

RESEARCH ARTICLE

The Development and Implementation of an Educational Intervention on Mental Health for Male Adolescents in Ireland

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Abstract

Background: Adolescent boys do not see depression as an illness and are highly reluctant to talk to anyone about personal issues; they do not respect medical professionals and they continue to have a high rate of suicide. Aim and Design: The presentation described here, devised for 15/16-year old boys in transition year in secondary schools in Ireland, aims to address these issues by giving clear facts and by discussing feelings in a safe environment. Methodology: The talk includes information about the symptoms and effects of depression, the different types of depression and their causes, behaviour that can help or hinder mental health, methods of treatment, and appropriate attitudes for dealing with mental health issues. Emphasis is placed on talking to an appropriate adult. Binge drinking alcohol and smoking cannabis, both common practices for male adolescents, are discussed. The presentation also includes time for questions and general discussion. Results and Conclusion: This intervention has been presented in a number of secondary schools in Ireland with a high degree of success, being well received by both pupils and teachers.

Keywords: Adolescent, Depression, Intervention, Ireland, Male, Mental health.

Introduction

The onset of puberty in males brings not only great physical changes but a sharp increase in mental health issues [1], especially so if puberty begins at an early age [2]. Furthermore, although depression is predicted to affect one in 25 adolescents per year, these disorders frequently go unrecognised and, therefore, untreated [3]. The incidence is higher in low-income countries and in families with a history of adult depression (*idem.*). The definition of depression involves dysphoric mood as the essential feature, disturbances of sleep, appetite, and energy as associated symptoms, a duration of at least 1 month, and impairment in everyday functioning [4].

During adolescence many young males engage in risk-taking behaviour involving alcohol, cannabis and other drugs, all of which have been shown to be strong indicators of subsequent bouts of depression [5, 6, 7]. Depression following cannabis use is strongly associated with lower socioeconomic status whereas alcohol-induced depression is common at all levels of society, even after just one year of drinking [8]. An increasing trend for adolescents to present at clinics with two or more issues has been noted [9] and this increases further in early adulthood [10].

One of the most consistent indicators of adolescent depression is abdominal pain and perspiration without exertion [11]; the suicide rate in adulthood among such adolescents is greater than for the rest of the population (*idem.*). The number of adolescent male suicides in Ireland remains high, being the second highest in Europe at 5.12 per 100,000 of the population [12]. This situation is exacerbated by the perceived stigma surrounding mental health issues which is keenly felt by male adolescents, who hold strongly negative views against medical treatment for depression [13]. This stigma is a serious barrier to help-seeking for adolescent boys, particularly so for those with high levels of alcohol consumption [14].

The Situation in Ireland

In Ireland, clinical depression affects about one-third of the population at some time in their lives, with another third suffering from less severe bouts of depression [15]. Research among adolescent males in Ireland found very low levels of knowledge about mental health, with many failing to differentiate between depressions and feeling sad [16]. Most did not recognise depression as an illness and they assumed it was always caused by an external factor, such as a

bereavement, bullying, or difficulties at home. Their levels of prejudice against medical professionals and medical treatment were very high, even for the sons of doctors, and the general belief was that men should be able to stand up to stress and not get depressed (*idem.*). Almost 500 lives were lost in Ireland in 2012 through suicide –three times the total number of road deaths for the same year [12]-with about 80% of these being suicides of males. The sustained, high rate of male adolescent suicide in Ireland has led to calls for an effective programme to promote positive mental health in schools [17].

Male adolescents associate antidepressant medication with extreme forms of the illness, particularly severe bipolar disorder, believing that taking medication “legitimises” their illness [18] and is “a life sentence” for medical treatment [16]. All antidepressant medication is considered both addictive and frightening, so an explanation of the role of medication, together with possible side-effects, is clearly required. Adolescents describe people on antidepressant medication as being dishevelled, unable to speak or move normally, and the thought of having a friend on antidepressants scared them. Psychiatric hospitals are described like prisons, with patients being “kept under control” through heavy sedation, “looking like junkies” and “losing their personalities” [16]. Depression is generally seen as an excuse for laziness and, since they believe that real men don’t get depression, the manly thing to do is to drink and smoke their way out of it [19]. These incorrect, highly negative and dangerous attitudes were found to be widespread, most especially among working class adolescents [18], who are also more likely to believe that depression can be cured with alcohol and/or cannabis.

Talking through a stressful situation with a suitable adult – such as a parent, teacher or telephone counsellor– is always positive and can help recover a more balanced perspective. However, teenage boys frequently talk exclusively about their issues only to each other, and their most common “solution” is to get very drunk, which exacerbates the problem [18]. There is a strong correlation between binge drinking and decrease in mood [19]. Since the average weekly alcohol intake of working class adolescent boys is almost four times that for the middle class., and with one third of adolescent boys starting to drink alcohol by the age of 13 (*idem.*) there is an urgent need to challenge their negative ideas by addressing some of their basic inaccurate beliefs, especially for working-class adolescents.

For effective change in their attitudes, information must be presented clearly and honestly, with open attitudinal statements that can be discussed in the group. A high proportion of adolescents show considerable interest in having more talks in school on mental health with more opportunities to discuss issues, with these talks being given by outside speakers rather than teachers [18, 19].

Showing emotions openly is regarded as unacceptable for any male who has reached puberty, and visiting a doctor for anything other than a serious physical illness is seen as compromising their masculinity [19]. In Ireland the minimum age for visiting a doctor without parental permission is 16 years; however, for visiting a counsellor or psychiatrist that age is 18 years. This officially rules out for younger adolescents the possibility of talking to a teacher about personal issues, although this is widely ignored in schools, even though many teachers feel seriously unprepared to handle mental health issues in pupils and would prefer not to be asked to give such talks [20]. Most adolescent boys are extremely reluctant to disclose sensitive information to a doctor or therapist in case of a breach of confidentiality [18]. There is a genuine fear that their friends would treat them differently if they knew about visiting a doctor, taking medication or treatment in a psychiatric hospital (*idem.*). This can lead to many adolescents self-medicating with alcohol (generally binge drinking) and/or cannabis [19], confusing the temporary relaxation with an easing of their problem.

Research in Ireland found high levels of adolescent drinking and drunkenness – higher than the European mean [21]- with four-fifths of the students having been drunk during the previous year, and almost half being drunk at least once each month [19], leading to high levels of antisocial behaviour. Many tend to be highly defensive about any signs of depression, blaming such feelings on extraneous factors such as examinations rather than on excessive drinking. Since alcoholic excess and hedonism are very common amongst male adolescents in Ireland- and therefore both exciting and acceptable to them- this makes effective education about alcohol and mood disturbance simultaneously more difficult and more urgent.

Very few male adolescents with diagnosable depression ever receive appropriate treatment, with anticipated shame and embarrassment acting as effective barriers to help-seeking.

Written comments made by adolescent boys in research indicate that even those with serious issues (such as abuse) feel unable to talk to somebody they know [19]. However, even a brief exposure to information about depression was found to help adolescents feel more confident about discussing their mental health, especially in lower socioeconomic areas [18]. The possibility of several interventions throughout secondary school to maximise the chance of attitudinal change has not yet been tested.

Methodology

The results from the literature and from the author's own research have been distilled into an educational intervention. This has been designed to improve adolescents' knowledge and attitudes towards mental health in themselves and others, and to introduce them to appropriate ways of dealing with depression and other mental health issues. Real life stories are included with the aim of helping the boys to understand the theory of diagnosis and appropriate action. Also included are discussions on the effects of alcohol and cannabis, with a general discussion at the end of the presentation. The intervention, given orally with support from Power Point slides, is designed to last about 80 minutes (i.e. a double period) and can be given to transition year students (typically aged 15-16 years) in groups of between 25 and 100 boys.

Introductory letters and emails offering to give the presentation were sent to boys' secondary schools in south County Dublin, east County Wicklow and Cork city. These schools were chosen for convenience as a first trial for the intervention and included different socioeconomic areas. Each letter/email was accompanied by a four-page handout for students giving the main points from the talk and contact details for suitable agencies, and a list of homework suggestions for teachers. The take-up for the intervention was about 40% overall, lower in working class areas. No reasons were given by any school for not taking the intervention; this could be lack of interest, already having a talk organised, or some other reason. At the time of writing, fourteen talks had been given. Each talk was attended throughout by one or more teachers from the school.

Programme Content and Structure

The following three factual statements are given as key points in the presentation and form the essential framework for the intervention:

- Not everything in print, on the internet, or that you hear from friends can be taken as absolutely

true. Information must be checked. This is especially important regarding drugs, both prescription and otherwise.

- At any time of stress or distress it is strongly recommended to talk to a responsible adult, such as a parent, teacher or telephone helpline.
- It is almost always possible to help a depressed person feel better, but there is nothing that can be done after suicide. Suicide is a permanent solution to a temporary problem.

Signs and Symptoms of Depression

The most common experience of mental illness for adolescent boys is depression, though anxiety disorders and obsessive compulsive disorder also feature. Given the constraints on time for the intervention it was decided to concentrate on depression, while explaining that methods of dealing with other mental illnesses are very similar to those for depression.

The major symptoms of depression in adolescent boys are outlined, including feeling down, tired or confused, sleep and/or eating disturbance, loss of interest in friends or hobbies, and reduced interest in sex. It is explained that many of these signs can also feature in healthy teenage boys for other reasons, so the length and severity of the symptoms are also important. Furthermore, not all cases of depression show the same signs, nor do the symptoms necessarily appear in the same order or with equal strength; hence the importance of seeking professional help.

Types and Causes of Depression

The four main types of depression are outlined. In particular, Reactive Depression (a response to an external loss such as bereavement or relationship break-up) and Endogenous Depression (arising from a chemical imbalance in the brain and which may not be linked to any event) are explained and the differences between the two are discussed, particularly with regard to treatment. The variation in severity of symptoms is again mentioned. Attitudes such as "all that is needed is to pull yourself together" are also discussed as well as unproductive behaviour such as prolonged use of alcohol and/or drugs. It is important to emphasise that the feelings associated with depression are natural, common, and will ease with time if they are treated properly, not necessarily with medication.

Helpful and Harmful Behaviour

Healthy living, including exercise, a good diet, Sufficient sleep and talking things through with others are all helpful actions which promote positive mental health. Other beneficial behaviours at times of depression include visiting

a counsellor, therapist or doctor and accepting that there is a problem that needs to be addressed. Harmful, self-destructive deeds that reduce a person's mood include binge drinking alcohol and frequent consumption of cannabis. This fact can be quite unpopular with some adolescents, who prefer not to believe that their current behaviour may affect them adversely in the future.

Methods of Treating Depression

The essence of any treatment for depression is the restoration of the correct chemical balance in the brain. This is generally addressed in the first instance through talking therapy, where someone suitable listens to the depressed person's story and attempts to stimulate the speaker to reassess his/her situation. This is often sufficient when treating Reactive Depressions. For more complex depressions the thinking process in the brain may need to be challenged, and this is often done using Cognitive Behavioural Therapy, which tries to normalise thinking that has reinforced a depression, such as taking the blame for events outside the person's control. For this to succeed the depressed person must want to relearn ways of responding in the brain to various stimuli. This method is commonly used with depressed adolescents. If the depression continues medication is sometimes used.

Since adolescents tend not to ask appropriate adults for help when faced with personal issues, this is a key matter for the intervention. How to deal with a situation when they or a friend is faced with depression, the wide variety of professional help and useful telephone helplines available, and the importance of bringing serious matters to a parent or school counsellor are discussed. Again, the unreliability of medical advice from the internet is stressed.

Attitudes

The fact that adolescents believe there is still a stigma surrounding mental illness in general and depression in particular demands to be addressed in any intervention. While awareness about such issues can be increased relatively easily, attitudes can usually only be changed more slowly. Education in this area is extremely difficult in a short period of time and may well be almost impossible in a single intervention. Nevertheless, it is hoped that the combination of new information and open discussion will have a positive effect.

A second attitudinal issue arises from adolescent boys' excess consumption of alcohol and/or cannabis. The short-term boost to their mood felt

by users can exacerbate the problem and tends to make achieving effective change extremely difficult. Getting pupils to moderate their consumption of alcohol or cannabis is certainly not easy, especially in one intervention, suggesting a benefit from multiple interventions throughout the senior cycle.

One possible approach to the introduction of new attitudes is for the speaker to tell his/her experiences of depression and medication, showing quite clearly that he/she is able to lead a normal life and enjoy work and family life to the full. This may help to get across to the students the facts that having a depression does not imply a permanent problem that cannot be fixed and that society's attitudes to depression are improving, thus reducing the students' fear of stigma.

The sharp reduction in overall mood following repeated bouts of binge drinking is explained, as well as the fact that a person may not notice such a decline until it is well progressed. Discussion of unwise activities undertaken when drunk may be a useful starting point. Only a small percentage of boys admit smoking cannabis, but the point about adverse side-effects through overuse should be made. The key issue here is to highlight the dangers of excess when dealing with substances not naturally found in the body. It is vital to show the adolescents some less self-destructive ways of dealing with tension and upset moods.

Any intervention, therefore, must encourage adolescent males to address feelings of depression in a healthy way, and give them the strength to seek appropriate help. Given the wide range of needs and experiences among 15- and 16-year-old boys a variety of approaches may be required when making a presentation to a transition year group. This further reinforces the suggestion that multiple flexible and adaptable interventions throughout second-level education might be useful.

Structure of Intervention

The intervention is designed to last two class periods, or 80 minutes, finishing at a time when the pupils are free from class, such as a break, lunchtime or the end of the school day. In order

to sustain interest for the entire presentation the content has been broken down into short units of 15 minutes each. In the first unit the speaker describes his/her own experiences with depression. Pages from the internet are introduced giving contrasting views on a related

topic; this is followed by a discussion about how to assess which is more likely to be reliable. The second unit includes an explanation of what depression is, the different types and their causes. This is followed in the third unit by describing methods of dealing with and treating depression; this includes a discussion about the pros and cons of antidepressant medication. The effects of alcohol and cannabis on depression and, in particular, the depressing effect of excess consumption of any drug, are discussed in the fourth unit. In the fifth unit the boys get to ask any questions they may have and any topic of note is discussed in more detail. After a final summary of the main points the pupils are free to leave. However, any boy who would like to discuss something further can stay behind at that stage and talk more privately. A teacher is required to be present in the room at all times.

Reaction to the Programme

Reaction to the presentation to date has been universally positive, both from students and teachers. All the students enjoyed the talk and were very grateful for the chance to discuss mental health openly. They were clearly interested in what was said and reacted openly and enthusiastically. In follow-up conversations with their Transition Year Coordinator (subsequently passed on to the author), the words "excellent" and "brilliant" were very commonly used by the students to describe the talk. In addition, when asked if they thought the presentation should be given again the following year, they were unanimous that it should.

At question time there was never a shortage of issues raised and these showed a high level of interest and intelligence. After the formal end of

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Conclusion

The educational intervention described here, which aims to address the highly negative views of adolescent males towards mental illness and its treatment, includes a high level of information and a consideration of appropriate attitudes for teenage boys when faced with personal mental health issues. The intervention, devised for 15/16-year old boys in transition year, has been presented in a number of secondary schools in Ireland and has met with a high degree of success. The openness and honesty of the students' comments and questions has indicated their genuine desire to learn more about this subject, and an emphasis is placed on discussing troubling matters with an appropriate adult.

This presentation, therefore, appears to address the negative attitudes of adolescent boys described in the literature in such a way that there is a demand both by students and teachers for further, similar talks. Hence, it seems reasonable to suggest that an intervention such as this could also be useful in other regions of Ireland.

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