Big boys don't cry: male secondary school students' attitudes to depression

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Abstract

Objectives: In an earlier qualitative study[1] we explored the attitudes of young men aged 15-19 (Group A) to mental health and, in particular, to engaging with the various mental health services available. We found that the participants perceived stigma in connection with mental ill health and they displayed particularly strong negative attitudes in relation to both doctors and medication. The investigation was then repeated with students who had been given a short (less than two-hour) programme called 'Beat the Blues' (BTB) about mental health (Group B) in order to assess the effect of that exposure by comparing the attitudes of the two groups of students. This present phase of the analysis is a quantitative examination of the written responses by both Groups A and B to an administered questionnaire.

Methods: A total of 42 young men took part in eight focus groups held in boys-only Dublin secondary schools, described in Burke et al.[1] A questionnaire, administered to each participant, examined the students' attitudes to depression and mental illness. The results were analysed by computer using SPSS to search for any trends and any contrasts between groups A and B and among the different socio-economic groups (SEGs) within the sample.

Results: Almost no statistically significant differences were found between groups A and B. However, some differences were found among the SEGs. In particular, very significant differences ($p < 0.01$ in each case), were found in attitudes towards depression, with increasing support for statements such as "People with depression just need to snap out of it", "Drinking alcohol can help cure depression" and "Depression is only an excuse for laziness" found among the lower SEGs. A very high percentage of students indicated their desire to talk to someone in times of personal stress; this was almost always their best friend or their mother. However, most students said they would be uncomfortable if a friend raised such a topic.

Conclusion: The main conclusion – that a single exposure to a positive programme about depression produces little or no effect – is hardly unexpected. Nonetheless, there are indications of a great willingness among older secondary students to learn about and discuss mental health issues. Furthermore, the highly negative attitudes among students from the lowest socio-economic group in this study would seem to indicate that the greatest need for education about mental health lies with working-class adolescents. Hence, it is recommended that a programme of multiple interventions be introduced into the senior cycle of secondary education.

Key words: Depression; Young men; Adolescents; Mental health; Attitudes.

Introduction

While there is some evidence that the suicide rate in Ireland is beginning to level out,[2] it nevertheless continues to be a cause of major concern, with (on average) more than one suicide per day. In particular, the number of suicides among young men (aged 15-24 years) is alarmingly high [81 in 2005],[3] virtually equal to the number of young men killed on Irish roads each year [86 in 2006].[4] Men in this age group are four times more likely than women to resort to suicide.[5]

As a step towards tackling this problem the HSE suggested that these issues be raised in schools in an attempt to promote positive mental health. Weare and Murray consider such an approach and emphasise the importance of whole school involvement in any such programme if improvements in attitudes are to be sustained.[6]

Depression affects about one-third of the population at some stage in their lives,[7] yet only about 25% of those people receive appropriate help. With men far less likely than women to access support services,[8] there is plenty of room for improving young men's attitudes towards dealing with stress and poor mental health.

In our previous paper we investigated the attitudes of school-going adolescent males towards using mental health services. We found clear evidence of a poor knowledge base among the students about what constitutes mental ill health and what options were available to them in dealing with this. They also displayed strongly negative views towards mental health services, particularly GPs and medication. These results are supported by research in Ireland on the calls received by Childline, where boys are far less likely than girls to contact the helpline.[9] The Childline report argues that it seems boys are underreporting such matters such as abuse and depression. More recent research in Ireland using questionnaires on minors showed that, in general, boys are more likely than girls to have a positive self-image. However, with 17% of adolescents in our survey saying they liked themselves 'little' or 'none of the time' there is a clear need for mental health support for these people.[10]

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Our choice of focus groups was based on a wealth of evidence[11-14] that suggests that this method is particularly appropriate when investigating sensitive issues with adolescents. It proved very successful in the first study and was used again in schools where the pupils had been exposed to a short information session on mental health.[15] The results from these two sets of data are compared in this paper.

Methodology

Sample

The target group for this study was male students in years 4, 5 and 6 of secondary school. The schools that took part in this research were chosen on the basis of two criteria. The first of these was to include a balance of schools that had presented the 'Beat the Blues' programme to their senior students and schools that had not, and the second was a desire to include a mix of socio-economic backgrounds. A list of about 12 schools was compiled and each principal was contacted to explain the research objectives.

Following discussions with the principals of those schools and among the researcher team, five all-boys schools were selected. These were all in the greater Dublin area, and included upper middle, lower middle and working class socio-economic groups. With permission from the principal, a teacher in each school explained the research to one or more of the senior cycle classes (total number ~ 350 students) and gave each pupil an information sheet and a consent form to be signed by both the student and either parent, if the pupil wished to volunteer to take part in the research. Only those students with completed forms were allowed take part. This resulted in a medium-sized convenience sample of students.

A total of 42 pupils participated in eight focus groups and each completed a questionnaire. Of these students 18 had not heard the 'Beat the Blues' presentation from Aware Defeat Depression; the remaining 24 had. The age range of the cohort was 15-18 and the mean age was 16.36 years.

The question of representativeness of the group is difficult to establish. Further discussions with the principals and year heads after the focus groups indicated that the participants conformed well to the socio-economic labels assigned earlier. However, since the topic under discussion was not one normally raised at secondary level it was not possible to ascertain if the young men's attitudes represented the general opinions of their wider age group.

Research instruments

In addition to the group discussions all students completed a simple questionnaire *(see Appendix)* during the focus group sessions. The questions were read aloud by one of the facilitators and any uncertainties were clarified before completion. This led to a 100% completion rate for all questions. Topics covered in the questionnaire included to whom the pupils would turn in time of stress, their factual understanding of depression, and their ideas about the effects of depression.

Data analysis

The completed questionnaire answers were transferred to an analysis package (SPSS) and the results were analysed for each phase separately and then jointly. Our null hypothesis (H0) was that the BTB programme had produced no measurable change in the students' attitudes. However, because of the small sample size there was a danger of Type I error (rejecting H0 when it is in fact true). To compensate for this we did not assume normal distributions but used t-statistics. Furthermore, we considered differences to be significant only in the extreme cases where $p < 0.01$.

Table 1: Number of students in each group

Beat the Blues	Number
No (Groups A)	18
Yes (Group B)	24
Total	**42**

Table 2: Age distribution of the participants

Age	Group A	Group B	Total
15	3	4	7
16	2	15	17
17	11	3	14
18	2	2	4
Total	18	24	42
Mean Age	16.67	16.13	16.36

The age distributions in the two groups were broadly similar. However, the standard deviation in the Group A was 0.907 and in Group B was 0.797. This led to a statistically significant difference at the 5% significance level in the mean ages of the groups, with Group A being slightly older than Group B: $t(40) = 2.054$, $p = 0.047$.

Almost half of the students in the sample were in fifth year, with the majority of the remainder in fourth year. Over 90% of the sample lived in a city or town *(see Table 3).*

The sample was split equally between those who had and those who had not felt unhappy enough to think about talking to someone else. Almost 50% of the sample said they would like to be able to talk to someone if they felt stressed *(see Table 4).*

These socio-economic labels were assigned to each school following discussions with the principals and the year head teachers regarding the catchment area for the school. For each school a clear designation, considered representative of the students from that school, was then allocated. Slightly less than half the total sample was classified as 'upper middle class', with the remainder being equally divided between 'lower middle class' and 'working class' *(see Table 5).*

The participants were asked to whom they would turn in times of crisis. Three points were assigned for a first choice, two points for a second choice and one point for a third choice. All participants listed at least one person to whom they felt they could turn for help. Three students gave only one choice and a further three gave only two choices. A total of 85% of the choices listed were for a best friend or close family member. The full distribution of the choices, based on the above scoring system, is shown in *Table 6:*

Ten negative statements in the questionnaire probed the students' attitudes towards depression and related matters. The score assigned to each response was one point for

Table 3: Year in school and location of home for participants

Year in school	Group A	Group B	Totals	Where living:	Group A	Group B	Totals
4th (%)	4 (22.2)	11 (45.8)	15 (35.7)	Town (%)	17 (94.4)	21 (87.5)	38 (90.5)
5th (%)	14 (77.8)	6 (25.0)	20 (47.6)	Village (%)	1 (5.6)	2 (8.3)	3 (7.1)
6th (%)	0 (0.0)	7 (29.2)	7 (16.7)	Country (%)	0 (0.0)	1 (4.2)	1 (2.4)
Total (%)	18 (100.0)	24 (100.0)	42 (100.0)	Total (%)	18 (100.0)	24 (100.0)	42 (100.0)

Table 4: Unhappiness and type of help sought by participants

Felt unhappy	Group A	Group B	Totals	Type of help:	Group A	Group B	Totals
No (%)	10 (55.6)	7 (29.2)	17 (40.5)	Practical (%)	3 (17.6)	5 (20.8)	8 (19.5)
Yes (%)	5 (27.8)	12 (50.0)	17 (40.5)	Talk (%)	10 (58.8)	10 (41.7)	20 (48.8)
Sometimes (%)	3 (16.7)	5 (20.8)	8 (19.0)	Both (%)	4 (23.5)	9 (37.5)	13 (31.7)
Total	18	24	42	Total	17	24	41

Table 5: Socio-economic groups of participants

Socio-Economic group	Group A	Group B	Totals
1 Working	4	7	11 (26.2%)
2 Lower middle	0	11	11 (26.2%)
3 Upper middle	14	6	20 (47.6%)
Total	18	24	42

Table 6: Percentage choices for support

Help choice	% of total choices
Best friend	41.1
Mother	22.5
Brother/sister	15.6
Father	13.4
Tel. helpline	3.5
School teacher	2.6
Social worker	0.9
Doctor	0.4
Totals	**100.0**

'strongly agree', two points for 'agree', three for 'neither', four for 'disagree' and five for 'disagree strongly'. Thus, a lower score indicated more general agreement with the negative attitudes in the statements.

With 10 questions this gave a possible maximum score of 50 and minimum of 10. There was no significant difference between Groups A and B on these attitudinal statements *(see Table 7)*.

However, a significant difference did exist when the responses were compared against socio-economic grouping. A gradual rise in the mean score was observed from the lowest socio-economic group to the highest. This difference was examined in an ANOVA table and was found to be statistically significant at the 1% level: $F(2, 39) = 7.204$, with $p = 0.002$. This means that those from the higher socio-economic groups were more likely to disagree with the negative attitudinal statements given *(see Table 10)*.

The only statistically significant differences between the socio-economic groups for individual statements were for 'People with depression just need to snap out of it' (snap), 'Drinking alcohol can help cure depression' (alcohol) and 'Depression is only an excuse for laziness' (lazy). In each case the difference is very striking ($p < 0.01$) *(see Table 11)*.

The results of the ANOVAs for each of these statements, shown in *Table 11*, indicate very significant differences in attitudes among the three socio-economic groups, with the working class students holding the most negative opinions.

The responses to these statements were also examined in relation to student age *(see Table 12)*. There is a general rise in mean score with age, indicating a gradual easing of more extreme views. This trend is significant at the 5% level, as measured by Pearson's correlation coefficient ($r = 0.370$, $p = 0.016$). However, a one-way ANOVA shows no statistically significant correlation between age and mean score ($p = 0.074$).

The difference in the mean score for the attitudinal statements between Groups A and B (those who had not seen BTB and those who did) is not statistically significant. In fact, the only statistical difference between the two groups is for the statement 'Drinking alcohol can help cure depression'. The significance here is at the 5% level and indicates that those who had received the Beat the Blues intervention were more likely to support the statement than those who had not: $t(36.009) = 2.218$, $p = 0.033$. However, the fact that Group B (those who had seen BTB) comprised a significantly younger sample than Group A, and the fact that the younger students were found to be more negative than the older ones, may explain this result, rather than having anything to do with the BTB programme itself.

The most negative impressions (low score) held by the students were those regarding recovery from depression, exercise, and the need for medication *(see Table 13)*. The most positive responses (high score) were in disagreeing that depression is only an excuse for laziness, that men of

Table 7: Responses to attitudinal statements

Statement	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Points
Snap	1	4	10	13	14	161
Alcohol	0	1	4	12	25	187
Illness	0	2	3	16	21	182
Exercise	0	8	8	23	3	147
Weak	1	1	6	16	18	175
Recover	1	5	12	18	4	139
Cannabis	0	3	8	15	16	170
Medication	0	6	11	18	7	152
Lazy	0	0	3	15	24	189
Not me	0	0	3	16	23	188
Total	**3**	**30**	**68**	**162**	**155**	**1,690**

Table 8: Scores for responses on attitudinal statements

Group	Range	Min, Max	Mean	SD
A	16	33, 48	41.22	3.557
B	12	35, 47	39.85	3.225
Total	**16**	**33, 48**	**40.24**	**3.406**

Table 9: Scores on attitudinal statements for socio-economic groups

Socio-economic grouping	n	Min.	Max.	Mean	SD
Working	11	33	43	37.82	3.060
Lower middle	11	36	44	39.55	2.697
Upper middle	20	36	48	41.95	3.086

their age don't get depressed and that drinking alcohol helps recovery.

The statements in Question 6 included a mixture of factually correct and incorrect statements about the symptoms of depression. *Table 14* gives the number of students (n = 18 in Group A; n = 24 in Group B; total n = 42) who were able to identify the correct statements and shows a high level of consistency. No significance differences were found between the two groups.

More than 90% of the students felt that a depressed person 'would not be a fun person to be with', and a similar percentage thought that he would be 'likely to talk about how he feels'.

The last two pairs of statements in this question asked about the student's own attitude to talking with a depressed person. For the two statements 'I would be nervous talking with them about how they feel' and 'If they spoke to me I wouldn't know what to say' the proportions agreeing were lower than for the previous statements *(see Table 15)*.

Question 7 included some statements to do with meeting and talking with a depressed person, how the students might feel about such a conversation, and some comments

Table 10: Mean responses to specific attitudinal statements for socio-economic groups

Socio-economic group	Means		
	Snap	Alcohol	Lazy
Working	2.91	3.91	4.27
Lower middle	3.73	4.36	4.00
Upper middle	4.40	4.80	4.90
Total	**3.83**	**4.45**	**4.50**

Table 11: ANOVA results for three attitudinal statements for socio-economic groups

Statement	df	F	p
Snap	2, 39	9.748	.000
Alcohol	2, 39	6.011	.005
Lazy	2, 39	12.734	.000

Table 12: Mean responses compared to age

Age	Group A		Group B		All groups	
	Mean	No	Mean	No	Mean	No
15	38.00	3	37.5	4	37.71	7
16	35.50	2	40.76	15	39.88	17
17	42.64	11	38.00	3	41.64	14
18	44.00	2	40.50	2	41.25	4
Total	**41.22**	**18**	**39.64**	**24**	**40.24**	**42**

Table 13: Responses to attitudinal statement

Statement	Group A mean	Group B mean	Total mean
Recover	3.56	3.41	3.47
Exercise	3.50	3.50	3.50
Medication	3.61	3.63	3.62
Snap	4.11	3.63	3.83
Cannabis	4.00	4.08	4.05
Weak	4.39	4.00	4.17
Illness	4.39	4.29	4.33
Alcohol	4.72	4.25	4.45
Not me	4.33	4.58	4.48
Lazy	4.61	4.42	4.50

on psychiatric hospitals. Although less than half of the sample had actually met and talked with a depressed person (as far as they knew), less than 20% said they would be uncomfortable in this situation. One third of the students thought a psychiatric hospital would be a scary place and just one-sixth thought the only treatment in a hospital was through giving drugs. However, almost two-thirds of the sample admitted they really had no idea what a psychiatric hospital was actually like *(see Table 16)*.

Only a small minority of the participants felt that 'If I said

Table 14: Responses re symptoms of depression

Statement	Group A	Group B	Total
Less energy	16	22	38
Sleeping badly	16	22	38
Less interest	16	24	40
Feeling sad	17	22	39
Difficulty	16	23	39
Not Fun	16	23	39
Likely to talk	17	21	38

Table 15: Responses re talking to a depressed person

Statement	Group A	Group B	Total
Nervous (%)	7 (39)	14 (58)	21 (50)
Wouldn't know what to say (%)	9 (50)	18 (75)	27 (64)

I was depressed my friend would think badly of me' while an overwhelming majority agreed that 'If ever my friend is depressed I hope he would talk to me about it'. There was no statistically significant difference between Groups A and B for these responses *(see Table 17)*.

The remaining few questions of the questionnaire were completed at the end of the focus group sessions and concerned how the students felt about the group interaction *(see Table 18)*. The vast majority said they had had a good chance to speak and no student indicated he had had no chance. Almost two-thirds of the participants said they felt more comfortable in talking about mental health following the interaction, with no student saying he felt less comfortable. The difference between Groups A and B here was statistically significant at the 1% level: $F(1, 40) = 8.104$, $p = 0.007$, with a substantial increase in the level of comfort with mental health matters in those who had heard the Beat the Blues talk. This is an important result. All bar one of the students (from sixth year) said they would like to be involved in another such group again.

Discussion

The objectives of including a balance between students who had heard the Beat the Blues presentation and those who had not and also a balance across the socio-economic groups were achieved in the final sample *(see Tables 1 and 5)*. The modal picture of the participants is a 16-year old male in fifth year in secondary school, living in the city or its suburbs and from the upper-middle class group. The variation in opinions among the different ages (15-18 years) of the participants is small but significant and seems to indicate that much of their negative feeling towards depression and mental ill health is already formed by at least the age of 15. However, there is some evidence of a moderating influence with increasing age. On the other hand, there is a very significant difference among the various socio-economic groups, with greatest negativity found in the working class students.

One feature of note is the very significant openness on the part of all the pupils. A willingness to talk about depression

Table 16: Positive responses on interaction with depressed people

Statement	Group A	Group B	Total
Met and talked	7	10	17 (40.5%)
Uncomfortable	2	6	8 (19.0%)
Hospital scary	9	6	15 (35.7%)
Drugs	1	6	7 (16.7%)
No idea	13	14	27 (64.3%)

Table 17: Responses to friend's depression

Statement	Group A	Group B	Total
He'd think badly of me	3	2	5 (11.9%)
Hope he would talk	16	20	36 (85.7%)

Table 18: Reactions to focus group session

Statement	Group A	Group B	Total
Good chance to speak	17	20	37 (88.1%)
More comfortable	7	19	26 (61.9%)
Involved again	18	23	41 (97.6%)

and to learn about mental health in general was apparent to the researchers, even though the students knew they were being tape-recorded. These facts suggest that efforts to prevent the initial negative image taking hold in the minds of adolescent young men could very usefully be applied, particularly in the case of the lower socio-economic groups. What is not clear is how this might best be done.

This apparent ability to talk openly about private and personal matters (found in both the questionnaire and, as previously reported, in the focus group discussions) is somewhat moderated by their stated intentions to restrict this almost exclusively to either a best friend or to their own mother *(see Table 6)*. A total of 62% of the total cohort said they would choose a best friend (male or female) to talk to in the first instance and a further 24% identified their mother as their first choice. Of all the choices identified, over 92% were for a best friend or a member of the immediate family.

The remaining figures were very low indeed and showed almost negligible support for talking to a teacher or GP doctor, whether as first, second or third choice. This reluctance to discuss personal problems with a teacher may indicate a difficulty with any in-house programme run for pupils and chaired by teachers.

There are a number of ways to interpret these findings. First, it is certainly good to know that so many of the participants would feel comfortable talking to someone – anyone – in times of stress, and particularly that a parent features so highly as the first choice. However, from the focus group discussions it was found that almost all of the students would try to 'fix' the problem if a friend spoke to them about feeling depressed, and indeed this is what many felt they would seek. Neither their close friends nor most parents are in any way trained to cope with serious stress in someone emotionally

close to them, and so the lack of willingness to talk with a doctor or teacher – even as a third choice, for example – is a cause for some concern.

Most of the participants, to whom their own friends will turn when stressed, were of the opinion that 'a good night out' (invariably involving the consumption of considerable quantities of alcohol) was the best remedy for one of their friends who was feeling down. This showed serious confusion between depression and 'the blues'.

Their reluctance to engage with, and a general lack of trust in, any professionals (including a telephone helpline) were apparent from the questionnaire replies. There was no significant difference among these responses for the three socio-economic groupings.

For the attitudinal statements *(see Table 7)* those who had seen the Beat the Blues (BTB) presentation showed no significant difference from those who had not. This is a little disappointing, if unsurprising, but the researchers had the strong feeling that those who had seen BTB had a slightly stronger factual base to their discussions.

There were also significant correlations between age and social class for the two groups and it is possible that these effects smothered any change due to BTB. This keenness to talk further about mental health suggests that a regular discussion programme in the senior cycle of secondary schools might be helpful.

As *Tables 10 and 11* show, there are highly significant differences – all at 99% confidence or better – among the socio-economic groups for a few attitudinal statements in particular. The upper-middle class group displayed less negativity towards depression than the other groups. This was most true of the statement 'People with depression just need to snap out of it', where working class pupils were especially negative.

The vast majority of the participants correctly identified the major symptoms of depression *(Table 14)*. It is possible that the very high proportion (90%) of students who felt that a depressed person would be 'likely to talk about how he feels' reflects their own expressed preference for talking to each other rather than professionals. However, given this desire to communicate with one another in times of stress, it is a little surprising that half the cohort thought they would be nervous in any such conversation and almost two-thirds admitted that they would not know what to say *(Table 15)*.

This picture is not completely consistent, however, with less than one-fifth of the total group saying they would be uncomfortable with meeting and talking to a depressed person *(Table 16)*. It may be that some participants interpreted these deliberately general statements, including adjectives such as 'nervous' and 'uncomfortable', in a very personal way where words may not mean exactly the same to one as to another.

Nonetheless, the low percentage that said they would be uncomfortable in an encounter with a depressed person is a positive sign, as were the general impressions of a psychiatric hospital, the very low fraction who felt a friend would think badly of them if they were depressed, and the high percentage who said they hoped their friend would talk to them if stressed.

These results, which did not show any statistically significant variations for BTB or SEG, support the general assertion that men of this age are generally well disposed towards each other's emotional needs. Whether or not these intentions transfer into practice cannot be clear from this research.

One statistically significant difference between Groups A and B, with those who had seen BTB saying they were 'more comfortable' with talking about mental health after the focus groups *(Table 18)*, may suggest that these students were better able to contribute more knowledgeably in the focus groups having heard the BTB talk, but this is not certain.

What is clear, however, is that there exists a strong willingness on the part of the vast majority of the participants to engage in further such discussions. Thus, the clear implication is that open discussion of mental health issues in the senior cycle of secondary schools would be a positive development that would be welcomed by students and that could work very well, particularly if led by an outside expert. It is not certain from this study whether the effect would be the same in rural areas.

Two factors need to be remembered when considering these results: the moderate size of the sample and the self-selecting nature of inclusion for the participants. A sizeable number of students had forgotten to get the form signed by a parent on the assigned day and so were excluded from the sample.

Coupled with the selection procedure for the schools themselves, it is thus very difficult, if not impossible, to claim that the above results are genuinely representative of the attitudes of adolescent young men. Nonetheless, the internal consistency of the findings is such that it seems to represent a useful start. A much larger study would be required to confirm these results.

Conclusion

These results suggest that a single exposure to mental health issues, such as the Beat The Blues programme, has no measurable effect on pupils' perceptions and attitudes. The only statistical difference (showing increased support for the statement 'Drinking alcohol can help cure depression' among those who had seen BTB) may be explained by the facts that the second group was slightly younger than the first and contained a much higher percentage of working class and lower middle class students. The clear conclusion is that one session on mental health, while very interesting to older secondary students, does not bring about any attitudinal change.

More positively, while the participants indicated their clear willingness to discuss such sensitive issues as mental health, they were also clear that they would choose to talk about this topic with their peers in the first instance, and then possibly their mothers. However, it was also clear that the knowledge base of their peers was very low.

Also, from the fact that almost 98% of the participants said they would like to be involved in such a discussion again, it was equally clear that this method of approaching mental health issues was strongly welcomed by the students.

It is suggested, therefore, that focus group discussions on mental health be introduced into the senior cycle for secondary students, with two or more sessions of at least one hour each being held in each of the three senior years.

The purpose of each session would be to increase the students' knowledge base, to improve their attitudes towards mental health, and to become more comfortable when dealing

with such situations, either for themselves or on behalf of another.

The students also stated their very clear preference to have such groups led by a non-judgemental outsider rather than by a teacher or medical professional.

The general picture, then, is of young men talking to each other about their problems and showing each other some measure of support. While this is a positive image it does not take cognisance of the fact that most of the participants did not know what to say or do if a serious situation was revealed to them. Most of the students were comfortable with the idea of a friend discussing something stressful such as the loss of a girlfriend but not with more personal sexual matters, for example.

One of the major issues to be addressed, therefore, is how to teach young men to know when a problem is beyond their scope and to feel comfortable talking to a professional in such cases. This needs urgent attention, and appears to be especially important in lower socio-economic groups.

This urgency is further displayed by the support shown for statements such as 'Drinking alcohol can help cure depression', again particularly among the lowest socio-economic group. Thus, while the need for mental health education is clearly present among all groups, it has been shown to be particularly pressing in the working class students. Given that many of such students leave school after their junior cycle it may well be appropriate to introduce some discussion groups before the end of their third year.

These results, therefore, strongly suggest that single interventions in schools about mental health do not alter young men's perceptions in any measurable way, although they do suggest that there is a willingness among senior students to be involved in repeated learning and discussions on this topic. It is recommended, therefore, that a mental health programme involving multiple interventions be included in the senior cycle of secondary schools.

Declaration of interest: None.

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Appendix: Questionnaire administered to participants in focus groups

1. Please ring the appropriate answer: [eg. Age: 15/16 /17]
   Age: 15 / 16 / 17 **Year in school:** 4 / 5 **Home:** town / village / countryside

2. Have you ever felt so unhappy or worried that you have asked someone for help?
   No ___ **Yes** ___ **I have thought about it but haven't asked yet** ___

3. If you have asked for help or think you might, would you be trying to get practical advice or just to have someone to talk things over with?
   Practical advice _____ **Talk things over** _____ **Both** _____

4. If you have asked for help or think you might, who would you ask? Write '1' beside your first choice, '2' beside your second choice, if there is one, and '3' beside your third choice, if there is one. You should not go any further than your first three choices.
   _____ Mother
   _____ Father
   _____ Brother or Sister
   _____ Special friend
   _____ School Teacher
   _____ Doctor
   _____ Social worker
   _____ Telephone helpline
   _____ None of these (If someone else, please say who: _____)

5. Please say how you feel about each of the statements given below. (Tick the appropriate box)

Statement	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
People with depression just need to snap out of it					
Drinking alcohol can help cure depression					
Depression isn't a real illness at all					
Regular exercise does not help prevent depression					
Men who get depression are weak					
Once you get depression you never fully get over it					
Smoking cannabis can help cure depression					
There is no need for medication if you're depressed					
Depression is only an excuse for laziness					
Men of my age don't get depressed					

Continued overleaf...

Appendix continued: Questionnaire administered to participants in focus groups

6. If you were describing pupils who are depressed, which of these do you think would be suitable? Please tick all that apply.

_____ They would have lots of energy
_____ They would have less energy than usual.
_____ They would be sleeping well at night
_____ They would be sleeping badly at night
_____ They would have less interest in things than they usually do
_____ They would have more interest in things than they usually do
_____ They would be feeling happy most of the time
_____ They would be feeling sad most of the time
_____ They would be having more difficulty with schoolwork than usual
_____ They would be having less difficulty with schoolwork than usual
_____ They would be fun to be with
_____ They would not be fun to be with
_____ They would be likely to talk about how they feel
_____ They would not be likely to talk about how they feel
_____ I would be nervous talking with them about how they feel
_____ I would not be nervous talking with them about how they feel
_____ If they spoke to me I wouldn't know what to say
_____ If they spoke to me I would know what to say.

7. Which of the following best describe your own situation? Please tick all that apply.

_____ I have never met or spoken to a depressed person before
_____ I have met a depressed person but didn't have a personal conversation
_____ I have met and spoken to a depressed person
_____ I'd be happy to have a personal conversation with a depressed person
_____ I would not be comfortable talking about depression with a depressed person.
_____ I think a psychiatric hospital must be a scary place
_____ I think a psychiatric hospital must be ok because people come out feeling better
_____ I think all they do for you in a psychiatric hospital is give you drugs
_____ I've really no idea what the inside of a psychiatric hospital is like
_____ If I said I was depressed my friends would think badly of me
_____ If ever my friend is depressed I hope he would talk to me about it.

At the end of the focus group session please complete the following few questions:

8. Which of these statements comes closest to how you feel now?

_____ During the discussion I had a good chance to say what I wanted to say
_____ During the discussion I had some chance to say what I wanted to say
_____ During the discussion I had no chance to say what I wanted to say.

9. With regard to your concerns (if any) about mental health, which of these statements comes closest to what you feel now?

_____ I am more comfortable talking about mental health than I was yesterday
_____ I am less comfortable talking about mental health than I was yesterday
_____ I feel the same as I did before the focus group.

10. Which of the following statements comes closest to what you feel now?

_____ I would like to be involved in another discussion like this next year
_____ I would not like to be involved in another discussion like this next year.

If you any other comments at all, please write them here:

_____

_____

_____

_____

_____

_____

Thank you very much for time and effort in taking part in this focus group.
We very much appreciate your contribution,

Shane Burke and Robert Kerr.