyle, loneliness and staying indoors can cause individuals to feel this way.

#### **4.4 Consequences of Anxiety**

To explore children's understanding about the consequences of anxiety, participants were asked, "what will happen next for Jenny/Harry?" or in some cases this was rephrased into "what will happen for Jenny/Harry in the future?". The section has been divided into two sections based on the participant's responses: Getting Worse and Getting Better.

##### **4.4.1 Getting Worse**

The majority of the participants, both male and female, believed that both Jenny and Harry's problems would get worse over time. In group 2, talking or telling someone about the problem was viewed as pivotal in preventing the problem from getting worse "*she's probably going to start getting worse and worse until she tells someone*" Male 1 (12yrs). With another participant recognising that Jenny was experiencing a mental health problem and describing the impact this would have on her if she did not seek help "*mental health it will affect her massively if she doesn't go to someone*" Male 5 (13yrs).

Participants in groups 2 and 3 discussed how a consequence of anxiety might be that Jenny and Harry might begin to hurt themselves or others around them:

Researcher: what's going to happen to him in the future?

Male 1 (10yrs): depends what he does

Female 2 (12yrs): if he doesn't talk to anyone it will probably stay that way and it will get worse

Male 5 (13yrs): he might get suicidal

Female 2 (12yrs): over time

Male 5 (13yrs): that's like the extreme

The participants suggest that if these problems persist for Harry, over time, he might feel suicidal. Male 3 suggests that whilst this is a possibility for Harry, it is an extreme consequence of his behaviour. Thoughts about how Jenny and Harry could become a danger to themselves through self-harm in group 3:

Researcher: What do you think is going to happen to Jenny now?

Female 3 (12yrs): she might do something bad

Researcher: like what?

Female 1 (14yrs): she might commit murder

Female 3 (12yrs): hurt herself or commit suicide

The participants demonstrate an awareness of the negative consequences, which can occur because of mental health problems. The fact that "getting worse" was viewed therefore by the majority of participant's indicates hopelessness in that these participants struggle to see a way out of the problem or a way for it to get better.

#### 4.4.2 Getting better

The second most popular consequence, which emerged from the data, was the possibility that the problem could improve. Interestingly, getting better was discussed only for the character Harry. In groups 1 and 2, two males discussed how seeking the support of his peers, could make Harry's problems get better "*I think he'll get better if he talked to his friends*" - Male 1 (13yrs).

Researcher: so things could turn round for him?

Collective: yeah

Male 5 (13yrs): that's only if he speaks out

Getting better was viewed as something that could only happen if Harry spoke out or sought support from others

#### 4.5 Duration of anxiety

In order to meet the aims of the research and explore participants understanding about the duration of anxiety, all participants provided an individual written response to the question "how long do you think Jenny/Harry will feel like this?" by writing on a sticky note and placing it on a large timeline. The children did not answer this question using a time scale and instead came up with several factors which could determine the duration of the problem. Participant's perspectives on the duration of the disorder varied from depending on an action to longer lasting durations with some participants suggesting that nothing would change the situation. The theme of duration has been divided into four sub-themes based on the participant's responses which are



'Disclosure vs. Help Seeking', 'Friendships', 'Permanent State of Helplessness' and 'Finishing School'.

Participants in all groups referred to the support that the characters needed in order for their problems to get better sooner. The type of support was characterised into two separate categories that will be discussed separately below – *Disclosure* (telling someone about the problem) and *Help Seeking* (actively getting help from others).

#### 4.5.1 Disclosure

Talking about the problem with others was viewed by some participants as an important factor which could determine the duration of the problem “*until he talks to someone*” G2 (11years). This indicates that this participant believes that the problems will remain until Harry talks to someone about how he is feeling. Similar responses were also observed for Jenny “*until she tells someone*” G4 (10years). Disclosing the problem to others was seen as important by both the younger and older children in the groups and suggests that the problems will not change until they tell someone. This implies that the children believe that the problems cannot be dealt with alone.

#### 4.5.2 Help seeking

Participants articulated that the duration of the problem was determined by whether the characters “got help” or not. Help seeking is the biggest sub-theme with it occurring most frequently within all of the groups. For example, Female 3, group 1 (13years) wrote “depends on whether she gets help or not e.g. no help – years, help – month” indicating that seeking help can significantly reduce the period of time that these

problems are experienced. One participant in group 2 went on to suggest some of the sources of support for Harry “until he gets help e.g. friends, family, counsellor” Male 5 (13years). Getting help was seen as crucial in alleviating the problems as a male in group 3 suggested “a long time if she doesn’t get help” Male 2 (11years). The duration of the character’s problems was determined by whether they got help or not and suggests that the characters can’t deal with their problems alone and need somebody else. There was a united agreement across all groups that the characters needed help in order for their problems to get better faster.

#### 4.5.3 Friendships

Friendships were viewed by some participants as an important factor which would affect how long the character would feel this way. A participant in group 2 responded to the question by writing “*until she gets friends or treated better*” F1 (12yrs) suggesting that the problems will persist until Jenny makes friends or is treated better by others. This suggests that the problems will be there until Jenny makes friends with others or good friends who will treat her nicely. This shows that friendships play a pivotal role with participants describing a lack of friendships as a cause of the behaviour but also as a determinant of how long the problem will persist and a potential turning point for the character.

#### 4.5.4 Permanent State of Helplessness

Some participant’s responses suggested that they believed that the circumstances were not changeable and that feeling like this was permanent for the character, as they responded to the questions by writing “*forever*”. This response was observed for

both Jenny and Harry. Interestingly, these responses came from the younger males in the groups. This suggests that the males did not see a solution to the problems the characters were facing and thought that they would be ongoing in the character's life. However, this view was contradicted by Female 3 in group 3 who responded with "*not forever because nothing is forever*" – (11yrs). This shows a contrast between male and Females' opinions on the duration of mental health problems with this participant showing a more optimistic approach to the problem. It may be that the males are unaware of the support available and further intervention could target these groups to educate them on the sources of help available.

#### 4.5.5 Finishing School

Some participants also described how the problems would get better once the characters had finished school. A Female in group 2 said the problems would persist "*until the end of his school life*" Female 2 (12yrs) indicating that the character Harry is going to feel like this for several more years. Similarly, a male in group 3 described how Jenny would feel this way "*until she leaves school*" M1 (11yrs) suggesting that school is the problem which would remain until the character no longer has to attend school and that the source of the problem is school.

#### 4.6 Treatment for Anxiety

One of the aims of the research was to explore children's understanding about the treatments available for anxiety. Participants were asked the question "based on how Jenny/Harry are feeling what should he/she do?" and were also asked "what would you do if you were in this situation?". Participants referred to several different types of

treatment which would be available to people experiencing anxiety. This theme has been broken down into several sub themes. The subthemes identified will be discussed independently, these are 'Support in School', 'Speaking vs. Writing', 'Anonymity', and 'Help from Professionals'.

#### 4.6.1 Support in school

Support in school was mentioned by all three groups as a source of support in the school environment with several participants referring to the support of members of staff "a *teacher*" Female 3 (12yrs) Group 3 with an older male participant referring to a specific type of teacher "*form teacher*" Male 1 (13yrs) Group 1 and one participant referring to a specific department called the "*Learning Support Unit*" Female 1 (14yrs) Group 3. One participant referred to a specific service available at their school targeted specifically at helping children with their wellbeing:

Researcher: so what do we think she should do about these problems she's experiencing?

Male 5 (13yrs): speak to someone

Researcher: who could she speak to?

Male 5 (13yrs): either like a wellbeing centre if they have it at the school or a counsellor or just like parents or friends or

Participants showed some awareness about the people who are able to support them in their school environment and are aware of the names of the places they can go to. However, when questioned further about this specific service it was evident that participants had little understanding about what the service encompassed:

Researcher: okay if you have a wellbeing centre at school

Male 2 (11yrs): what's wellbeing?

Male 1 (11yrs): where you get help

Researcher: help to?

Female 2 (11yrs): help to be confident

There is evidence here that this participant is aware of a specific name of a place where support is available for them in the school environment, but when asked about this service, appeared to be unsure and began to speculate about the type of help available at the Wellbeing Centre. Considering that the children are questioning one another about this service suggests that this is not something that is widely available in all schools.

However, whilst the participants suggested the Wellbeing Centre as a source of support for the characters, this did not necessarily dictate their own behaviour. When the participants were asked "what would you do if you felt like this?" the same participant who suggested the wellbeing centre as support for Jenny disclosed that the wellbeing centre would not be a place that he would use for support.

Researcher: okay yeah. So putting jenny aside then a minute, what would you do if you felt like this?

Male 1 (10yrs): speak to someone

Male 5 (13yrs): if I could id speak to someone but if I felt like I couldn't then I'd probably try and sort it out myself probably wouldn't go the wellbeing centre normally it gets really bad and then really good faster rather than like building up bad which it does and then really plummets down completely, once you tell someone

This suggests that this participant is aware of the sources of support available but would rather attempt to deal with their problems alone in favour of using these services. The stigma associated with the wellbeing centre at school is evident with this participant as he suggested it as a good source of support for the character but not for himself. It appears that this participant may be speaking about mental health from personal experience, but this is unconfirmed.

#### 4.6.2 Speaking vs. Writing

There was a united agreement across all groups that telling someone about the problem was the right thing for the characters to do. However, there was a clear distinction about the types of disclosure available. Many participants suggested telling or talking to someone about how they feel whilst others indicated that writing things down would be a good way to communicate how they were feeling.

Participants emphasised the importance of telling someone about their problems for it to get better and without doing so the problems would not change or worsen. Across all three groups, participants suggested people the characters could tell including their parents, peers, extended family, teachers, “someone s/he trusts” and one of the youngest participants suggesting “*tell her pets*” and “*a teddy bear*” Female 4 (10yrs).

Parents was suggested as the first source of support in all groups:

Researcher: we’ve talked about how she’s (Jenny) feeling and whys she’s feeling like this but what should she do now to overcome this feeling or to make it better?

Female 4 (10yrs): tell someone

Researcher: who should she tell

Collective: Parents

Female 1 (12yrs): or teachers

Female 4 (10yrs): or teacher

Male 1 (13yrs): a trusted adult

Talking to others about the problem was viewed as a crucial turning point in order to alleviate the problems experienced by the characters. In groups 1 and 2 participants suggested that the problem would get worse unless the characters spoke to someone about how they were feeling. This implies that the participants do not believe they can get better without sharing their problems with others and that the problems could become worse if they did not do so:

Researcher: so what do we think will happen to him then. So we know all this information about how he's feeling now but what's going to happen to him in the future?

Male 1 (10yrs): depends what he does

Female 2 (12yrs): if he doesn't talk to anyone it will probably stay that way and it will get worse

Although participants emphasised the role of speaking to others about their problems, when asked what they would do in the same situation they expressed difficulties about speaking to people about how they were feeling "*if I could do it I'd talk to someone, if I felt like I'd be able to*" Female 2 (12yrs). This participant implied that it can often be difficult to discuss feelings and although talking about their problems was seen as essential for the characters, this may not reflect the participants own behaviour when faced with a similar situation. This shows the participants understanding about the importance of talking to others to help with problems but highlights some of the barriers

that they may face when trying to do so. Such findings are problematic considering that many types of therapy and counselling offered to young people involve communicating with others verbally.

Some participants spoke about communicating how they are feeling in writing to share with others. A clear gender difference was observed here with males suggesting written methods of communication more frequently than Female participants:

Researcher: Anything else he could do?

Male 4 (12yrs): he could erm write it down and give it to someone if he doesn't like speaking to people

Male 6 (10yrs): or like make a diary that somebody checks

Whilst the males also agree that sharing their problems is a good thing to do, they suggested alternative ways of communication such as writing things down or making a diary to share how they are feeling with the people around them to avoid talking to someone about their problems. This information is useful for practitioners working with young people and highlights how they are comfortable to communicate and how they might supplement talking therapies with other means of communication.

When asked what would you do if you felt like this?, the participants in this group echoed their thoughts about writing things down and said that this is what they are most likely to do if faced with the same problems as the characters by writing things down or using technology as a mode of communication:



Researcher: so what do you think you would do though?

Female 1 (12yrs): leave a note out somewhere for like your mum and dad like just leave it on the side

Researcher: ok so if you don't want to go up to them. It's quite hard face to face sometimes

Male 5 (13yrs): maybe text them like if you don't want to tell them face to face you could text someone or call them

The participants show a desire to share their problems with those close to them such as their immediate family but also demonstrate a dislike of talking about their feelings to others. This shows that the males in the group understand that there is support available for those who experience anxiety but are aware that speaking about how they feel can be difficult. The findings in the current study may be useful to inform mental health interventions particularly with boys who may not get the most out of counselling intervention due to a preference of writing things down.

#### 4.6.3 Anonymity

Anonymity and the ability to conceal your identity was viewed as an important factor when seeking help by communicating with people that they don't know. The participants appear to have some awareness that internet posting is a possibility but are unclear about where to go or how to get the support:

Researcher: okay so parents, friends, counsellor. Do we have anymore?

Male 5 (13yrs): like if she doesn't like if she doesn't want someone she knows too she could do it like anonymously or something like online or something like that

Researcher: like go on the internet or something

Male 5 (13yrs): yeah like a friend's app

Researcher: like a friend's app? What's that

Male 5 (13yrs): I don't know like a dating app for friends

Male 6 (10yrs): for friends

This implies that meeting new people online may be more appealing to young people due to not having to say the words out loud and avoid communicating with those they know. Technology is becoming more popular with younger children and is often something that is used regularly. This suggests that young people may find it easier to speak to someone that they don't know and might not want to cause concern to those closest to them or feel embarrassed.

#### 4.6.4 Help from professionals

When asked the question "what could Jenny/Harry do?" participants as young as ten years old were able to distinguish between the types of support which are required for mental and physical health "*a physical therapist or a mental therapist*" Female 4 (10yrs). Participants referred to the names of some professionals involved in the treatment of mental health problems and described the support available for the most complex cases with a very limited understanding about these roles. This implies that the participants do not have an understanding about the concept of the continuum of mental health problems. During the discussion about what Harry should do, the children discussed the role of a psychiatrist:

Researcher: who's he going to get help from?

Male 1 (11yrs): psychiatrist

Researcher: what is the psychiatrist going to do for him?

Male 1 (11yrs): erm going to help him. What's a psychiatrist?

Researcher: what do you think?

Male 2 (11yrs): psychiatrist they kill you their psychos

Researcher: they kill you is that right? What do psychiatrists do?

Female 2 & Female 3 (12yrs): they help you

Male 2 (11yrs): they help you stop killing other people

Researcher: does anyone know what a psychiatrist is?

Female 3 (12yrs): yes, they help with your mental

However, despite displaying that they “know” what a psychiatrist is, there is an element of confusion and stereotype as they interpret the clients supported by a psychiatrist as dangerous. The participants appear to have developed unrealistic ideas about what a psychiatrist is and the type of people they work with leading to the children developing their own ideas about what this means. When asked about receiving support from a psychiatrist, the children were unaware of how this service would be accessed:

Male 2 (11yrs): get a psychiatrist

Researcher: how do you get a psychiatrist?

Male 2 (11yrs): erm phone them up

Female 3 (12yrs): erm psychiatrist costs money and what if harry is broke?

Male 2 (11yrs): walk around every road and you’ll probably find a psychiatrist

Female 3 (12yrs): no go to this free place for poor people. For help for people who aren’t as lucky and get help there

The children appear to “know” the names of the types of professional support which are available yet they are unaware of how such services are accessed. Participants suggested that professionals could be contacted by “*phoning them up*” Male 2 (11yrs) or through the internet “*you go online and type in therapists*” Female 4 (10yrs) and did not mention the traditional route of gaining support of going through the General Practitioner.

Participants showed some awareness of the role of charities such as Child Line as an alternative source of support and advice in the absence of support from friends:

Researcher: who will help him?

Female 2 (12yrs): mum dad

Male 6 (10yrs): someone who's stayed with him for a while

Male 2 (12yrs): social worker

Male 5 (13yrs): because he doesn't like going to like friends and because he doesn't have many maybe he could like call child line because like they I've never rung obviously but like they might tell you what to do and give you some advice and maybe they just might chat to you

Male 5 appears to speculate about the support available from this service and suggests some of the things they might be able to help with. This participant attempts to distance himself from this and suggests that this is not something he has used previously. A lack of understanding about this type of support could discourage children use this support due to the stereotypical beliefs associated with them.

## **5. Discussion**

The increase in mental health problems in children and unmet care for this age group is recognised as a global public health concern (Polanczyk et al., 2015). The aim of the research was to explore children's understanding of anxiety. The current study adopted the theoretical framework of the Common Sense Model of Illness by Leventhal et al. (1980) which has previously been used in physical health research (Fischer et al., 2010) but less so in research around mental health. The findings contribute to the literature by demonstrating what children understand about anxiety, and the gaps in their understanding.

### **5.1 Children's understanding about the identity of anxiety**

The children described what the characters would look like using physical descriptions, feelings and drawings. In the current research, the young people identified some of the key emotions and feelings that the characters would be experiencing, such as feeling sad and worried. Across all three groups, the children held a negative view of the characters and described them as having bad hygiene, smelly and ungroomed, messy, wearing used and stained clothes and attributing them with features unexpected of a typical child.

A potential explanation of the above findings is the role of stigmatising attitudes towards people with mental health problems. The World Health Organisation (2013) indicate that stigma develops as the result of a lack of knowledge around mental health. It could be suggested that the children were displaying stigmatising beliefs and subsequently created a distance between themselves and the characters due to a lack of understanding about anxiety. The current findings are consistent with the findings

of MacLean *et al* (2013) who found that children aged as young as nine viewed behaviours such as crying in class as weird, babyish and silly, and children would hide their symptoms to avoid stigmatising responses to avoid the judgement of their peers (MacLean *et al.*, 2013). This finding is important as it highlights the wider social significance of mental health problems in children in relation to peers and in turn, school experience.

It is credible that the negative social attitudes towards those who suffer from a mental health problem may be the result of misconceptions and stigmatising presentations from the media. In the media, those experiencing a mental health problem are often presented in a negative light appearing as dangerous and violent (Murphy, Fatoye, & Wibberley, 2013) which can contribute to the development of negative perceptions and attitudes. Children often have frequent exposure to several forms of media including television and internet access for around 6 to 7 hours per day (Rideout, Foehr, & Roberts, 2010) and so the media is an important source of education about mental health which may influence young people's attitudes. Such stigmatising attitudes can be problematic and may mean that children are less likely to seek help for such problems due to worry about how they will be perceived by others.

Future in mind – promoting, protecting and improving our children and young people's mental health and wellbeing (The Department of Health and NHS England, 2015) stated that by 2020, it aimed to improve public awareness of and understanding about mental health problems in children and young people to reduce stigma and improve attitudes. According to the current findings, this objective has not yet been achieved. The participants held a negative view of both characters, which was evident through their drawings and descriptions with the children attempting to create distance between themselves and the characters. Therefore more work is required as it is

crucial to put educational interventions into place to improve the young people's attitude towards mental health problems and normalise the behaviour, to encourage young people to recognise the problem and seek help.

Mental health education may help to reduce stigma and encourage young people to seek help. It is plausible that educating young people about anxiety could lead to children having a more accurate understanding of anxiety, prevent stigmatising and labelling responses, and promote help seeking for young people who experience such problems. Considering that the media is an influential tool in shaping the perceptions of children, a positive approach to framing those with mental health in a positive way may help to reduce the stigma and a change in attitudes. Mental health awareness workshops aimed at challenging negative stereotypes and increasing the mental health literacy of young people have found to have a small positive impact on students in schools (Pinfold et al., 2003). However, such short term interventions are problematic as these changes were found to be weakened at a long term follow up of 6 months (Pinfold et al., 2003). The researchers acknowledged that implementation of mental health education into the curriculum for longer term education may have more impact on increasing the mental health literacy and reducing the stigma associated with mental health problems (Pinfold *et al.*, 2003). Education about anxiety may encourage young people to seek help by providing knowledge about where to seek the help and the type of support available for them.

## **5.2 Children's understanding about the causes of anxiety**

In the current study, when searching for an explanation for the character's behaviour, participants were able to identify more external causes of anxiety including difficulties with friendships, problems in school and problems with their home life. Rejection or

isolation from peers was viewed as an important factor which could contribute to the way the characters were feeling. Internal causes were less frequently mentioned though participants were able to recognise that internal feelings about the self-e.g. insecurities and feelings of sadness and paranoia could contribute to making someone feel anxious.

These findings are consistent with previous research by Dixon et al. (2013) who found that children aged between eight and ten years old were more likely to identify external and environmental factors such as problems with school work and friendships as causal factors for emotional difficulties. However, contrary to the findings of Hennessy and Heary (2009) children's understanding about the causes of anxiety did not appear to differ based on their age. In the current study the older participants did not refer more to internal causes than the younger participants.

The finding that children were more likely to identify external causes than internal causes could be due to their school age and the factors that are important to them. When children are of school age, social relationships are of great importance with peer relationships becoming increasingly important as they provide emotional and social support (Wilkinson, 2004) with young people facing increasing pressure to fit in with their peers. The lack of internal causes of anxiety found in research conducted by (Dixon *et al.*, 2013) and in the current study may be explained in terms of development. The discussion of the feelings which cause mental health problems requires the use of abstract thinking and vocabulary to express their thoughts which according to Piaget (1964) and the Theory of Cognitive Development does not develop until later childhood, at around 11 years old.



### **5.3 Children's Understanding About the Consequences of Anxiety**

The children in the current study were able to discuss the consequences of the character's behaviour. More children spoke about the problem getting worse, which was observed for both characters with only a few participants suggested that it could get better. It was difficult to use the CSM (Leventhal et al., 2016) to explore the consequences of anxiety as there was some overlap between consequences, duration and treatment with participants suggesting that the problems would get worse if help was not sought. The current findings suggest that children are aware of the negative consequences associated with anxiety and demonstrate a general feeling of hopelessness, with only a few participants believing that the situation could change or get better. This suggests that the domains of the CSM (Leventhal et al., 2016) are not individual domains and could be interconnected.

### **5.4 Children's understanding about the duration of anxiety**

The literature review did not reveal any previous research which had explored children's understanding about the duration of anxiety. To explore the participants understanding about the duration of anxiety, participants were required to respond to the question "why does Jenny/Harry feel like this?" by writing their response on a post-it note. Almost all participants responded to the question by suggesting factors which could determine the duration of the problem such as leaving school or making friends, rather than using a time period. Therefore, the CSM (Leventhal *et al.*, 2016) did not appear to be a useful model to explore children's understanding about duration. The model was problematic as children did not respond to the question as expected, using a time scale, but instead reported determinants of the situation. Interestingly, some of

the males in the focus group responded with “forever”. This gender difference indicates that males do not see a solution to the problem and may feel more helpless than females. The current research gives an insight into how children understand the duration of the disorder and suggests that they may be unsure about a specific time period in which it can affect an individual.

### **5.5 Children’s Understanding About the Treatments for Anxiety**

Participants vocalised their thoughts about the different types of treatment and support available for people who experience anxiety including support from parents, school, professionals and different ways of communicating. The most frequent source of support reported by the children was their parents. Parental relationships were viewed as pivotal by many of the participants highlighting parents as a good source of support though some also viewed this as a potential cause of mental health problems for example due to neglect or abuse in the home environment. The role of professionals such as the GP and NHS staff were not discussed in any groups. Participants in the current study referred to the school environment and distinctive members of staff and areas in the school to support the characters. The children discussed the names of people or places such as Psychiatrist and The Wellbeing Centre but appeared to speculate about what these services have to offer. Children appear to have the verbal ability to discuss mental health and use terminology related to the topic without a full understanding about what the words mean for example “*psychiatrist they kill you their psychos*”.

These current findings about the sources of support are consistent with previous research by Hennessy and Heary (2009) and Armstrong et al. (2000) with the family and peer group reported as the main source of support for those experiencing

emotional problems. Previous research has however revealed that parents face barriers when seeking help on behalf of their child including a lack of uncertainty, attitudinal barriers such as stigma (Crouch, Reardon, Farrington, Glover & Creswell, 2019) and communication problems with professionals (Reardon *et al.*, 2018). Such findings are concerning considering that parents are often the first port of call for children who are experiencing mental health problems.

The findings are also problematic when considered against The Green Paper (Department of Health and Department of Education, 2017) which emphasised the role of educational settings such as schools in early detection and prevention of mental health problems (Department of Health and Department of Education, 2017). This document stated that a designated mental health lead would be trained in schools and staff would receive mental health awareness training. The findings in the current research and previous research (Hennessy & Heary 2009b) found that school was viewed as one of the main problems contributing to the character's problems. Therefore, children may be less likely to make use of such services implemented in schools due to worries around stigma and fear of labelling and confidentiality (MacLean *et al.*, 2010). Therefore, it is problematic that emphasis is placed on the school environment and it is essential to understand how these concerns regarding stigma may prevent or hinder children reaching out for this type of support. It is crucial that more is done to educate young people and develop their understanding in order to break down the stigma and encourage help seeking in the school environment. If such interventions are to be put in place, more needs to be done to educate young people about the different sources of support available in school and the type of support offered to them. If children are unaware of the support or do not have the trust in the services, they will not access it.

The Green Paper's proposal was challenged by Young Minds who responded to this paper requesting that the government invest in additional resources to support young people and their families in order to educate them about self-management of mental health and emotional conditions and investing in a youth led literacy campaign in order to improve the emotional literacy of young people and their families. The findings of this research support this request. Such intervention would ensure that the family of the child receives the support which will be beneficial considering that parents are frequently reported as the main source of support. Future in mind – promoting, protecting and improving our children and young people's mental health and wellbeing (The Department of Health and NHS England, 2015) outlined their aims which included appointing specialist points of contact in schools. According to the current findings, this objective has not yet been achieved as not all participants were aware of the support available in schools and were not likely to use it. It may also be the case that schools have specialist points of contact but that the children are not aware of them or what they offer. Therefore, promotion of the different types of support including the names of services and types of support available is crucial if children are going to access these services.

## **5.6 Limitations of the study**

Whilst the current research is a useful contribution to a current worldwide problem, there are a number of limitations that must be discussed. At the beginning of the research and on review of the previous literature focus groups were deemed the most suited method for the current research. Although the use of focus groups in this research had some strengths, allowing the aims of the research to be met, on reflection, it also had several limitations. The focus groups consisted of a minimum of

five participants which made it difficult during transcription to distinguish which participant was speaking when several participants spoke at the same time meaning that key comments during discussion may have been missed. It was also evident that some children were influenced by the ideas of others so may have adopted the understanding of others rather than speaking about their own understanding of anxiety. Another limitation is that the context of the group dynamic may have meant that those who held opposing views did not feel comfortable to share these and challenge participants who were more vocal in the group, although the researcher did prompt those who did not share their views to ensure that all participants had a chance to speak. An alternative method may be to use Photovoice with groups of children. Photovoice may be more helpful at eliciting all participants views as it requires them to express their perspectives through photography or through other visual forms, which has been used successfully in previous health research with children and adolescents (Greco, Lambert, & Park, 2017; Percy-Smith, 2007; Wells, Ritchie, McPherson, & development, 2013; Whiting, 2015). This method may have encouraged all participants to participate and elicited the views of all participants by selecting individual photos in advance of the group to discuss during the group.

One other limitation is the use of character vignettes. These were created based on the diagnostic criteria for anxiety in the DSM V to direct the focus group discussion. Whilst the creation of vignettes allows for the discussion of hypothetical characters and take the focus away from discussing problems about oneself, it can be argued that character vignettes are not an accurate reflection of everyday life and therefore questions the validity of the participant's responses.

## **5.7 Strengths**

Whilst the current research has a number of limitations, it is important to consider the many strengths of the research procedure which allowed the research to be successful. The study took place in an environment which was familiar and comfortable to the participants and is used consistently for their weekly Scouts' sessions. At the time of the focus groups, the researcher worked in a school supporting children with special educational needs. This can be seen as a strength due to the experience of working with children on a daily basis and an increased sensitivity to the type of vocabulary used, ensuring it was child friendly.

The current study collected data from three individual focus groups consisting of participants who were mixed in age, gender and ethnicity. The use of focus groups in comparison to one to one interview meant that participants were surrounded by familiar faces with their peers rather than a researcher who was unfamiliar to them. The small group discussion used in the focus groups is a method which is familiar to the children as it is often used in the school setting and in the community group. A further strength of the procedure is the use of the innovative methods such as the use of character animations and the draw and write part of the task. This method used at the start of the focus groups proved to be a good ice breaker and gave all participants the opportunity to participate in the research, particularly those who struggled to communicate their thoughts verbally.

## **5.8 Implications for Clinical Practice**

Although the current study did not ask participants directly to make recommendations for policy, several implications have been drawn and will be discussed below.

The current and previous research have highlighted the central role of the parents and family to provide support for mental health problems. It is important that this support network is provided with mental health education to ensure that they are well equipped with the knowledge and resources to support young people. Given that children rarely use mental health vocabulary, it is important for parents and carers to use alternative child friendly vocabulary or provide careful explanations of what they mean when communicating about mental health with children.

The current research brings attention to the preferred communication methods utilised by children. Many of the participants, particularly males, held a preference to communicate in writing rather than speaking about their problems. Children's opinions and views should be considered when developing services to maximise engagement and get the best out of the services aimed at their age group.

Young people are uncertain about the different types of professionals who can provide support and advice for mental health problems. Mental health education is needed in order to inform young people about the role of professionals to enable them to seek help from relevant services. Such education should also be directed at parents and those supporting young people to signpost relevant services and avoid treatment delays.

Stigma towards mental health problems is something that exists in even the youngest members of today's society. More work is needed in order to educate young people about mental health problems to reduce the negative attitudes associated with them. Education and intervention programmes should be provided in school allowing children to discuss freely and ask questions to develop their knowledge. A reduction

on stigma and negative beliefs towards those with mental health problems may encourage those in need of help to reach out.

The current research showed some preference to seeking support anonymously. Young people showed some awareness of using charities such as ChildLine where they can remain anonymous. Children would benefit from more information about the role of these charities so they are aware of the types of support available.

### **5.9 Recommendations for future research**

Given the substantial increase of those diagnosed with a mental health problem in childhood, further research should focus on developing interventions aimed at understanding symptoms, causes and treatment of common mental health problems, which address the barriers identified and experienced by children and their parents in relation to help seeking. Consulting with young people and their parents directly about this matter will enable the relevant work to be undertaken in order to break down these barriers and encourage help seeking behaviours. This framework was useful for meeting the aims of the research to explore children's understanding of anxiety across some of the five domains of the CSM, but it did not prove to be useful in exploring the duration and consequences of anxiety as there was overlap between some domains. When using this model with children, in the topic of mental health, an adapted model of the CSM model may be required. The current research adds to the limited number of studies exploring children's understanding of anxiety and mental health problems.



## **6. Conclusion**

The aim of the current research was to explore children's understanding of anxiety using the CSM (Leventhal et al., 2016) by looking at the five dimensions of understanding using a combination of focus groups, visual methods and the draw and write technique. In conclusion, children aged between ten and 14 years old have some understanding of how anxiety manifests itself and can make links between thoughts, feelings and behaviour but demonstrate negative attitudes towards those with mental health problems. The present findings confirm that children are more likely to identify external causes of anxiety located outside the individual than internal causes but do not demonstrate a developmental difference in this age group. From the current research it is arguable that children have a poor awareness of the broad scope of professionals available to support those with mental health problems. Due to the gaps in children and parents knowledge, there is a definite need for education about the identity and symptoms, causes, duration, consequences and treatment of anxiety and other mental health problems in order for early intervention and prevention, set out in the government objectives, to be achieved.

## 7. References

## 8. Appendices

### Appendix A. Literature Review Search Strategy and PRISMA Flow Chart

The aim of the systematic search of the literature was to find primary and secondary research relating to children's understanding of anxiety. The search was conducted in the following databases - PsycINFO, SCOPUS and CINAHL. PsycINFO is a database with over 4,000,000 records in the field of psychology. Scopus is a database containing over 69,000,000 citations in the health sciences discipline. The third database CINAHL includes journals from multiple disciplines comprising of allied health and healthcare. To ensure the highest quality review of the literature, the systematic process (Noyes, 2008) was used alongside the PRISMA (Preferred Reporting Items of Systematic Reviews and Meta-Analyses, 2009) checklist to guide the process. The following key terms were used to obtain the results from the databases;

*“children OR young people OR childhood AND understanding OR perceptions OR beliefs OR views OR opinions AND mental health OR anxiety OR mental ill health OR mental illness”*

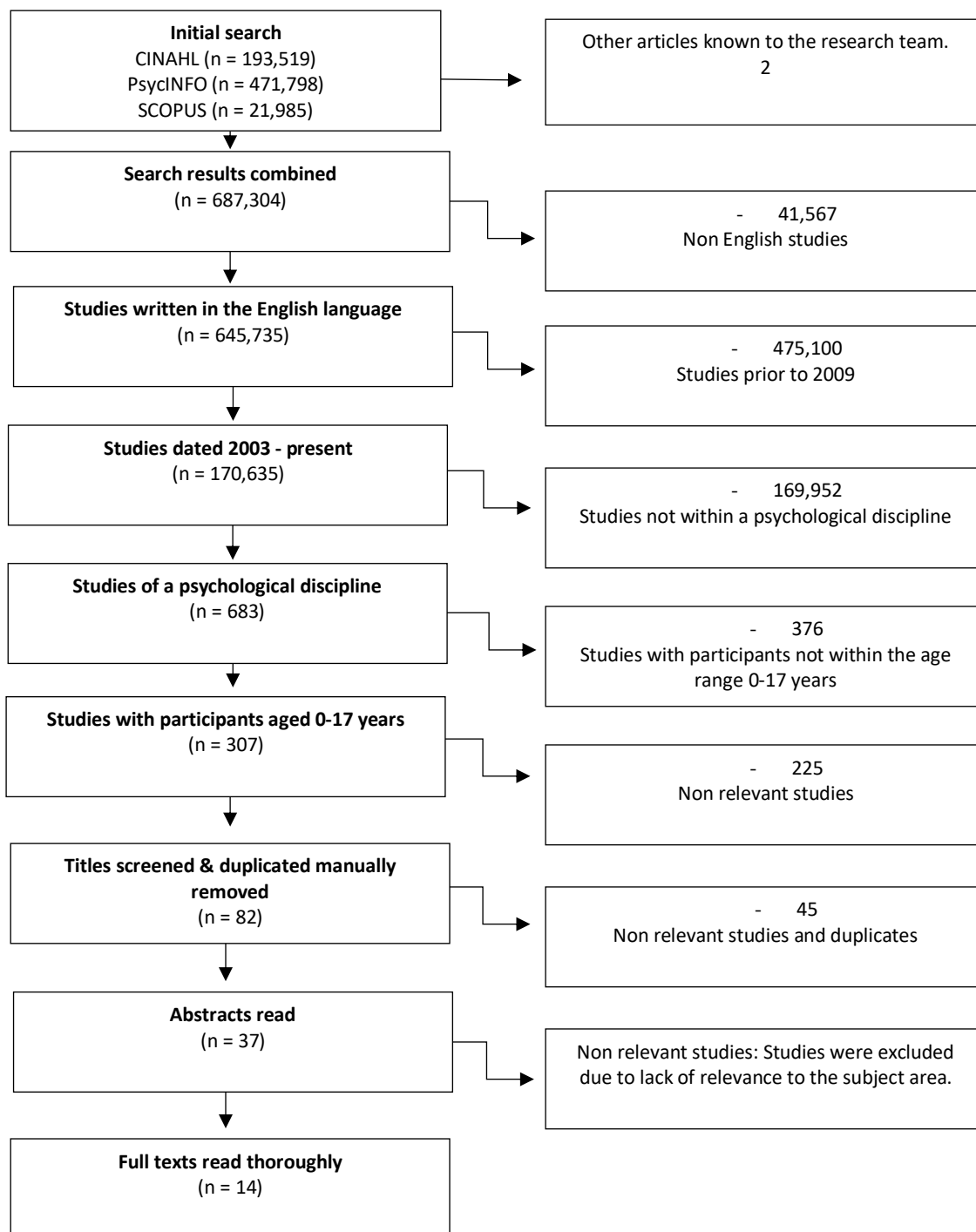
A systematic search of the databases using the following inclusion and exclusion criteria to ensure that the most appropriate articles were found. The initial search found 600,000 studies. As this figure was so high, the refinement options on the

databases were used to seek out the most appropriate articles. The following inclusion and exclusion criteria were used:

- Articles which were in the English language
- Dated 2003 to the present day
- The filter was applied to only include studies that were of a psychological discipline
- Filters for age were then applied to include research conducted with children aged between 0 and 17 years (this filter was available only on PsycINFO and CINAHL),

leaving 302 articles. These articles were scrutinised by looking at the title and studies which were deemed irrelevant were not included in the review. The abstracts of the remaining articles were then read to disqualify any studies which were not relevant to the research topic, leaving 37 articles to be examined by a full text reading. After removing further articles which did not meet the inclusion criteria, the final number of articles included in the review was 14, see....

Five common themes which have emerged from the literature based on the summarised findings of the included articles are: *Children's understanding about the causes of mental health problems; Children's understanding about the sources of help available; Parental barriers to accessing treatment; Parent and child agreement and Stigma.*



## Appendix B. Table of study characteristics

Reference	Type of research	Sample	Methods	Results	Themes	Limitations
Dixon, C., Murray, C., & Daiches, A. (2013). A qualitative exploration into young children's perspectives and understandings of emotional difficulties in other children. <i>Clinical Child Psychology and Psychiatry</i> , 18(1), 72–90. <a href="https://doi.org/10.1177/1359104511433194">https://doi.org/10.1177/1359104511433194</a>	Qualitative	25 children mixed gender 8-9 years' old White British	Vignettes depicting childhood anxiety and depression.  Draw and write technique and focus group discussions	Much of children's explanations were of a psychosocial nature and referred to external causes. Some children made sense of causes by drawing on physical symptoms of vignettes e.g. sleeping difficulties and loss of appetite Children did not perceive professional help necessary for characters. Little mention of biological or internal causes.	Causes of anxiety  Sources of help	Vignettes do not necessarily reflect reality.
Hennessy, E., & Heary, C. (2009). The development of children's understanding of common psychological problems. <i>Child and Adolescent Mental Health</i> , 14(1), 42-47.	Qualitative	116 children 8-14 years	Focus groups & interviews  Vignettes	Children as young as 8 years offer a range of explanations for problem behaviour in their peers. Explanations include some that are internal to the individual (such as attention seeking) and others that are external (such as parenting practices). Children of all ages saw family as the most important source of help for individuals with problems. Only a minority of children suggested that professional help was needed.	External causes of anxiety  Sources of help	Character presented was male or female
Stafford, V., Hutchby, I., Karim, K., & O'Reilly, M. (2016). "Why are you here?" Seeking children's accounts of their presentation to Child and Adolescent Mental Health Service (CAMHS). <i>Clinical Child Psychology and Psychiatry</i> , 21(1), 3–18. <a href="https://doi.org/10.1177/1359104514543957">https://doi.org/10.1177/1359104514543957</a>	Qualitative	28 families attending first assessment at CAMHS for children whose problems 'non urgent'	Recorded appointments	It was found that when children were asked for their reasons, they either offered explanations using diagnostic labels or used lay descriptions, or they claimed to not know the reasons for attending the assessment.	Lack of understanding	
Roose, G. A., John, A. J. C. c., health, & development. (2003). A focus group investigation into young children's understanding of mental health and their views on appropriate services for their age group. 29(6), 545-550.	Qualitative	16 children 10-11 years	Focus groups	Children had a sophisticated understanding of mental health. Awareness of the issues which can lead to problems in their age group. Family and friends viewed as first to be asked for support. Wary of confiding in teachers due to worries about confidentiality.	Sources of help	
Armstrong, C., Hill, M., & Secker, J. (2000). Young people's perceptions of mental health. <i>Children Society</i> , 14(1), 60-72. doi:10.1111/j.1099-0860.2000.tb00151.x	Qualitative	145 children 12-14 years	Focus groups & individual interviews	Young people would only discuss problems with those they trust. Girls reported a preference to discuss their problems with friends and family, boys more like to internalise feelings and bottle them up. Family and friend relationships were seen as important in affecting how young people felt.	Sources of help	
Crouch, L., Reardon, T., Farrington, A., Glover, F., & Creswell, C. (2019). "Just keep pushing": Parents' experiences of accessing child and adolescent mental health services for child anxiety problems. <i>Child: Care, Health and Development</i> , 45(4), 491-499. doi:10.1111/cch.12672	Qualitative	Parents of 16 children 7-12 years	Interviews	Parents reported a number of factors which helped or hindered the family gaining access to necessary treatment. These were; parental recognition, contact with professionals, reaching CAMHS, Parental effort and Parental knowledge or concern.	Parental barriers	Only one area and service in UK. May be different for different ethnic background/services.
Reardon, T., Harvey, K., Young, B., O'Brien, D., & Creswell, C. (2018). Barriers and facilitators to parents seeking and accessing professional support for anxiety disorders in children: qualitative interview study. <i>European Child &amp; Adolescent Psychiatry</i> , 27(8), 1023-1031.	Qualitative	Parents of children with diagnosed anxiety disorders 7-11 years	Interviews	Barriers identified in the four distinct stages of help seeking process. These were; recognising the anxiety difficulty, parents recognising the need for professional support, parents contacting professional and families receiving professional support.	Parental barriers	Predominantly white British sample. Not generalisable.

doi:10.1007/s00787-018-1107-2						
Grills, A. E., & Ollendick, T. H. (2003). Multiple informant agreement and the anxiety disorders interview schedule for parents and children. <i>Journal of the American Academy of Child</i>	Mixed Methods	165 children and their parents 7-11 years	Interviews  Self-report measures	Poor levels of agreement between child and parent.	Parent and child agreement	Limited to the specific outpatient setting.
Persson, S., Hagquist, C., & Michelson, D. (2017). Young voices in mental health care: Exploring children's and adolescents' service experiences and preferences. <i>Clinical Child Psychology and Psychiatry</i> , 22(1), 140–151. <a href="https://doi.org/10.1177/1359104516656722">https://doi.org/10.1177/1359104516656722</a>	Qualitative	Seven people 10-18 years  106 people	Focus groups on service user views  Written suggestions about service improvements	Young people, especially those aged under 14 years, made suggestions about nonverbal methods e.g. writing and drawing for communicating their thoughts and feelings. Three overarching themes were accessibility, being heard and seen and usefulness of sessions.		Young people who have difficulty in expressing themselves in writing may be underrepresented.
Courtney L. Benjamin MA, Connor M. Puleo MA & Philip C. Kendall PhD (2011) Informant Agreement in Treatment Gains for Child Anxiety, Child & Family Behavior Therapy, 33:3, 199-216, DOI: <a href="https://doi.org/10.1080/07317107.2011.595987">10.1080/07317107.2011.595987</a>	Mixed methods	161 children and their parents 7-14 years	Interviews  Self-report methods	Poor levels of parent and teacher agreement. Parents reported more improvement than their children. Mothers and fathers agreed on their child's improvement for CBT.	Parent and child agreement	Children might not have understood self-report questions.
Choudhury, M. S., Pimentel, S. S., Kendall, P. C. J. J. o. t. A. A. o. C., & Psychiatry, A. (2003). Childhood anxiety disorders: parent-child (dis) agreement using a structured interview for the DSM-IV. <i>42(8)</i> , 957-964.	Qualitative	45 children and their parents 7-14 years	Interviews	Parent and child agreement levels were found to be poor.	Parent and child agreement	Not representative. Did not control for comorbid diagnosis.
MacLean, A., Hunt, K., & Sweeting, H. (2013). Symptoms of Mental Health Problems: Children's and Adolescents' Understandings and Implications for Gender Differences in Help Seeking: Symptoms of Mental Health Problems. <i>Children &amp; Society</i> , 27(3), 161-173. doi:10.1111/j.1099-0860.2011.00406.x	Qualitative	90 children 10-15 years	Focus groups	Participants viewed psychological and physical symptoms as different in the way they are experienced and how they are treated. Both boys and girls said they would be less likely to seek help for symptoms of mental health problems than physical illness. Symptoms of psychological problems were seen as rare and participants had stigmatising responses.	Sources of help  Stigma	Focus groups were friendships groups which could have led to bias.
MacLean, A., Sweeting, H., & Hunt, K. (2010). 'Rules' for boys, 'guidelines' for girls: Gender differences in symptom reporting during childhood and adolescence. <i>Social Science &amp; Medicine</i> , 70(4), 597-604. doi:10.1016/j.socscimed.2009.10.042	Qualitative	90 children 10-15 years	Focus groups	Both boys and girls said they would feel pressure to react to symptoms in controlled and independent ways in front of their peers. Both said they could incur negative consequences if they had physical symptoms such as tummy aches or psychological symptoms such as crying.	Stigma	Focus groups may have encouraged participants to focus on differences between males and females and the way they behave.



## Appendix C. Vignettes Animation

## Appendix D. Information Sheet



### Information Sheet

**Title of study:** Exploring Children's Understanding of Anxiety

**Name of researcher:** Leah Day-Wood

[u1456167@pgr.hud.ac.uk](mailto:u1456167@pgr.hud.ac.uk)

Your child is being invited to take part in this study because they are aged between 7-10 years old. Please consider the below information carefully and discuss it with the researchers if needed. Please do not hesitate to ask the researchers any questions or to request further information.

### What is the study about?

This study is exploring children's understanding of anxiety. Mental health problems in children are becoming increasingly common with 1 in 10 young children experiencing some form of poor mental health. Anxiety is one of the most common mental health problems experienced by young people. This research will look at children's understanding of anxiety to contribute to the development of interventions which build resilience towards mental health problems and helping us to better support children.

### What will my child need to do?

Children will be involved in a focus group where they will watch 2 videos of pretend characters who are displaying symptoms of anxiety. Children will then be asked questions such as "why do you think they are feeling like this?", "what do you think made them feel like this?" and "what could they do?" in order to explore their understanding of anxiety. Children will also be asked to describe what they think the character looks like and to identify how long they think the character will experience the problem on a large timeline. The research will last approximately 1 hour, no longer than a normal scout's session.

### Does my child have to take part?

Your child will only take part if you give consent for them to do so. Informed consent can be given by completing the attached consent form and returning it to a member of staff at Scouts. You are free to withdraw your child from the research at any time without reason until 31<sup>st</sup> July 2019. This can be done by contacting the researcher. If the research has been conducted, your child's data will be destroyed and will not be included in the report. A decision to withdraw your child from the research will not affect them in any way.

### **Who is conducting the research?**

The research is being conducted by myself Leah Day-Wood (a master's student from the University of Huddersfield) and my supervisors Amanda Edmondson ([A.edmondson@hud.ac.uk](mailto:A.edmondson@hud.ac.uk)) and Barry Percy-Smith ([B.percy-smith@hud.ac.uk](mailto:B.percy-smith@hud.ac.uk)) from the University of Huddersfield.

### **Who will have access to the data?**

Nobody outside the research team from the University of Huddersfield will have access to the data.

### **What will happen to the information?**

Personal data shared by participants in the research will be held confidentially by the University of Huddersfield in accordance with the requirements of the General Data Protection Regulation (GDPR) and Data Protection Act 2018.

All information collected from your child during this research will be kept securely and accessed only by the research team. Any identifying material, such as personal and place names, will be removed in order to ensure anonymity. It is anticipated that the research may, at some point, be published as thesis or reports to the University, journal articles and/or presented at conferences. Material from the study may also be used for teaching purposes, at seminars or workshops. However, should this happen, your anonymity will be ensured.

No information will be shared in a way that would make participants personally identifiable except where legal obligations would require disclosure by the researchers to the appropriate personnel. The data will remain confidential unless information is disclosed which could suggest a risk of harm. In such a case, the information will be passed on to the relevant persons following the Scout's reporting system.

Your data will be kept on a secure system at the University of Huddersfield for ten years beyond the end of the study.

The University of Huddersfield is the 'data controller' and will be responsible for the secure management of the information you provide. The researcher or research

team is 'the data processor'. If you wish to complain about the management of your data, you should contact the University of Huddersfield Solicitor (Protection Officer) by emailing [legal@hud.ac.uk](mailto:legal@hud.ac.uk). If you are not satisfied, you may take your complaint to the Information Commissioner's Office (ICO).

The data collected during this research will be stored securely for 10 years. After this time it will be safely destroyed.

Please do not hesitate to contact myself or my supervisors using the contact details below with any further questions. I will be available to speak to at the end of Scout's sessions on the following dates (insert dates).

If you would like to find out more information about anxiety please see the contact details below;

**MIND – Mental Health Charity**

[www.mind.org.uk](http://www.mind.org.uk)

Call - 0300 123 3393

Text - 86463

**Young Minds**

[www.youngminds.org.uk](http://www.youngminds.org.uk)

Call - **0808 802 5544**

Thank you for your time,

**Leah Day-Wood (Researcher)**

[U1456167@pgr.hud.ac.uk](mailto:U1456167@pgr.hud.ac.uk)

**Amanda Edmondson (Supervisor)**

[A.Edmondson@hud.ac.uk](mailto:A.Edmondson@hud.ac.uk)

**Barry Percy-Smith**

[B.percy-smith@hud.ac.uk](mailto:B.percy-smith@hud.ac.uk)

## Appendix 4. Blank Consent Form



### Consent Form

**Title of study:** Exploring Children's Understanding of Anxiety

**Name of researcher:** Leah Day-Wood

[u1456167@pgr.hud.ac.uk](mailto:u1456167@pgr.hud.ac.uk)

If you are happy for your child to take part in the above study please tick the boxes below, sign and date this form. **All information on this form will remain confidential and will not be shared with anyone except the researchers.**

Please tick/cross as appropriate

I can confirm that I have read the information sheet for the research and I have had the opportunity to ask any questions and these questions have been answered.

I understand that my child's participation in the research is voluntary and I am free to withdraw my child or my child's data from the research at any time until 31<sup>st</sup> July 2019 without reason by contacting Leah Day-Wood ([u1456167@pgr.hud.ac.uk](mailto:u1456167@pgr.hud.ac.uk))

I understand that my data will be used for only the purpose of this research. I understand that this information will be confidential unless legal obligations require information to be shared with relevant personnel.

I understand that my data will be handled in accordance with the provisions of the General Data Protection Regulation (GDPR) and UK Data Protection Act 2018.

I understand that my child's participation will be audio recorded and transcribed by the researcher.

I understand that my child will remain anonymous and that names will be replaced with numbers. I understand that the information collected about my child may be shared with other researchers anonymously.

I understand that after the study has finished the data will be stored securely at the University of Huddersfield for a maximum of 10 years according to legal requirements. Following this, the data will be destroyed.

I give consent for my child to take part in this research.

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*Name of child*

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*Date*

---

*Signature*

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*Name of parent/guardian*

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*Date*

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*Signature*