Mental health among young people during COVID-19: an intersectional perspective

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This thesis is as much yours as it is mine.

ABSTRACT

The COVID-19 pandemic has had a significant impact on the mental health of young people in the United Kingdom, intensifying existing challenges and exposing gaps in support systems. While concerns about rising psychological distress were evident prior to the pandemic, the disruption to education, employment, and social life exacerbated vulnerabilities for many.

This research adopted a mixed methods design to explore both population-level trends and lived experiences of young people's mental health during and after the pandemic. The qualitative component involved 26 young people aged 16–24 in Sheffield participating in semi-structured interviews and a focus group. Reflexive thematic analysis developed a set of themes that illustrated pandemic-related disruptions to education, employment, and social life exacerbated existing vulnerabilities and inequalities, while also generating feelings of isolation, uncertainty, and anxiety. Young people described varied coping strategies and differential access to support, shaped by their personal circumstances.

The quantitative component analysed data from the UK Household Longitudinal Study (UKHLS), specifically Waves 7 and 13. Mental health was measured using the Strengths and Difficulties Questionnaire (SDQ) for adolescents and the General Health Questionnaire (GHQ-12) for young adults. Multilevel Analysis of Individual Heterogeneity and Discriminatory Accuracy (MAIHDA) was used to examine how mental health outcomes varied across dimensions of sex, ethnicity, household income, and urbanicity. MAIHDA facilitated the exploration of how combinations of these social factors intersect to produce differing risks for poor mental health.

By integrating qualitative insights with longitudinal quantitative data, this thesis offers a comprehensive account of the pandemic's impact on young people, while illustrating the potential of advanced intersectional approaches like MAIHDA in mental health research. The findings highlight the need for improved mental health services and policies that address the compounded effects of social disadvantage and the challenges intensified by the pandemic.

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DECLARATION

I, the author, confirm that the Thesis is my own work. I am aware of the University's Guidance on the Use of Unfair Means (https://www.sheffield.ac.uk/study-skills/assessment/academic-integrity/academic-integrity). This work has not been previously been presented for an award at this, or any other, university.

CHAPTER 1 INTRODUCTION

This thesis examines the mental health of young people (aged 16-24 years) in the context of COVID-19, using an intersectional perspective. The core objective is to explore how experiences and outcomes vary across social categories and how structural, social, and individual-level factors shape these patterns. To achieve this, a mixed methods research design was adopted, combining statistical analysis of a large-scale, longitudinal UK population dataset, with qualitative interviews and focus group discussions. This approach enabled the exploration of both population-level patterns and individual lived experiences, addressing the multiple layers of influence on mental health. Situating this research within broader social and policy contexts, the following chapters address how the pandemic intersected with existing vulnerabilities and support systems to affect youth mental health in complex and uneven ways.

To contextualise this research, it is essential to understand the broader landscape of youth mental health prior to and during the COVID-19 pandemic. In recent years, concern has grown over the mental health of young people, a population already experiencing increased rates of mental health challenges prior to the COVID-19 pandemic (Collishaw et al., 2019; T Gagné et al., 2021; Pitchforth et al., 2019). Before 2020, evidence pointed to a rising prevalence of common mental health conditions such as anxiety and depression among adolescents and young adults, particularly young women (NHS Digital., 2018; Vizard et al., 2020). The onset of the pandemic intensified these concerns, as widespread disruption to education, employment, and social life added layers of stress and uncertainty. Since then, indicators such as increased school absences, worsening classroom behaviour, and rising numbers of young people not in education, employment, or training (NEET) suggest a continued deterioration in mental well-being (Coxon et al., 2025; Isherwood, 2023; Lester & Michelson, 2024; The Children's Society, 2023). At the same time, mental health support systems have struggled to meet growing demand; mental health services are overburdened, waiting times remain long, and access to care is highly uneven (Children's Commissioner, 2023; The Health Foundation, 2022).

This situation is particularly concerning given the unique position of young people in the life course. Adolescence and early adulthood are formative periods marked by biological, psychological, and social transitions. Young people are navigating the challenges of identity development, educational and career pathways, and shifting social roles (Patton et al., 2016). The pandemic did not only disrupt their routines, but it also altered the environments in which these critical processes take place, potentially leaving long-term effects on health and wellbeing. However, the experiences of young people during this time have not been uniform. Variability in mental health outcomes raises critical questions about whose mental health was affected, in what ways, and why. These differences may

reflect intersecting factors such as sex, ethnicity, socio-economic status, and place, dimensions too often overlooked or homogenised in youth mental health research (YoungMinds, 2023).

Despite an expanding body of work on mental health, significant knowledge gaps remain. Young people are still under-researched relative to other age groups (Donnelly, 2022; Ford & Cross, 2021), and when included, they are frequently treated as a homogeneous group. Moreover, while it is widely accepted that inequalities shape health, less is known about how multiple social identities interact to produce different outcomes in young people. There is also an ongoing debate about whether the apparent rise in mental health conditions represents a true increase in morbidity or reflects changing social attitudes, reporting practices, and diagnostic thresholds (Elgot, 2025; Foulkes & Andrews, 2023). These uncertainties shaped the rationale for this thesis. Understanding what is happening to young people's mental health, and to whom, is essential for the development of targeted and effective interventions, policies, and support services. Furthermore, my own observations during the COVID-19 pandemic particularly the contrasting experiences of my daughters and the young people around them, highlighted the uneven distribution of support and resilience across different social groups. These personal insights, grounded in both professional expertise and lived experience, reinforced the importance of investigating how intersecting social identities mediate the mental health impacts of the pandemic and motivated my commitment to this area of research.

1.1 Aims and objectives

The overall aim of this PhD research was to generate a comprehensive understanding of young people's mental health during and after the COVID-19 pandemic, and to explore if intersectionality can help this understanding. The four key research questions were: -

1. How have key social determinants shaped young people's mental health before and after COVID-19, and what patterns have emerged from this change over time?
2. What are the lived experiences of mental health in young people, during and post COVID-19?
3. To what extent can intersectionality aid the understanding of mental health in the young people population?
4. What do the findings suggest for improving mental health support and reducing inequalities among young people?

1.2 Methods

This research was conducted using an exploratory sequential mixed methods design, underpinned by a pragmatic paradigm (Biesta, 2010). The study drew on two key theoretical frameworks - intersectionality and the social determinants of health, to examine how structural and social inequalities shape mental health outcomes. In addition, Social Identity Theory is drawn upon as a

complementary lens to support interpretation of how group affiliations and identity processes may influence young people's experiences of mental health. By combining qualitative and quantitative methods, the research aimed to capture both lived experience and broader structural patterns.

The qualitative component was conducted first and involved 26 young people aged 16–24 years living in Sheffield. Between November 2022 and March 2023, semi-structured interviews (n=16) and one focus group (n=10) were carried out to explore participants' experiences of mental health during the pandemic. Participants were recruited using purposive and snowball sampling strategies to ensure diversity in age, sex, ethnic group, and background. Data were analysed thematically to identify key themes relating to mental health, identity, and coping in the context of disruption and uncertainty. The objectives of the qualitative component were:

- To explore the lived experiences of mental health in young people in Sheffield, during and after the COVID-19 pandemic, and understand some of the mechanisms of mental health in young people

The quantitative component used secondary data from the UK Household Longitudinal Study (UKHLS), a large longitudinal UK panel survey. The analysis focused on three cohorts of young people using data from Waves 7 (2015/16, pre-pandemic) and 13 (2021/22, post-pandemic): -

- Wave 7 Youth - ages 10-15 years
- Wave 7 Adult - ages 16-30 years
- Wave 13 Adult - ages 16-30 years

Mental health outcomes were measured using the Strengths and Difficulties Questionnaire (SDQ) for the younger group and the General Health Questionnaire (GHQ-12) for the older group. Statistical analysis included descriptive statistics, multilevel modelling, and Multilevel Analysis of Individual Heterogeneity and Discriminatory Accuracy (MAIHDA) to assess how mental health outcomes varied by sex, ethnic group, household income, and urbanicity. The objectives of the quantitative component were: -

- To describe the mental health of young people in the UK, before and after the COVID-19 pandemic
- To examine associations between identity variables (sex, ethnic group, household income, and urbanicity) and mental health outcomes
- To identify the strength and interaction of these associations using MAIHDA

1.3 Contribution to knowledge

This thesis makes several original contributions to knowledge at the intersection of youth mental health, intersectionality theory, and mixed methods research. Empirically, it provides a detailed account of young people's mental health experiences during the COVID-19 pandemic, drawing on both primary qualitative data and longitudinal survey data. While existing studies have documented rising rates of psychological distress among young people during this period (Pierce et al., 2020; Vizard et al., 2020), this research moves beyond surface-level prevalence by examining how intersecting dimensions of identity including sex, ethnic group, household income, and place (urbanicity) shaped both outcomes and lived experiences. It offers a rare, nuanced understanding of how structural inequalities and lived realities converged during a time of profound social disruption.

Theoretically, the thesis contributes to the evolving use of intersectionality in public health and youth mental health research. Intersectionality has often been referenced conceptually (Crenshaw, 1989; Crenshaw 1991) but it remains underutilised in empirical studies, particularly in terms of methodological application (Bauer, 2014; Bowleg, 2012). This study addresses that gap by employing both qualitative analysis and Multilevel Analysis of Individual Heterogeneity and Discriminatory Accuracy (MAIHDA), enabling a robust examination of how intersecting social positions influenced mental health outcomes. The application of MAIHDA within a broader mixed methods framework represents a novel methodological contribution. It demonstrates the value in capturing interactional effects between social categories while avoiding the limitations of traditional stratified or interaction models (Evans et al., 2018).

Furthermore, the integration of qualitative and quantitative strands allowed for the generation of complementary insights enriching the overall explanatory depth of the study. This level of methodological integration remains relatively rare in intersectionality-informed health research (Ford et al., 2024; Holding et al., 2022; Tinner & Alonso Curbelo, 2024).

1.4 Thesis structure

Chapter 2 presents the background and context to the overall thesis aims and objectives. This includes an overview of the age period considered adolescence, how it has evolved over time and age definitions. It also discusses the important developmental changes that young people experience during this time in their lives and their health, physical and mental. The chapter then provides an overview of the concept of intersectionality and how interest in this conceptual framework has recently grown within health research. As previously highlighted, there is a lack of research focused on young people, and this is particularly evident within the use of intersectionality and mental health. This forms the basis of the final section of this chapter where the findings of relevant qualitative and quantitative studies are discussed.

Chapter 3 outlines the methodological framework and research strategies employed in this thesis. The chapter begins by presenting the research paradigm of pragmatism, along with the epistemological and ontological assumptions that underpin the research. The two key theoretical frameworks selected to guide this research, intersectionality and social determinants of health, are discussed in the theoretical perspective, along with Social Identity Theory which provides complementary insights. A mixed methods approach is adopted, combining qualitative and subsequent quantitative components to capture both lived experiences and broader structural patterns of mental health among young people. The rationale for using an exploratory sequential design is explained, with attention given to the selection of datasets, analytic techniques, and key intersectional variables. The chapter also details how the integration of findings was achieved across the methodological components and concludes with a discussion on the quality, rigour, and ethical considerations inherent in the chosen research design.

Chapters 4 and 5 present the qualitative findings from this mixed methods thesis, outlining the findings derived from semi-structured interviews and a focus group with young people. Drawing on their narratives, Chapter 4 provides an overview of the participants and their lives before and during the COVID-19 pandemic. It then examines how the pandemic disrupted these routines and reshaped social identities, focusing on changes to living arrangements, loss of structure, social isolation, and altered relationships. The findings illustrate how the abrupt disconnection from familiar environments and support networks generated feelings of uncertainty and dislocation. Chapter 5 explores the emotional and psychological impact of the COVID-19 pandemic on young people. It examines how the crisis intensified existing vulnerabilities and mental health challenges, while also exposing barriers to accessing appropriate support. Participants described experiences of anxiety, uncertainty, and isolation, often shaped by intersecting social identities. The chapter also considers how young people made sense of their experiences, highlighting the development of self-awareness, resilience, and evolving understandings of identity and wellbeing in the context of prolonged disruption.

Chapter 6 reports the results of the quantitative analysis, which includes statistical exploration of mental health outcome measures, the Strengths and Difficulties Questionnaire (SDQ) and the 12-part General Health Questionnaire (GHQ-12) using secondary data from the UK Household Longitudinal Study (UKHLS). This analysis highlights variations in psychological distress among young people, with attention to intersecting factors such as sex, ethnic group, household income and urbanicity. Patterns of heightened distress among specific subgroups are identified, pointing to structural inequalities exacerbated by the pandemic. These chapters provide a comprehensive account of how young people navigated the pandemic, illustrating the multidimensional impact of COVID-19 on their mental health and how accounting for intersecting social identities may aid mental health research and policy.

Chapter 7 synthesises insights from the qualitative and quantitative components. It identifies convergence in the data around key issues such as the role of uncertainty, disrupted transitions, and access to support while also recognising areas of divergence. The integrated analysis shows how structural factors and identity-based inequalities shape both population-level trends and individual experiences. The chapter reflects on the methodological and theoretical benefits of intersectionality and mixed methods in health research and considers the findings in relation to existing literature.

As the final chapter of this thesis, Chapter 8 reflects on the strengths and limitations of the research, discussing the implications for policy and practice with a particular focus around the accessibility and responsiveness of mental health support for young people. The chapter concludes with recommendations for future research and a reflexive account of the researcher's positionality, acknowledging how lived experience and professional background influenced the research process.

CHAPTER 2 BACKGROUND

2.1 Outline of chapter

Utilising literature from multiple sources, this chapter presents an overview of the age period considered adolescence, how it has evolved over time and age definitions. It also discusses the important developmental changes that young people experience during this time in their lives and their health, both physical and mental. The chapter then provides an overview of the concept of intersectionality and how interest in this conceptual framework has recently grown within health research. As previously highlighted, there is a lack of research focused on young people, and this is particularly evident within the use of intersectionality and mental health. This forms the basis of the final section of this chapter where the findings of relevant qualitative and quantitative studies are discussed.

2.2 Overview

> I'm going through a hard time.
> I sit in my room most of time.
> I throw things around.
> Just to calm me down.
> I thought one day everything was going to be okay.
> But I'm still waiting for that day.
> School is just getting in the way,
> And I'm getting judged every day.
> It's just not fair.
> I don't know what to wear.
> I try my hardest.
> But no one thinks it's my hardest.
> I just wanna give up.
> But I can't as I need to show them up.

Poem Titled Teenage Life by Maddison-Sheree, 2011.

(*https://www.familyfriendpoems.com/poem/teenage-life-3*)

This is a reflection of the critical period referred to as adolescence, a transition stage from childhood to adulthood, where constant change is taking place. Irrespective of where a young person during this phase may live in the world, they will experience change in their environment from different educational settings to employment, new and changing relationships with friends and family, and in their own personal development. From the perspective of a young person, it is a time of increased independence and responsibility such as being able to travel without an adult and having your own house keys. Navigating through these changes can be difficult with adolescence often associated with feelings of awkwardness and uncertainty (Vaghi & Emmott, 2018), however it can also be viewed as

a time of excitement and opportunity as young people begin to explore their identity and their position in society (Viner, 2012).

Although every child is different and surrounded by many diverse social and cultural influences, the commonly recognised age range for adolescence is 10-19 years (Hagell & Shah, 2019; UNICEF, 2011; WHO, 2017), with numerous scholars considering adolescence continues up to 24 years (Sawyer et al., 2018; Sawyer et al., 2012). Even before adolescence begins, the health and well-being of young people has already been influenced by their early life experiences, they 'do not enter adolescence with a "blank slate"' (National Academies of Sciences Engineering and Medicine, 2019, p. 37). Additionally, there are numerous indirect and direct factors that affect their health and well-being from birth such as education, family and friend relationships, wealth and social position. Not only do these factors have the potential to impact health greatly during adolescence, they continue to be influential to health in later life. Mental health is particularly vulnerable with up to three quarters of all lifetime mental health disorders found to start by the age of 24 years (Kessler et al., 2007), a reflection of the continual life changes and impactful broader influences.

There has been a shift in focus in global and national policy towards adolescent health during the last 15 years (Department of Health and NHS England, 2015; Department of Health and Social Care and Department for Education, 2017; EWEC, 2015; Fares et al., 2006; UNICEF, 2011), with recognition of the importance of this life stage, coinciding with concern over increasing deficient mental health in young people.

This literature review will provide an overview of adolescence and the main dimensions in adolescent health. Firstly, a historical perspective will be discussed outlining how this unique period has changed over time, its definitions and social/ cultural context. An overview of adolescent development will follow, before moving the focus to adolescent health, with an emphasis on mental health.

2.3 Adolescence

The unique period referred to as adolescence is a critical life stage where rapid change is experienced. Taken from the Latin *adolescere* meaning growing up (HarperCollins, 2021), an adolescent is described as experiencing a 'complex multi-system transitional process' (Curtis, 2015, p. 1) when they mature from childhood into an adult, becoming independent from their parents and taking on key social roles. The biological changes associated with puberty are generally accepted as being the start of adolescence but the end of this life phase is not clearly determined (Sacks, 2003). Age and social roles are commonly used to define adolescence but these differ with time and between cultures (WHO, 2014). More recently, research also suggests that this transitional period is taking longer (Clark, 2007) with adolescents in some parts of the world appearing to experience puberty earlier and changes in society and social roles, along with increasing knowledge regarding brain development,

pushing the end of adolescence later (Arnett, 2000; Crosnoe & Johnson, 2011; Sawyer et al., 2012). These ambiguous borders make defining adolescence very difficult, resulting in confusion for young people and potential serious implications for education, healthcare and the legal system (Ledford, 2018; Steinberg, 2014).

Prior to the start of the nineteenth century, young individuals were referred to as 'Youth' with little attention paid towards this specific period of life (Demos & Demos, 1969). It was the American psychologist, G. Stanley Hall also known as the 'Father of child study' (Grinder, 1969, p. 355) who raised its profile by publishing numerous papers on his theory of adolescence. Strongly influenced by the theory of evolution, Hall outlined his thinking in his 1904 comprehensive work titled *Adolescence: It's Psychology, and It's Relations to Physiology, Anthropology, Sociology, Sex, Crime, Religion, and Education* (Hall, 1904) suggesting a theory of recapitulation, where young people enter a process of psychosocial rediscovery and reorder, or 'rebirth' (Muuss, 1968). Hall fostered the notion that development during adolescence was abrupt rather than gradual (Dubas et al., 2003) and a period of 'storm and stress' where young people fluctuated between conflicting impulses such as happiness and depression, and sensitivity and cruelty (Demos & Demos, 1969). At the time, many of Hall's ideas were challenged by other well-known psychologists including Thorndike and Hollingworth (Dubas et al., 2003), and over 100 years later such suggestions of transmission of acquired characters or the Lamarckian Theory of Evolution (Burkhardt, 2013) and psychosis as a result of masturbation seem absurd but yet, many of Hall's ideas now form the 'core knowledge of the field of adolescence' (Arnett, 2006, p. 190). In particular, his opinions that adolescence is a phase where depression is more common, where there is a heightened need for sensation-seeking, and that media can exert a negative influence, were ahead of their time and remain influential today. Hall's concerns about the media reflected a belief that adolescents, as they navigate identity formation and increased emotional sensitivity, may be particularly susceptible to harmful content or unrealistic portrayals that could influence mental health, self-esteem, or behaviour. He also highlighted biologically-based differences in growth rates within the body and between genders (Arnett, 2006; Dubas et al., 2003; Ledford, 2018). Furthermore, Hall also emphasised not only that environmental factors were important, but that their influence increased during adolescence, as young people become more socially aware, increasingly autonomous from caregivers, and more engaged with broader peer and cultural contexts (Branwhite, 2000; Grinder, 1969), a theory built on later by psychologists including Lewin and Bronfenbrenner with the concept of the Ecological Theory of Human Development (Bronfenbrenner, 1979).

Different perspectives exist in relation to adolescence; it is often referred to as a modern phenomenon originating in the 19th century (Arnett, 1999) however this life stage has been referred to in historical literature many times. Aristotle described youth as changeful, passionate, hopeful, fickle and prone to sexual desire with no self-restraint (Kiell, 1969), concluding 'the young are heated by nature as

drunken men by wine' (Dobbs, 2011, p. 37). Similar characteristics of youth are portrayed in books written by religious and moral leaders in the 17th century, with examples found through to the 19th Century and the writings of G Stanley Hall (Arnett, 1999). A commonality throughout these writings is the perspective that these characteristics in young people needed to be managed and in some cases such as sexual desires, suppressed. Without appropriate control, young people posed a unique danger to society (Fox, 1977, p. 278). For centuries, marriage and labour were ways of applying such control, and viewed as training for adulthood. These perspectives continued throughout the centuries but the control mechanisms altered as society evolved, and young people began to gain economic independence (Hanawalt, 1992).

During the time of G. Stanley Hall in the late 1800s and early 1900s, race, sex and class became the foundations for the progression and degeneration of existing and future civilisations. Great change was taking place and at a very rapid speed. Industrialisation was occurring, creating profound social and cultural shifts, confusion and unease, particularly in the white middle classes of America and Europe who felt the changes were threatening to traditions and social order of the time (Lesko & Topping, 2012). Young white boys were considered central to the progress of civilised nations, so adolescence became a 'multi-level entity', used as a platform to discuss unwanted racial changes as well as bringing issues of sex and class into the conversation (Lesko & Topping, 2012, p. 38). The resulting impact of this created social segregation, of which adolescence was an active part.

Only middle-class White adult males were considered 'civilised' (Lesko & Topping, 2012, p. 17) with hierarchies and comparisons applied to everyone else based on their race, sex and class. This was physically displayed in 1893 in the 'Great Chain of Being' at the World's Columbian Exhibition where architecture and spatial layout were used to rank order species from least primitive to most civilised (Lesko & Topping, 2012, p. 16). In this evolutionary set-up, European white middle-class males sat at the top followed by white women, savage tribes (non-White men and women) and then animals. The popular recapitulation theory offered by G Stanley Hall became the central theme across many scientific disciplines (i.e. anthropology, psychology and child study) and compared children with animals and savages due to their apparent lack of discipline, civility and basic instincts (Garrison, 2006). Insinuating 'primitive as child' helped perpetuate the racist and colonial message (Johnson, 1995), which was repeated often in writings about travel, child rearing and popular culture.

One of the many changes to occur during this period was the traditional role of the female and the emergence of the 'New Woman' (Siegel, 1985). Women were increasingly challenging the privilege held by White males and in turn their masculinity associated with the power and control they enjoyed. Equality was sought and as a consequence, higher numbers of women enrolled in education and were employed, along with rising voices calling for fairer wages and voting rights (McClintock, 1995). This shift in the gender roles was seen as a danger to future progress of the nation, threatening masculinity (the superior male) and described by the Positivist Lawyer, Frederick Harrison, as to

‘bring about the ruin of civilisation, return all of us to a condition of "Barbarism."’ (Siegel, 1985, p. 212).

These historical anxieties were underpinned by assumptions about race and gender that were treated as natural and self-evident at the time. It is important, however, to recognise that race and gender are socially constructed categories rather than fixed biological realities. Although bodily differences exist, the meanings attached to racial and gender classifications are produced and reproduced through particular historical, political and cultural processes (Omi & Winant, 2015). In the late nineteenth and early twentieth centuries, racial hierarchies were reinforced through colonial ideologies and scientific racism, positioning whiteness as civilised, rational and superior (Bonilla-Silva, 2018). Whiteness functioned not simply as a racial descriptor but as an unmarked norm against which other groups were measured (McIntosh, 1988; Ahmed, 2007). Within early developmental theory, the imagined adolescent subject was frequently white, male and middle-class, reflecting and reinforcing these hierarchies. Recognising race and gender as socially constructed enables a more critical reading of how adolescence was conceptualised and how particular identities were privileged within psychological and social theory. This perspective also provides an important foundation for the intersectional analysis developed later in this chapter.

Alongside race and gender, class – particularly as framed through concerns about national strength and degeneration, also played a central role in shaping constructions of adolescence, again with a primary focus on males. Young males were viewed as key to a successful future and so it was felt necessary that they be guided and prepared for this by adults focusing on their education, masculinity, beliefs and health, all based on middle and upper class ideologies. Those that did not fit the ‘norm’, for example due to poor health, poor physical fitness, or involved in antisocial or immoral behaviours were considered degenerate and a threat to national identity and power (Lesko & Topping, 2012). This was of particular concern following the Boer War in the early 1900s in Britain where panic occurred due to the state of the health and well-being of the population, described as physically deteriorated (Dyhouse, 2012) and young men viewed as being weak (Baden-Powell, 1908), taking on adult-like behaviours that for an adolescent were still considered prohibitive such as drinking, gambling and sexual activity (Fox, 1977). Not only did this give rise to the association between young people and social problems (Macleod, 1983), an association that still exists today with adolescence, but also organisations such as the Boy Scouts and Girl Guides (Pryke, 1998). Women were partly blamed for this degeneration of the nation because of their apparent neglect of home and domestic duties (McCrindle & Rowbotham, 1977, p. 218). In response, girls were encouraged to focus on domestic subjects in schools including cookery, hygiene and childcare (Dyhouse, 2012) and directed away from participating in sports so that they could be moulded into ‘efficient women citizens, good home-keepers and mothers’ (Dyhouse, 2012, p. 114). Quite the opposite, boys were offered competitive sports programs, after school activities and encouraged to stay in school longer (Lesko &

Topping, 2012). Outside of school, the Boy Scouts and Girl Guides were established to help promote masculinity and domestication respectively (Lesko & Topping, 2012). In 1914, seven years after its launch in Britain, the Boy Scouts had become the largest youth movement in the world providing training in appropriate citizenship service, discipline and out-door activities (Mills, 2011) as well as responsibility for one's own personal health and towards other people (Lesko & Topping, 2012). Increasingly, the perspective was that independent young people were threatening and being drawn into hooliganism (Lesko & Topping, 2012); the anxieties, hopes and fears of the nation were projected onto young people and as the key to the future, there was a move towards slowing development and socialisation, which the Scout movement (including the Girl Guides) contributed to.

The adolescent period became labelled as the 'perpetual becoming' (Macleod, 1983, p. 23) and real changes took place in the structure of adolescent lives. In England, education had been recognised as a national responsibility since the introduction of the 1870 Elementary Education Act, however attending school was not compulsory nor free until the early 1900s (Stephens, 1999). As this changed, part-time and seasonal school attendance which had previously been custom disappeared, and full-time attendance was expected. The class system that existed in society was reinforced with the creation of different school types, elementary for the 'masses'; grammar schools for the 'middle-class' and public/ private schools for those considered 'great' (Gillard, 2018). Recognisable certification on completion of studies became an important factor for a route into good employment opportunities, further stratifying young people by class and race.

With the industrial revolution came more jobs and better wages. This encouraged young people, particularly those from working class backgrounds, to relocate from the rural areas and smaller towns to the larger urban cities (Lesko & Topping, 2012). This created a new breed of independent young people, no longer economically reliant on parents and for those that had migrated, a sense of freedom from direct adult oversight (Hanawalt, 1992). They had time and their own money allowing them to pursue activities of interest and seek out others of similar thought and behaviours based on identifying features like clothes, hairstyles, language (slang) and ideologies (Garland et al., 2012). Activities became 'youth created and dominated' (Hanawalt, 1992, p. 347) and peers, rather than adults, became the controlling influence of when adolescence began and ended. Using the description proposed by Benedict Anderson of imagined communities (Anderson, 1991), young people came together for various different reasons seeking and establishing their own identity (Fox, 1977), forming clubs for leisure such as dancing as well as groups with similar behaviours, i.e. gangs. The latter giving rise to an association with antisocial behaviour and juvenile crime. Due to adolescents not being recognised as children or adults and thus, not fully responsible, young people involved in such behaviour were viewed from a different perspective and not as 'hardened criminals' (Hanawalt, 1992, p. 348). The different treatment of young people in respect to the juvenile system, along with educational age

segregation, youth services expansion and later National Service (1948), contributed to the identification of young people as a distinct social group (Garland et al., 2012).

Following World War 2 (WW2), youth employment was buoyant and wages grew exponentially for young people, an estimated average of 400% in the UK (Fowler, 1995, p. 93; Ministry of Education, 1960) and much faster than adult earnings (Abrams, 1959). Subsequently, young people had disposable income to spend and were often referred to as 'youth with affluence' (Osgerby, 2011g). In reaction to this, there was substantial expansion of the commercial youth market and creation of the 'teenager-as-consumer' (Garland et al., 2012, p. 266). As well as cinemas and dance halls, young people were enticed by magazines, cosmetics and music, accompanied by an increase in radio and television media directed at the youth audience. Although subcultures had existed prior to WW2 amongst young people, for example, gangs known as Peaky Blinders (Osgerby, 1996), the economic and social circumstances in the 1950s allowed this to flourish and continue to do so through the following decades from Teddy Boys (1950s), Mods and Rockers (1960s), Punk (1970s), Generation 'E' (1990s) to Millennials (2000 onwards) (Lesko & Topping, 2012; Osgerby, 2011a, 2011b, 2011c, 2011d, 2011e, 2011f, 2011g). With each subculture, there has appeared to be a continuing association of delinquency and 'moral panic' (Cohen, 2011), often exaggerated by media and politicians of the time. However again, this is often a reflection of the worries within society of social changes and uncertainty as described by Garland et al. (2012):

> Youth was not only recognised - albeit rather amorphously - as an intermediate stage between childhood and adulthood, but also served as a metaphorical device to embody both the aspirations and anxieties of a particular historical time. Youth could be a harbinger of change, an emergent consumer, a signifier of hope, or a portent of social decline. In other words, youth was a social construct shaped in accordance with a variety of socio-economic, cultural and political determinants; its meaning - and its relationship to wider society - could vary according to the context. (p. 265)

2.3.1 Age definitions

It is important to acknowledge that the adolescent experience is vastly different for all young people, with many individual, sociocultural and economic influences. However, to enable these young people to thrive and reach their full potential it is vital that there is clarity in the language used to describe adolescence, its boundaries and its various sub stages. In westernised societies systems such as education and healthcare commonly apply arbitrary chronological thresholds, thus for such systems to be accessible and work for young people, adolescents as a group need to be recognised. As stated by Anne-Lise Goddings in relation to funding for research into adolescence 'it's hard to give money to something when you can't say what it is' (Ledford, 2018, p. 430).

Defining adolescence appears to be a problem dating back centuries. Latin texts from the Middle Ages referred to schemes of Ages with *adolescentia* being one such life stage that *adolescens*, individuals passed through (Dunlop, 2003). Often these schemes of Ages differed between texts, were

based on males and were not chronologically denoted. It was in 1440 in the 'Promptorium Parvulorum' that *adolescentia* was defined as the period between the ages of 15 and 29 years (Galfridus & AL., 1908), although how this was decided or whether this life stage corresponds to what is understood by adolescence today is unclear (Schultz, 1991). Over 400 years later, Hall's conception of adolescence spanned the ages of 14-24 years (Arnett, 2006) and as the 19th century has progressed, the chronological age definition of adolescence has continued to vary depending on the source. In their theories of intellectual and psychosocial development, the psychologists Piaget and Erikson suggested that adolescence started at the age of 12 years and continued until adulthood (Erikson, 1956; Orey, 2010). For the purposes of paediatric healthcare in the United States of America, the American Academy of Paediatrics identified adolescence as 11-21 years in 1988, repeatedly recommending this age range in 2012 and 2015 (American Academy of Pediatrics Council on Child and Adolescent Health, 1988; Hagan et al., 2015; Hardin et al., 2017). In contrast, paediatric health services in the UK do not define adolescence but include children up to the age of 19 years, with an aim to increase this to 25 years by 2028 (NHS, 2019). Sawyer and colleagues used an expanded definition of adolescence of 10-24 years in their paper published in The Lancet in 2018, with the reasoning that this age span was more reflective of contemporary adolescence (Sawyer, 2018; Sawyer et al., 2012). This is used by the United Nations in its report on 'Adolescence: An Age of Opportunity' (UNICEF, 2011). The age definition widely recognised globally is that given by The World Health Organisation (WHO) which states that an adolescent is aged 10-19 years, with those aged 10-14 years referred to as 'Young adolescent' and 15-19 years, 'Older adolescent' (WHO, 2017, p. viii). Key organisations and researchers in the UK, including the Chief Medical Officer, The Royal College of Paediatrics and Child Health and the Association for Young People's Health (Hagell & Shah, 2019; RCPCH, 2020; Viner, 2012) also use this (Table 2.1).

Table 2.1 Definitions of adolescence, years and stages.

Author	Adolescence, years	Stages of adolescence
Promptorium Parvulorum, 1440 (Galfridus & AL., 1908)	15-29	
Hall (1904)	14 - 24	
Erikson (1968)	12-adulthood	
American Psychological Association. (2002)	10-18	
Sawyer et al. (2012)	10-24	10-14 years, early adolescence; 15-19 years, late adolescence; 20-24 years, young adulthood
WHO (2017)	10-19	10-13 years, early adolescence; 14-16 years, middle adolescence; 17-19 years, late adolescence
United Nations General Assembly (1981) (UNDESA, n.d.)	15-24	
Viner et al. (2012)	10-19	
Hagell and Shah (2019)	10-19	10-24 years, young people; 15-24 years, youth; 20-24 years, young adults;

2.3.2 Social and cultural boundaries

A cross-cultural study undertaken by Schlegel and Barry (1979) demonstrated that adolescence was a 'Human Universal' (Ember et al., 2017), existing in almost all societies. Although there was great variation, one of the commonalities found was the blurred start and end points often based on biological and societal events with links to culture, history, religion and law (Newman & Newman, 2020). Puberty is commonly used as a biological indicator for the start of adolescence but the end tends to be social events that are associated with adult roles. Within contemporary westernised society, these are the social processes of marriage, moving out of the family home and having children. All of these events, whether biological or social, occur at different times for individuals as well as being influenced by wider structural factors. For example, in 1968 in the UK, the average ages of women getting married and having their first child were 22 and 23 years respectively, approximately 9-10 years following menarche, their first period (House of Commons Library, 2012). In comparison to figures from 2018, the average age of women getting married was 36 years and the average age of motherhood started earlier at 31 years, a gap of at least 21 years from puberty (ONS, 2019a, 2021a). This pattern is reflected in education, where young people are studying longer, and in employment. Economic conditions combined with national and regional policy have increased the cost of living and cost of secure housing meaning many young people cannot afford to move out of the family home as young as they once did. Similarly, reduced cultural and familial traditions with influences from globalisation and increased access to media have also contributed to this. The delayed

undertaking of such social events and elongated adolescent period also results in a much bigger window for exploration and increased risk-taking behaviours. At a time that 'falls between two stools', i.e. between childhood, a time focused within the family, and adulthood, a time of independence, that is full of transition and when many health-related behaviours start, adolescence is a unique period for the wider factors to affect health. Wealth and income, education, environment, family and peers/ social network have all been identified as being important during this life stage (Hagell et al., 2018; Viner et al., 2012).

2.3.3 Adolescent development

The adolescent period is unique due to the many physical, psychological and social changes which take place as a child begins the process of maturing and transitioning into an adult. There are many theories of how the development during this phase takes place, with varying perspectives. They tend to fall into one of four categories - biosocial, organismic, contextual or sociological (Table 2.2), and although there is no single agreed theory, many of them follow a similar concept to that which was established during Greek times. That is that life is a sequence of stages, adolescents are generally considered different to children and they (development theories) are structured around specific tasks or adult competencies (Fox, 1977).

What is lacking in many development theories, particularly the biosocial (Hall) and organismic (Freud, Erikson and Piaget) is the acknowledgement that young people are part of a system, with their position in that system dependent on factors such as relationships and tasks (internal and external) (Christie & Viner, 2005). A biopsychosocial model addresses some of this criticism as it considers the complex interconnected roles of biology, psychology and socio-environmental factors (Dodge & Pettit, 2003), all of which play an important role during adolescence.

The successful achievement of the many tasks a young person needs to accomplish to reach adulthood requires negotiation of a myriad of interacting internal and external changes. Further unique challenges arise associated with risk taking behaviours when this volatile mix combines with health (Christie & Viner, 2005).

Table 2.2. Theories of adolescent development (Arizona State University, n.d.; Curtis, 2015).

	Theorists	Theory
Biosocial	G. S. Hall (1844-1924);	Recapitulation
Organismic	S. Freud (1856-1939)	Psychoanalytic/ Psychosexual
	A. Freud (1895-1982) P. Blos (1904-1997)	Psychoanalytic/ Psychosexual (Neo Freudians)
	E. Erikson (1902-1994)	Psychosocial
	J. Piaget (1896-1980)	Cognitive
	L Kohlberg (1927-1987)	Moral development
	J Fowler (1940-2015)	Faith development
	A.Gesell (1880-1961)	Maturational-developmental
	R Selman (1942-)	Social cognition
Contextual	BF Skinner (1904-1990)	Operant/ psychological conditioning
	A Bandura (1925-)	Social learning
Sociological	U Bronfenbrenner (1917-2005)	Ecological
	L Vygotsky (1896-1934)	Social constructionism
	K Lewin (1890-1947)	Behavioural science
	P Levin R Havighurst (1900-1991)	Developmental task
	K Mannheim (1893-1947)	Concept of generations
	J Coleman	Focal
	R Lerner (1946-)	Developmental contextualism
	C Gilligan (1936-)	Moral development/ feminist perspective
	M Mead (1901-1978)	Anthropological

2.3.3.1 Physical development

Puberty, neurobiology and psychosocial are three important areas of adolescent development (National Academies of Sciences Engineering and Medicine, 2019) leading to internal and external changes, and influencing behaviour. Described as 'one of the central biological dramas of human life' (Viner, 2012, p. 3), puberty is a gradual process and instigated by the brain, it involves hormone production and changes through mechanisms known as adrenarche, gonadarche and activation of the growth axis (Blakemore et al., 2010). Puberty is associated with adolescence as the process tends to occur during this life stage, however it is known that adrenarche can begin as early as 6 years old (Patton & Viner, 2007) and may continue into the 20s (Dorn et al., 2006; Gerhardt et al., 2009). The purpose of the pubertal process is sexual maturation thus biologically, adrenarche is the development of the adrenal system which produces adrenal androgens and gonadarche is the increase in gonadal

steroid hormones as a consequence of the reactivation of the hypothalamic-pituitary-gonodal (HPG) (National Academies of Sciences Engineering and Medicine, 2019). Along with changes in growth hormones, all of these processes result in physical changes to the body including body odour, skin change, growth spurts, primary and secondary sex characteristics (Blakemore et al., 2010; Dorn et al., 2006; Hagell & Shah, 2019; SPEG MNCN, 2019). Additionally, girls also experience menarche in later puberty (Patton & Viner, 2007).

2.3.3.2 Brain development

Along with puberty, significant changes take place in the brain described as 'second only to infancy in the extent and significance' (National Academies of Sciences Engineering and Medicine, 2019, p. 46), preparing it for adolescence. This major reorganisation of the brain is particularly associated with emotional and cognitive modifications (Konrad et al., 2013) so that a young person can mentalise, that is to have the 'ability to reflect on the emotional, instinctive responses in ourselves and others' (Anna Freud NCCF, n.d, p. 1), be more adaptable to their environment and be able to empathise. Each of these abilities assist young people in their transition to adulthood developing more analytical thinking and the ability to learn from their experiences. The darker aspect to this brain development is that it 'also makes them vulnerable to dangerous behaviours and serious mental disorders' (Giedd, 2015, p. 34). A particular characteristic that is heightened during adolescence is the attraction towards risk-taking driven by the desirability of new experiences and rewards. In early adolescence this tends to be propelled by impulsivity, and a lack of acting without thinking (Romer et al., 2017), moving more towards 'sensation-seeking' tendencies as adolescence progresses. As further cognitive development takes place, there is more capacity for self-control and a move to more purposeful thinking, thus this risk-taking behaviour then tends to decline (Steinberg, 2008).

2.3.3.3 Psychosocial development

For young people, understanding and managing the physical and mental changes taking place can be challenging, and contribute to behaviour change. At the same time, their outlook broadens so that they begin to question 'who am I?', described as a 'central task of adolescence' (National Academies of Sciences Engineering and Medicine, 2019, p. 60), as well as considering their own position in the world, debating and questioning society's issues, and starting to consider the bigger picture of the future. This is all influenced by the young people's environment - their family, friends, living circumstances, media and lived experiences (Berenbaum et al., 2015; Coleman, 2011). As a child, the principal relationships are usually with family and, although these remain important through adolescence, friends and peer groups become significant and influential (Brown & Bakken, 2011). This expansion of relationships reflects the development of the young people's network as they move towards more independence.

2.3.4 Adolescent health

Health has been recognised globally as a fundamental right, written into both the Universal Declaration of Human Rights (1948) (United Nations, 1998) and the International Covenant on Economic, Social and Cultural Rights (1966). It is much more than illness and infirmity, it is much more than the individual, it is the foundation that enables people to enjoy a long and fulfilling life, be active and have the ability to cope with stresses and strains, in turn it facilitates them to participate in wider society and support the well-being of their community. Good health and well-being should also be equal for all as ‘a matter of social equity and justice’ (Sen. A 1985 in The Health Foundation, 2018, p. 12). This is recognised in the definition provided by WHO which states health is ‘a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities’ (WHO, 1986); it also lists a number of prerequisites fundamental for health including peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity (WHO, 1986). These fundamentals are applicable to everyone, however for young people there are some unique and specific issues that they have to manage. The developmental changes they experience make them particularly vulnerable to the impact of the wider environment (Viner et al., 2015) thus the importance of each of the listed fundamentals cannot be emphasised enough.

There is a perception that for young people the adolescent period is the ‘healthiest time of life’ and that they have fewer needs (Giedd, 2015; Patton & Temmerman, 2016) but during the last 50 years all other age groups have seen greater health improvements. With the success in improving global child health and mortality (Horton, 2022), and the acknowledgement that a good start in life is vital for a better future, there is renewed focus on the health of adolescents. As well as being referred to as ‘overlooked’ (Patton et al., 2016, p. 2423) and ‘nearly invisible’ (Viner, 2012, p. 3) in the context of health, the importance of adolescence has increased as more has been learnt about the changes and development that takes place, and the significant role it plays in the life course: -

- Good health and particularly well-being in childhood and adolescence, helps young people as they transition through the turbulent phases and many developmental changes they will experience.
- Adulthood is underpinned by learnt knowledge, experiences and behaviours gained in adolescence. A healthy, stable and secure young person is more likely to evolve into a successful adult - living a long healthy life, developing secure relationships and having the capacity to positively contribute to society.
- All of the health attributes important during adolescence and adulthood support healthy parenting. Health behaviours viewed as risky and often first experienced during adolescence such as smoking, substance misuse and drinking alcohol not only can affect the health of the

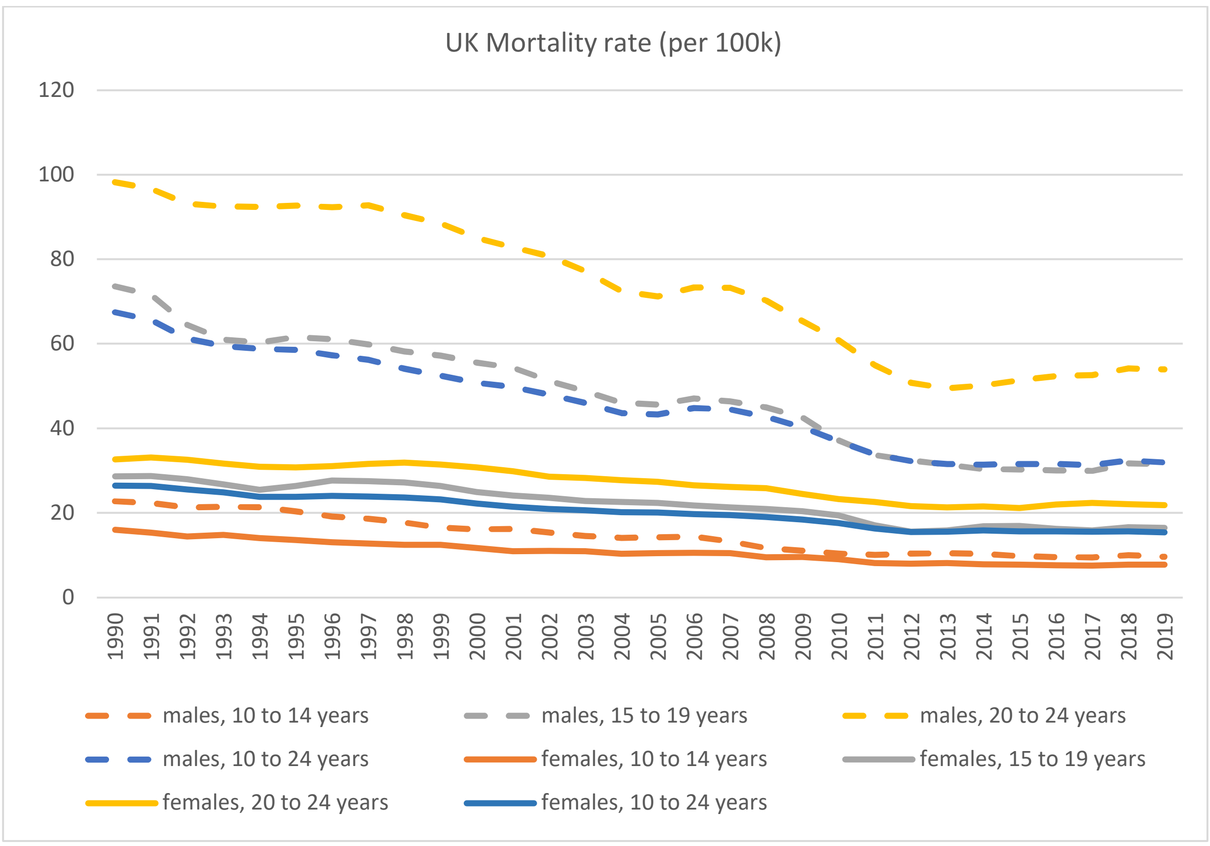
parents but also their offspring, thus encouraging good health and health behaviours during adolescence can bring generational benefits (Patton et al., 2016).

In 2019, there were 1.2 billion adolescents (aged 15-24 years) living across the world, accounting for 16% of the world's population (UNICEF, 2019). Numbers vary greatly between countries, for example in low-income countries young people account for up to 23% of the population compared with 10% in countries considered high-income, i.e. those in Western Europe and Asia (UNICEF, 2019). These differences are expected to grow due to 'youth bulges', a phenomenon experienced in many developing countries where young people represent a disproportionally large group of the population (Lin, 2012), whilst many high-income countries are likely to experience shrinkage in the proportion of young people (Friedman, 2014). Population variances are a reflection of the health of the population and its epidemiological transition (Sawyer et al., 2012); high fertility rates, reduced infant mortality and improved child health have not only changed population structures but also shifted the burden of disease (Jimenez & Murthi, 2006; Patton et al., 2016; Pearce, 2013).

Within the UK, young people aged 10-24 years account for 17.5% of the population (11.6 million) with little change in the past 10 years (ONS, 2021b). One in five young people (aged 10-19 years) in England and Wales identified themselves from a minority ethnic background in the 2011 census, a higher proportion than the general population (ONS, 2019e). Although not the experience for every young person, from early to late adolescence most young people are in education of some type and live with families, either parents that are married, cohabiting or lone parents (94%) (Hagell & Shah, 2019; ONS, 2016). As they enter young adulthood (18 years onwards) and the broadening of future prospects, the experiences of young people diverge into higher education, employment, training or unemployment. Many young people remain living with their family throughout their 20s, a trend which has increased over the years; by the age of 24 years approximately 60% of young adults had left home in 2017 compared with over 70% in 1997 (ONS, 2019f).

In relation to health, the mortality rate for young people in the UK is low at 15.9 deaths per 100,000, aged 10-19 years in 2015 (Shah et al., 2019) compared to both global rates (11 deaths per 1000 adolescents in 2020) (WHO, 2022b) and those in countries similar to the UK including Australia, Canada, USA and many other European countries. Shah et al. (2019) reported out of 19 countries, the UK had the fifth lowest all-cause mortality rate, with considerable declines over time (Figure 2.1). However, around 2012 this downward trend plateaued, particularly for males in older adolescence and young adulthood (20-24 years), and increases have been noted since amongst girls (15-19 years) (Global Burden of Disease Collaborative Network, 2020). This is concerning as over the same period, rates have improved for young people in similar comparable countries (Ward et al., 2020), and health and mortality in young children has improved in the UK. Additionally, although low, adolescent mortality remains at an unacceptable rate (Salam et al., 2016) with a significant proportion of deaths preventable (Sawyer et al., 2012; Viner, 2012).

Figure 2.1. UK all-cause mortality rate, per 100,000 population by age group and sex, 10-24 years (Global Burden of Disease Collaborative Network, 2020).



As with any life stage, young people experience a considerable burden of ill health due to disease and disorders limiting their everyday activities and opportunities to be socially engaged (Gore et al., 2011; Salam et al., 2016). The burden of disease is usually presented using the measure 'disability-adjusted life years' (DALYs), an indicator of the number of years lost due to ill health and early death (Murray & Lopez, 1999). Using data from the Global Burden of Disease Study, young people in high-income countries had a lower overall burden than those in low and middle-income countries, with an estimated 82 DALYs per 1000 population (10-24 years) (Gore et al., 2011). In 2016 in the UK, the overall DALY rate for this age group was an estimated 28 DALYs per 100,000 (Hagell & Shah, 2019) and in contrast to adolescent mortality, the UK had the fifth highest DALY rate meaning young people in the UK appeared to experience a greater burden than other similar high-income countries (Hagell & Shah, 2019).

The main health issues that young people experience are listed below, with the first three all included in the top ten leading causes of global mortality and disability. (Patton et al., 2016; Slogrove & Sohn, 2018): -

- Injuries (intentional and unintentional)
- Non-communicable diseases (NCD) including mental health

- Infectious diseases including HIV
- Overweight and obesity
- Alcohol and drug use
- Tobacco
- Sexual health and early pregnancy

2.3.4.1 Injuries

Mirroring the global picture and sometimes referred to as 'external causes', injuries are the most common cause of mortality and disability in the UK. This reflects the 'underlying risk profiles' of young people which has shifted away from childhood diseases (Salam et al., 2016; Vos et al., 2020; WHO, 2022b, 2022c). Including self-harm, road traffic accidents, assault, drowning and other accidents, this group accounted for over 1200 deaths amongst 10-24 year olds in England and Wales in 2018, and 50% of all deaths amongst young people (ONS, 2022b). A large proportion of these deaths were attributed to transport accidents or intentional self-harm, where the UK has fairly low rates compared with New Zealand, Canada and Ireland, and many other similar countries (Shah et al., 2019; Ward et al., 2020). As young people age, differences between males and females in terms of mortality and disability become more evident. A pattern seen globally, more young men die of external causes than young women in the UK, with studies reporting young men are three times more likely to die of violence (intentional injury) (RCPCH & University College London, 2013) and four times more likely to die of suicide (NCISH, 2017).

Also included within the external causes group is bullying, recognised as another form of violence. Bullying is common in schools across the world and experienced by a significant amount of adolescents. Prevalence rates vary widely due to different populations and questions used, in the UK these range from 22% to 66% amongst young people aged 10-15 years (Ditch the Label, 2018; HSCIC & NHS Digital, 2015; Roberts et al., 2020). In a survey of 17 European member states undertaken in 2018, England had the 2nd highest rate of reported bullying (OECD, 2019). Bullying can take many forms; physical bullying is more common amongst younger adolescents (10-14 years) and males, with rates decreasing with age (Biswas et al., 2020; WHO, 2016), however cyberbullying is now an increasingly worrying trend due to the growth of social media. Experiencing bullying can have wide implications spanning into adulthood, a systematic review exploring the consequences of bullying included 165 articles and found strong causal relationships with poor health, depression, anxiety, suicidal ideation and behaviours, and probable causal relationships with smoking and illegal drug use (Moore et al., 2017).

2.3.4.2 Non-communicable diseases (NCDs)

Along with external causes, non-communicable diseases (NCDs) are a major cause of adolescent mortality and disability accounting for 27% of deaths (Ward et al., 2021) and 56% of the total global adolescent (10-24 years) DALYs burden (Armocida et al., 2022). The majority of countries, including the UK, are considered NCD predominant where 50% of all deaths in young people in the UK are due to this group (ONS, 2022b) and an estimated 7829 DALYs per 100,000 in 2019, the highest DALY rate amongst the EU member states (Armocida et al., 2022). NCDs have been described as a 'growing public health crisis' (Akseer et al., 2020, p. 2) as rates continue to increase worldwide particularly in high-income countries (Guthold et al., 2021). The group includes chronic diseases such as cardiovascular diseases, cancers, chronic respiratory diseases (such as chronic obstructive pulmonary disease and asthma), diabetes, somatic (headaches) and mental health conditions, many of which are often referred to as 'diseases of adulthood' although this is a misconception (NCD Alliance, 2011). Research has established the critical role that the adolescent period plays in relation to NCDs, demonstrating that many of the fundamental risk factors that lead to NCDs, develop during this period (Beaglehole et al., 2011; Gore et al., 2011; Patton et al., 2016).

One of the unique characteristics of the adolescent life stage is the exploration and establishment of identity, where 'social, cultural, emotional, educational and economic resources' (Patton et al., 2016, p. 2427) are assembled as a foundation for future health and wellbeing. As part of this, many health-related behaviours are introduced and adopted, which may be health promoting as well as harmful (McKeown & Hagell, 2021; Salam et al., 2016; Viner, 2012) including physical activity, diet, smoking, alcohol and drug use. These have also been identified as significant factors in the development of NCDs and poor future health.

2.3.4.3 Overweight and obesity

Healthy dietary habits and regular physical activity are critical for current and future physical health. While malnutrition remains a global challenge (WHO, 2021c), in the UK, overweight and obesity are of particular concern. These conditions are linked not only to physical health complications such as type 2 diabetes and cardiovascular disease (Freedman, 2004; McCrindle, 2006) but also to psychosocial issues, including weight-related stigma (Read, 2019). Prevalence is high from an early age, with 34.3% of adolescents in England classified as overweight or obese (NHS Digital, 2020), a trend consistent with findings from the Millennium Cohort Study at age 17 (Fitzsimons & Bann, 2020). Socioeconomic disparities are pronounced: young people from low-income households are twice as likely to be overweight or obese compared to their more affluent peers (Fitzsimons & Bann, 2020). These patterns mirror broader inequalities in health behaviours, including physical inactivity and poor diet (HSCIC & NHS Digital, 2015), and are reflected across Europe (Mayor, 2017).

Regular physical activity enhances not only physical health but also social and psychological well-being (Malm et al., 2019). Despite its benefits, sedentary behaviour has increased, with a majority of young people in the UK not meeting recommended activity levels (Sport England, 2021; Guthold et al., 2020). Gender disparities persist, with boys more active than girls globally (Guthold et al., 2020). While the COVID-19 pandemic initially disrupted physical activity due to lockdowns (Stockwell et al., 2021), activity levels among young people in England have since stabilised (Sport England, 2021).

2.3.4.4 Smoking

Risk-taking behaviours that are established during adolescence and that have been found to cluster together include smoking, alcohol use, substance use and risky sexual behaviour (Wiefferink et al., 2006). Tobacco use is a major concern as most adults smoking today began during adolescence, with two out of three starting by age 18 years (HSCIC, 2015b; WHO, 2021a). It is a leading cause of preventable illness (NHS Digital., 2017) and directly impacts health, causing respiratory illness in the short term, and recognised as a major risk factor for NCDs such as cancer in the long term (Hagell & Shah, 2019; Patton et al., 2016). Data from the portal 'Smoking in England' indicates that in 2019, cigarette smoking prevalence was estimated to be 8.7% for 16-17 year olds, increasing to 16.7% for those aged 18-21 years (West et al., 2022). There is a lack of comparable survey data for cigarette prevalence amongst young people both nationally and internationally; where it has been estimated, prevalence in Wales was 3.6% self-reported smoking (11-16 years) (Public Health Wales, 2020), in Scotland 7% were regular smokers (15 years) (The Scottish Public Health Observatory, 2022) and in a group of 17 westernised countries, daily prevalence ranged from 8-32% (18-24 years) (Shah et al., 2019). Cigarette smoking had been in decline for over a decade but following the COVID-19 pandemic, prevalence appears to have increased in young people (West et al., 2022).

Since their introduction in 2006 (O'Brien et al., 2021), e-cigarettes have become increasingly popular as they are often viewed as a less harmful alternative to (combustible) cigarette smoking (Hilton et al., 2016). There is ongoing debate regarding their effects on health (Green et al., 2018; Marques et al., 2021) and if they potentially increase the risk of traditional cigarette use in adulthood (Jones & Salzman, 2020; Miech et al., 2019; O'Brien et al., 2021). Surveys in the UK and USA have reported that approximately 20% of young people (11-17 years) had tried e-cigarettes in 2018 (Bauld et al., 2017), with this estimate rising for older adolescents (16-24 years) to 31% in England (NHS Digital., 2020). Current e-cigarette use amongst young people in England is much lower, 7% and 5% for young men and women respectively (16-24 years) and it has remained relatively stable between 2016 and 2019 (NHS Digital., 2020).

2.3.4.5 Alcohol

Similarly, alcohol is a worrying issue due to its immediate and long-term health effects. Being under the influence of alcohol can lead to reduced inhibition such that judgement can be impaired and risky

behaviours increased (Brown & Taper, 2004). Smoking, drug use, unsafe sex are all associated with alcohol use (Drobes, 2002; Felson et al., 2020; Royal College of Physicians, 2011; Schmid et al., 2007) as well as it being a significant contributor to injuries, violence and premature deaths (Marshall, 2014). As with smoking, there is a difference between younger and older adolescents in their alcohol habits. Using data from a multitude of surveys, prevalence of regular drinking (defined as alcohol in the last week) amongst younger adolescents (11-13 years) was 6% or lower, and for those aged 15 years between 14-20% in Scotland and Wales, and 24% in England (Inchley et al., 2020; Ipsos Mori, 2015; Ipsos Mori Scotland, 2019; NHS Digital., 2017). There have been significant declines in alcohol consumption over the last 12 years amongst young people aged 16-24 years in Great Britain, with 48% reported as drinking alcohol in the last week in 2017 compared to 60% in 2005 (ONS, 2018). Increased awareness along with changes to licensing and legislation have helped to contribute to this decline, witnessed in many countries as well as the UK including USA and many European countries (Shah et al., 2019). The amount consumed has also declined but much more slowly and young people still have higher consumption rates when they do drink compared with older age groups (ONS, 2018). This appears to be a trend amongst young people as a report comparing substance use in 36 countries reported 29% young girls (age 15 years) were drunk in the previous month, placing the UK in the top three countries (Hibell et al., 2012).

2.3.4.6 Substance and illegal drug use

Particularly relevant to young people is substance and illegal drug use, as adolescence is a time of exploration and trying new things. However, drug misuse can lead to addiction and significantly damage many aspects of a young person's life including mental and physical health, social capability and, relationships with family and friends (Manor Clinic, 2022). Due to the nature of this topic, research is challenging to undertake and comparability of results between surveys and across years is often difficult. According to statistics from The Crime Survey for England and Wales 2019/20, young people (16-24 years) are most likely to have taken a drug in the past year (21%) and be the most frequent users of drugs than any other age group (Home Office, 2019). For younger adolescents aged 11-15 years, average prevalence of taking any drug was estimated to be 15% in England and Wales but prevalence increases with age, and so ranges between 2% (11 years) to 24% (15 years) for England (HSCIC, 2015a) and similarly in Wales, 1-20% (Ipsos Mori, 2015). For all young people the most commonly used drug is Cannabis, followed by nitrous oxide and cocaine. Except for the new psychoactive substances (NPS) where prevalence is much higher in young men than women (16-24 years), rates in drug use between sex is similar (Home Office, 2019).

2.3.4.7 Sexual health and early pregnancy

A key part of adolescent development is sexuality. It is influenced by a wide range of factors, of which, biological psychological and sociological are the most important (Kar et al., 2015). A key

milestone in sexual development is puberty, recognised generally as the start of adolescence. This then starts the development journey when 'an individual's thought, perception, as well as response gets coloured sexually' (Kar et al., 2015, p. 70). Navigating this transition can be difficult. Higher numbers of sexual partners and poor contraception use are associated with young people (Slater & Robinson, 2014), exposing them to increased risks of sexually transmitted infections (STIs) and early pregnancy, impacting wellbeing and potentially leading to longer-term negative health, economic and social consequences (Hagell & Shah, 2019; WHO, 2022a).

Pregnancy can be an overwhelmingly positive experience but for young people there are increased health issues to themselves (e.g. anaemia, STIs and mental disorders) (Goonewardene & Waduge, 2009; Hodgkinson et al., 2014) and their child (Paranjothy et al., 2009), as well as the social implications such as interruption of education, living circumstances and family planning support (WHO, 2022a). Global rates of early pregnancy (under 18 years) have fallen since the 1960s (World Bank, 2022). Rates of decline vary tremendously but in England and Wales, the conception rate (15-17 years) fell by 69% to 13.1 per 1,000 women in 2020 (ONS, 2022a), with a similar decrease observed in Scotland (Public Health Scotland, 2021). Amongst 20 economically similar countries however, the UK under 18 birth rate compares unfavourably with only the USA and New Zealand reporting higher rates (WHO, 2022a). Data from 2017 reported that over half of under 18 conceptions lead to abortion but this figure has declined in recent years (ONS, 2019d, 2022a).

Surveys that have explored the sexual behaviour in young people have found that the majority of young people do not start to have sex until they are 16 years or older, with an estimated range of 20-33% for those who were under 16 years (Brooks et al., 2020; Mercer et al., 2013). This is important as the longer a person is sexually active, the more likely they are to have higher numbers of sexual partners and thus increasing their risk to poor sexual outcomes (Mercer et al., 2013). Although contraception use was reportedly 85%, young heterosexuals (15-24 years) have the highest rates of sexually transmitted infections compared to all other age groups (Public Health England, 2021) and accounted for nearly two thirds of all chlamydia infections in England in 2016 (Hagell & Shah, 2019).

2.3.5 Adolescent mental health

Mental health is a crucial element of overall health along with physical and social wellbeing, and without it 'there is no health' (WHO, 2022d). It is a fluid state that affects everyday emotions and activities, providing the foundation for how we think, act, cope and feel, throughout every stage of life. Poor mental health may develop at any time and with appropriate support, may not be permanent unlike a learning disability (Mental Health Foundation, 2022), however the experience can be 'just as bad as a physical illness, or even worse' (Mind, 2017, p. 2). Through the medicalisation and broadening of mental health, there has been a gradual change in how mental health is portrayed and viewed socially (Conrad, 2007). Although there is still stigma associated with more serious mental

health disorders such as schizophrenia, the re-labelling of most common mental health disorders as 'diseases' and increase in mental health awareness implies different perspectives. Emotional disorders and behaviours that were once ignored, tolerated or dealt with 'using prayer, counselling or punishment' (Horwitz, 2009, p. 15) can be treated medically, consequently reducing stigma and increasing the number of people seeking professional help. Stark examples of how the treatment of mental health disorders have evolved over time can be seen in children and young people where there have been significant increases in the diagnoses and treatment of mental health disorders. Over a 20-year period in the UK, the incidence of first ever antidepressant prescriptions for 3-17 year olds nearly doubled (Sarginson et al., 2017) and paediatric prescriptions for attention deficit and hyperactivity disorder (ADHD) drugs increased by almost 800% (Renoux, 2016).

For young people, mental health is a fine balance. They need to manage the many developing social and emotional behaviours whilst discovering their own place in society. This challenging navigation makes them vulnerable to wider factors that can interact and tip the balance. These factors are broad ranging from identity exploration, relationships, influence from peers and media, home environment, socioeconomic position to much larger structural factors such as stigma, discrimination or lack of opportunities and access to services (WHO, 2021b). In what is already a tricky life stage, these factors (usually multiple) can add to stress and negatively impact young people's mental health, potentially disrupting all aspects of life including family, friends, education, employment as well as quality of life (Hale & Viner, 2018; Horwitz, 2009; McKeown & Hagell, 2021; Patton et al., 2016). Obtaining support and treatment early has been found to improve mental health outcomes for young people (Hagell & Shah, 2019; Marshall et al., 2005; NICE & NHS England., 2016) however, many mental health conditions remain undiagnosed and untreated (Kessler et al., 2007). When 50% of all lifetime mental health disorders start by the age of 14 years and 75% by the age of 24 years (Kessler et al., 2005), failure to help young people has serious implications for their future health and ability to thrive, as well as wider social and economic consequences (Barican et al., 2022).

There has been increasing concern about young people's mental health, particularly in the UK, which has performed poorly in international comparisons of child wellbeing and mental health burden (Global Burden of Disease Study, 2022; Maughan et al., 2008; UNICEF, 2007). Mental wellbeing - reflecting how individuals feel and function socially and psychologically (Woodhouse, 2014), is typically self-reported through measures such as life satisfaction, loneliness, and financial security (ONS, 2019b). While the majority of young people in the UK report high wellbeing, over 80% rating their health and life satisfaction as good or excellent (HSCIC & NHS Digital, 2015; ONS, 2019b, 2020; Pitchforth et al., 2019), young men consistently report higher scores than young women. These findings may seem contradictory in light of rising mental health issues, but research indicates that mental wellbeing and mental illness are distinct, though interrelated. For example, data from the UK Household Longitudinal Study found only moderate correlations between life satisfaction and mental

health symptoms, suggesting young people may experience psychological distress while still reporting overall life satisfaction (Marquez et al., 2023). This supports the view that wellbeing and mental illness operate along overlapping but separate dimensions, potentially explaining the coexistence of high subjective wellbeing and increased mental health burden.

In contrast to national data, international comparisons with 37 countries ranked the UK in the bottom third for mental health outcomes (including life satisfaction and suicide rates) for children aged 15 years, alongside a number of other high-income countries (USA, New Zealand, Canada and Australia) (UNICEF, 2020). Data covering the start of the COVID-19 pandemic (March 2020) reported a decline in the five years leading up to March 2020 in the proportion of young women (16-24 years) with very high life satisfaction and happiness, as well as very low anxiety (ONS, 2020). Other studies have presented a mixed picture with some reports of no change or wellbeing improving (Widnall et al., 2020), and others, that young people had felt their life had been made worse by the COVID-19 pandemic, particularly if they had an existing mental problem (Vizard et al., 2020).

Different to mental wellbeing, mental health disorders are diagnosable with a standard set of criteria, and the presence of different symptoms (Taylor Counseling Group, 2021). However, sociological critiques have long raised concerns about the expansion of diagnostic categories and the increasing medicalisation of everyday emotional experiences. For instance, some scholars argue that broader definitions have blurred the boundaries between normal developmental struggles and psychiatric pathology, potentially leading to the over-diagnosis of normative distress and everyday behaviours (Conrad & Slodden, 2012; Malla & Gold, 2024). This expansion reflects not only changes in diagnostic criteria but also the influence of pharmaceutical marketing, awareness campaigns, and shifting cultural narratives. These trends risk medicalising normal emotions and may divert attention from those with more severe mental health needs. These disorders are a leading cause of disability (Erskine et al., 2015) with three mental health disorders ranked in the top ten NCD burden for 10-19 years olds (Guthold et al., 2021), and accounting for the most DALYs in NCDs amongst young people globally (Akseer et al., 2020). Rates are generally highest in high-income countries (Global Burden of Disease Study, 2022); in a systematic review undertaken in 2021 including studies from 10 high-income countries, prevalence of mental health disorders ranged between 7.6% and 11.7% in young people (13-17 years) (Barican et al., 2022). In England, 17.6% of younger adolescents (11-16 years) met the criteria for having a mental disorder rising to 20% among 17-22 years, with rates in young women three times higher than young men (Vizard et al., 2020). Scotland and Wales do not report prevalence of mental health disorders, alternative measures are used in Scotland such as the Strengths and Difficulties Questionnaire and General Health Questionnaire. In those aged 13-15 years, 31% had an 'abnormal' or borderline' score for emotional and behavioural problems (The Scottish Government, 2017b), and 22% of 16-24 year olds recorded a score indicating the presence of a possible psychiatric disorder (The Scottish Government, 2017a). Although different measures, both

suggested that young women were likely than young men to experience emotional or behavioural problems, particularly symptoms of anxiety. This is a well-established finding, often attributed to gendered social roles and stress exposure, as well as differences in emotional expression and help-seeking behaviours (Rosenfield & Mouzen, 2012).

There are a wide range of mental health conditions that affect young people, the most common in the UK include anxiety, depressive and behavioural disorders (Michaud & Fombonne, 2005). Prevalence varies by age and sex, demonstrated clearly in behavioural disorders which are mostly found among younger males (11-16 years), but in older age groups and for males and females, anxiety and depression are the most common (Table 2.3).

Table 2.3. Common mental health disorders by age group and sex (NHS Digital., 2018).

<table>
<tr><th rowspan="3">Mental health disorder</th><th colspan="6">Prevalence (%)</th></tr>
<tr><th colspan="2">11-16</th><th colspan="2">17-19</th><th colspan="2">16-24</th></tr>
<tr><th>Males</th><th>Females</th><th>Males</th><th>Females</th><th>Males</th><th>Females</th></tr>
<tr><td>Anxiety</td><td>6</td><td>8</td><td>6</td><td>20</td><td rowspan="2">14.7</td><td rowspan="2">24.6</td></tr>
<tr><td>Depressive</td><td>1.5</td><td>3.5</td><td>3</td><td>6</td></tr>
<tr><td>Behavioural</td><td>7.4</td><td>5</td><td>1</td><td>0.5</td><td></td><td></td></tr>
<tr><td>Hyperactivity and attention deficit</td><td>3.2</td><td>0.7</td><td>1.5</td><td>0</td><td></td><td></td></tr>
<tr><td>Other less common</td><td>2</td><td>1.5</td><td></td><td></td><td></td><td></td></tr>
</table>

McManus et al. (2016) determined that ‘young women were a high-risk group’ following the high rates of anxiety and depression reported in England. This is further supported in statistics of self-harm where similar patterns have been observed among 16-24 years (women 25.7% compared to 9.7% men) (McManus et al., 2016). In contrast, suicide rates are consistently higher in young men, and in those aged 20-24 years (ONS, 2021c). Over the past 15 years, suicide rates have been fairly stable, reported in 2020 as 7.0 per 100,000 for young men and 2.5 per 100,000 for young women (ONS, 2021c). Unlike many of the individual mental health disorders, data from other countries is available and when compared the UK ranks between third (10-14 years) and eighth place (15-24 years) for suicide rates in 2016 (Global Burden of Disease Study, 2022).

Prior to the COVID-19 pandemic, mental health disorders among young people had been increasing in the UK (Collishaw et al., 2019; Collishaw et al., 2004; Pitchforth et al., 2019), and it was well reported that certain groups were considered high-risk (women and individuals of low socioeconomic position) (Patil et al., 2018). The closure of educational establishments, work and leisure places following the arrival of COVID-19 resulted in the structure of everyday life being disrupted and increased social isolation. Job losses and reduced financial income meant many households experienced financial insecurity, and for those already in such circumstances, these problems were heightened. There is strong evidence that young people living in households with financial difficulties or of low deprivation (Hagell & Shah, 2019; Vizard et al., 2020) are more likely to have a mental

health condition, thus the COVID-19 pandemic has ‘magnified health, educational and social inequalities’ (Ford & Cross, 2021, p. 272). The consequences of this period are unlikely to be fully understood for a number of years but indications from the early waves of the COVID-19 pandemic suggest that the mental health of young people was negatively affected. Increases in anxiety and depressive symptoms have been reported along with increases in a range of factors that can be harmful to mental health including sleep problems, loneliness, cigarette smoking, alcohol, gambling and illicit drug use (Ford & Cross, 2021; Mansfield et al., 2020; Vizard et al., 2020). In a systematic review of studies exploring mental health following school closures, 28% (n=7) were UK-based with reports of anxiety and trauma 53.3% and 44% above the population threshold for boy and girls (13-18 years) respectively; declining life satisfaction and wellbeing and 25% experiencing new onset of sleep problems (16-24 years) (Viner et al., 2022).

Whilst mental health was reported to be declining in young people during COVID-19, many of the routes to access mental health support for young people were changed. Schools, which provide an important link to services, were closed, and GPs were generally accessed remotely (The Health Foundation, 2022). Following the closures, new referrals to mental health services declined steeply (35%), and did not recover until July 2020. By July 2021, referrals reached a new high with suggestions that services were struggling to cope (The Health Foundation, 2022). A likely reason for this surge in demand is that young people delayed seeking help about their mental health.

2.4 Intersectionality

Intersectionality is a theoretical framework that emerged from feminist and anti-racist activism in the late 20th century. The term was first coined by legal scholar Kimberlé Crenshaw in 1989, who used it to describe the ways in which multiple forms of oppression and discrimination intersect and compound to create unique experiences of inequality and marginalisation (Crenshaw, 1989). The idea of intersectionality has long historical roots and grew out of a critique of traditional single-axis approaches to identity and oppression, which treated sex, race, class, and other identity categories as separate and distinct experiences (Collins, 2002; Combahee River Collective., 1977; Crenshaw, 1989; Crenshaw, 1991). Collins et al. (2021) described it as:

> …investigates how intersecting power relations influence social relations across diverse societies as well as individual experiences in everyday life. As an analytical tool, intersectionality views categories of race, class, gender, sexuality, nation, ability, ethnicity, and age - among others - as interrelated and mutually shaping one another. Intersectionality is a way of understanding and explaining complexity in the world, in people, and in human experience.
>
> *(Collins et al., 2021, p. 2)*

It recognises that categories of social locations and oppression are interconnected and mutually constitutive, meaning that they cannot be understood or addressed in isolation (Hankivsky, 2014).

Contemporary researchers tend to agree there are a number of foundational beliefs of intersectionality (Jackson et al., 2021), Bowleg (2012) outlined these in relation to public health: -

1. Social identities are not independent and unidimensional but multiple and intersecting,
2. People from multiple historically oppressed and marginalised groups are the focal or starting point, and
3. Multiple social identities at the micro level (i.e., intersections of race, sex, and socioeconomic status) intersect with macro level structural factors (i.e. racism, sexism and poverty) to illustrate or produce disparate health outcomes

(Bowleg, 2012, p. 1268)

For example, an individual who identifies as a Black woman may experience unique forms of discrimination and inequality that are not accounted for by considering either race or sex alone. This individual may face discrimination based on both race and sex, and this compounded experience of oppression may have different implications for their life experiences, such as their access to employment, healthcare, and education. It provides a critical lens for understanding how discrimination and social determinants of health contribute to both health inequality and health inequity. Health inequality refers to measurable differences in health outcomes between groups, while health inequity refers to those differences that are unjust and avoidable, often rooted in systemic discrimination and social disadvantage (Braveman, 2006). Young people, particularly those from marginalised backgrounds, are disproportionately affected by both health inequalities and inequities. This has been highlighted in studies exploring disparities in access to healthcare due to systematic discrimination, as well as economic barriers and cultural stigmatisation (Kapadia et al., 2022).

The intersectional framework has been adopted widely and applied across many disciplinary fields to explore a broad range of social justice issues, including but not limited to, race, sex, sexuality, class, ability, and religion (Bastia et al., 2023). It has been used to analyse and challenge power structures, to understand how systems of oppression intersect and reinforce one another, and to inform activism and policy change (Hankivsky, 2014). However, it is not a 'clear-cut and coherent concept' (Trygg et al., 2021, p. 2) and due to its development across different ontologies, epistemologies and methodologies (Trygg et al., 2021, p. 2), there is no singular intersectional framework leading different disciplines to view and use differently (Motley et al., 2023). This lack of precision (Nash, 2008) and diversity (McCall, 2005) in applying intersectionality is likely a consequence that it is still a concept in development (Collins & Bilge, 2020). The absence of a rigid structure in intersectionality is considered by some to be a fundamental factor in its success with Davis (2008) suggesting it can be used for examining and interpreting 'any social practice, any individual or group experience, any structural arrangement, and any cultural configuration' (p. 72). As an analytical tool, a central tenet of intersectionality is that it allows for working at greater depth and intricacy, helping to shape the

critical questions asked and encouraging greater reflexivity in the research process. Collins and Bilge (2020) advocate intersectionality has six core themes which are social inequity, intersecting power relations, social context, relationality, complexity and social justice (Collins & Bilge, 2020, p. 31). These act as recurring signposts and help tether the framework. While intersectionality provides a powerful framework for analysing how structural inequalities and power relations shape lived experience, it is less focused on the ways in which social identities are negotiated as everyday psychological and relational processes. To address this dimension of identity, this thesis also draws on insights from Social Identity Theory (SIT) to complement the intersectional perspective on identity and belonging (Jenkins, 2014).Interest has been growing in the use of intersectionality as a framework within health (Bauer, 2014; Bowleg, 2012; Holman et al., 2021) as complexity is considered one of intersectionality's key principles (Collins & Bilge, 2020), essential when trying to understand the complex nature of health inequalities. As a form of critical inquiry and critical praxis in synergy, where "knowledge-making (e.g., intellectual and analytical work) happens together with change-making (e.g., systemic change and activism)" (Motley et al., 2023, p. 417), there are concerns about integration of intersectionality in health research and policy frameworks (Collins & Bilge, 2020; Kelly et al., 2021). For example, intersectionality is sometimes reduced to a checklist of identities, with limited attention to how power structures shape lived experience. Kelly et al. (2021) warn that such superficial use risks depoliticising its intent and note that dominant evidence-based frameworks can constrain its full application by prioritising quantifiable outcomes over structural and contextual understanding. There are, however, examples where intersectionality has been applied successfully. Abrams et al. (2020) reviewed a number of health-related studies where multiple forms of marginalisation were found to shape individuals' healthcare experiences (Agénor et al., 2015; Jaiswal et al., 2019). These studies also uncovered previously overlooked sociocultural factors that influence health behaviours and outcomes (Bond & Gunn, 2016; Opara et al., 2019), and amplified the voices of marginalised individuals to inform recommendations for interventions and policy reforms (McLemore et al., 2018). Abrams et al. (2020) highlighted that often in these studies, the key elements of intersectionality were considered but an intersectionality framework was not explicitly applied or recorded. A strong advocate for intersectionality, Bowleg (2012) has published widely on the framework and in her paper titled 'The Problem With the Phrase *Women and Minorities*: Intersectionality - an Important Theoretical Framework for Public Health', she outlines the benefits of intersectionality within public health (Holman et al., 2021): -

- Offers a unifying language and framework for those interested and working in intersections of inequality
- Recognises health disparities as complex and multidimensional
- Emphasises macro-level factors that address the root causes of health inequalities

- Guides the creation of targeted, cost-effective interventions and policies
- Enhances the collection and analysis of detailed sociodemographic and health data

The lack of rigid structure continues when applying intersectionality practically in research, where there is no single approach used. There are a number of fundamentals that are important including the use of a methodologically grounded method (Winker & Degele, 2011) and the consideration of an appropriate epistemological foundation, providing a deeper understanding of knowledge acknowledging complexity, relationality and the structural nature of inequalities (Bowleg, 2017).

To reflect the complexity of intersectionality as a framework, McCall (2005) developed three research approaches based around categories of difference: -

- Anti-categorical complexity - this deconstructs categories (i.e. ethnic group and sex), arguing that social life is too complex for fixed classifications and that categories create inequalities. It emphasises the ways in which concepts, terms and categories are constructed with a 'focus on particular social groups at neglected points of intersection…in order to reveal the complexity of lived experiences within such groups' (McCall, 2005, p. 1774)
- Intracategorical complexity - this critically engages with categories to explore neglected intersections of social groups and their lived experiences.
- Intercategorical complexity - this adopts existing categories to examine inequality and its changing configurations among groups. It primarily focuses on the relationship between categories in quantitative research, such as modelling differences in income across fixed social groups. In this approach, categories of interest are predetermined.

Each of the three intersectional research approaches align with different methods. Anticategorical and intracategorical approaches are primarily associated with qualitative methods, which allow for a nuanced exploration of lived experiences, social contexts, and the relational aspects of identity (Evans, 2019). These methods include ethnography, case studies, and narrative analysis, which have been widely used to examine health disparities among marginalised populations (Lahiri-Dutt, 2024). For example, Tinner and Alonso Curbelo (2024) used qualitative interviews to explore how the experiences of mental health and inequalities of young women in Scotland were shaped by discrimination. Similarly, Morgan et al. (2024) coproduced a secondary school-based study in the UK involving interviews and focus groups to explore how to create an inclusive and mentally healthy environment for lesbian, gay, bisexual, trans and queer (LGBTQ+) students.

In contrast, intercategorical approaches, which examine patterns of inequality between existing social groups, are closely linked to quantitative methods (McCall, 2005). Qualitative methods have been traditionally associated with intersectionality (The Scottish Government, 2022) but there is growing interest in the application of quantitative analyses within an intersectionality framework as researchers

seek to quantify health disparities across intersecting social categories (Bauer, 2014; Bowleg & Bauer, 2016; Evans, Leckie, et al., 2024). Unlike qualitative methods which focus on lived experiences at the individual level, quantitative intersectional analyses can help reveal broad societal patterns in health inequalities (Cairney et al., 2014), provide longitudinal insights (Bell et al., 2024) and generate evidence-based foundations for the development of targeted interventions (Bauer et al., 2021).

Historically, descriptive estimates and conventional regression models including interaction effects have been used in quantitative intersectionality studies (Bauer & Scheim, 2019; Keller et al., 2023), an example of this is the study by Jordan et al. (2022), in their exploration of citizenship among young people with mental health challenges. However, there are criticisms that these do not address contexts sufficiently (Bauer et al., 2021; Evans, 2019), and have limitations such as scalability, model parsimony and sample size (Evans et al., 2018). In response to this, multilevel modelling approaches have been developed which not only do not experience the same methodological issues, but also are able to integrate context as group-level variables such as school or neighbourhood indicators (Bauer et al., 2021). Multilevel analysis of individual heterogeneity and discriminatory accuracy (MAIHDA) is one of these methods and is increasingly used successfully in exploring health disparities. For instance, Moreno-Agostino et al. (2023) used MAIHDA to map mental health inequalities during the COVID-19 pandemic across multiple social identities in two British cohorts, revealing significant disparities, particularly for sexual minority groups, and highlighting the compounded effects of intersecting marginalised identities. Similarly, in a MAIHDA analysis containing data from 33 countries, Kern et al. (2020) found that national contexts, such as income equality and migration policies, influenced adolescent social identities and shaped mental well-being, with disadvantaged groups facing exacerbated inequalities in less equitable countries and mitigated effects in more inclusive ones.

Despite the increasing application and advancement of quantitative methods, challenges remain in fully integrating intersectionality into statistical analyses with concerns persisting about whether quantitative methods can adequately capture the relational and structural dimensions of intersectionality (Bell et al., 2024). To strengthen the use of intersectional approaches, researchers advocate for combining qualitative and quantitative methods, where a more comprehensive understanding of health inequalities can be developed, bridging theoretical insights with empirical data to inform equitable health interventions and policy reforms (Bowleg, 2017; Holman et al., 2020).

2.4.1 Young people and mental health

Intersectionality offers a nuanced lens with which to explore mental health in young people, an age group that is particularly vulnerable to mental health challenges due to the developmental, social and environmental factors. Although described as a ‘great leveller’ (Jones, 2020), the COVID-19

pandemic has further complicated these dynamics, with disproportionate adverse effects underscoring and intensifying inequalities (Marmot & Allen, 2020).

As previously discussed, trends have shown that mental health has been worsening in young people prior to the COVID 19 pandemic, with rates of probable mental disorders increasing from 10.8% to 16% between 2017 and 2020 in those aged 5-16 years (NHS Digital, 2020), and rates of severe distress doubling in those aged 16-24 years between 1991-2018 (Gagné et al., 2021). This has continued through the COVID-19 pandemic, with women, sexual minorities and older adolescents more impacted than others (Madigan et al., 2023; Pierce et al., 2020; Racine et al., 2021). There remains a significant gap in research on young people's mental health (Donnelly, 2022), with existing studies often examining the relationship between mental health and social factors in isolation (Patil et al., 2018). Women, racial/ ethnic group, low income, low parental education and immigrant status have been found to be potential risk factors for poor mental health outcomes in young people (Kumra & Patange, 2025; Lafontaine-Poissant et al., 2025; Park, 2024; Prichett et al., 2024; Reiss, 2013) but this limited perspective fails to capture the complex interactions between social, economic, and demographic factors that shape young people's experiences (Lorthe et al., 2023). Critically, the combined effect of multiple marginalised identities may be multiplicative, exacerbating mental health challenges beyond a simple accumulation of risks (Kern et al., 2020). Using an intersectional framework recognises that individuals possess multiple social identities and aids examination of how these identities maybe further marginalised by the influence of unequal social structures (Patil et al., 2018).

Research applying an intersectional framework to examine young people's mental health remains limited, further complicated in literature by the lack of a clear definition of the framework or the absence of explicit acknowledgment of intersectionality (Patil et al., 2018). This is particularly true in qualitative studies (Abrams et al., 2020) where ironically, intersectionality has a longer association and is typically more aligned (Bowleg, 2008, 2017; Shields, 2008; Syed, 2010). Despite the lack of definition or clear use of an intersectional approach, several studies report findings that illustrate the effects of intersectionality. Young people with intersecting marginalised identities often face compounded stressors that negatively impact their mental health. For instance, young Black people in the UK experience higher rates of depression and anxiety but are less likely to receive timely or appropriate care due to racial stereotyping, misdiagnoses, and cultural stigma around seeking support (Bansal et al., 2022). LGBTQ+ youth similarly report disproportionately high levels of mental health difficulties, often exacerbated by discrimination, inadequate healthcare access, and societal exclusion (Di Giacomo et al., 2018; Irish et al., 2019; McDermott et al., 2024; Ruprecht et al., 2024; Semlyen et al., 2016). Socioeconomic factors further compound these disparities, with young people from low-income backgrounds experiencing heightened distress due to poverty, limited access to mental health services, and the effects of austerity measures on youth support systems (Rainer et al., 2024; Treanor

& Troncoso, 2023). Structural barriers also affect rural youth, who struggle with transportation issues and fewer mental health resources (Salaheddin & Mason, 2016), while young people with disabilities frequently encounter dismissive attitudes and inadequate facilities in mental health care (Clark & Maclennan, 2023; NIHR Evidence, 2021). For those young people living with an existing mental health condition, the COVID-19 pandemic was particularly difficult (NHS Digital, 2020; YoungMinds, 2021).

2.4.1.1 Qualitative studies

Studies that explicitly define or use an intersectional approach through qualitative methods provide a deeper understanding of these compounded challenges. Marginalised youth, whether young Arab women (Alani, 2022), Black college students (Ncube et al., 2022), LGBTQ+ individuals (Griffin et al., 2023; Ruprecht et al., 2024), or those from low-income backgrounds (Fairbrother et al., 2022; Scott et al., 2021), faced compounded mental health challenges due to systemic discrimination, inadequate healthcare access, and societal expectations. Three qualitative studies conducted in Canada further underscore these dynamics, documenting the profound mental health impacts of COVID-19 on Black youth. These studies highlight elevated levels of stress, anxiety, and depression, shaped by the intersecting influences of social isolation, financial insecurity, and racial discrimination (Brouillette et al., 2025; Osman et al., 2025; Salami, Maduforo, et al., 2024). More broadly, young people navigating multiple marginalised identities, such as ethnicity, sex, and disability, reported heightened emotional strain including stress, exhaustion, and distrust in healthcare systems, often exacerbated by experiences of dismissal, neglect, and micro aggressions (Alani, 2022; Griffin et al., 2023; Ncube et al., 2022). These findings, drawn from studies across Canada, the UK and US studies highlight how overlapping forms of oppression including racism, sexism, ableism and transphobia, create unique mental health risks that extend beyond the sum of individual factors, underscoring the multiplicative nature of intersectional discrimination (Griffin et al., 2023; Ncube et al., 2022).

Furthermore, the studies emphasise the role of structural inequalities in exacerbating mental health disparities, particularly during the COVID-19 pandemic. Young people from deprived areas or marginalised communities in the UK described how poverty, inadequate housing, and lack of access to culturally responsive mental health services intensified feelings of anxiety, isolation, and powerlessness (Fairbrother et al., 2022; Scott et al., 2021). For example, LGBTQ+ youth faced discrimination and long waiting times for mental health support, with some reporting harmful experiences such as misgendering and deadnaming (Griffin et al., 2023). Similarly, Black college students in the US, balanced caregiving responsibilities and academic pressures with limited institutional support, often neglecting their own well-being due to societal expectations of resilience (Ncube et al., 2022).

2.4.1.2 Quantitative studies

Although numbers are increasing, studies applying quantitative intersectional methods such as MAIHDA are small, particularly in exploring mental health in young people. In comparison to qualitative methods, quantitative approaches help researchers to assess whether belonging to multiple marginalised groups has an additive effect where disadvantages accumulate independently, or a multiplicative effect, where overlapping identities interact to produce disproportionately worse outcomes (Kern et al., 2020). Across multiple studies that have focused on young people, additive effects dominate mental health differences, with individual factors such as being female, LGBTQ+, from an ethnic minority, or of lower socioeconomic status independently contributing to poorer outcomes (Balloo et al., 2022; Bell et al., 2024; Evans & Erickson, 2019; Kern et al., 2020; Lorthe et al., 2023; McIsaac et al., 2021; Moreno-Agostino et al., 2023; Pilz González et al., 2025). For instance, Bell (2024) applies a novel longitudinal MAIHDA approach and finds significant intersectional inequalities in mental health trajectories, where younger individuals experience mental health disparities primarily through additive effects, while older individuals face compounded, multiplicative disadvantages as inequalities accumulate over time. Similarly in their MAIHDA analysis, Evans and Erickson (2019) show that women, racial/ethnic minorities, immigrants, and low-income individuals report higher depression scores, with most differences explained by additive effects. This pattern is echoed in Kern et al. (2020), where MAIHDA found low socioeconomic status, immigrant backgrounds, and female gender associated with higher levels of life dissatisfaction and psychosomatic complaints, primarily through additive rather than multiplicative effects.

However, some studies reveal contexts where multiplicative effects emerge, particularly among groups facing multiple layers of marginalisation. Pilz González et al. (2025) find that while most mental health disparities among university students in Germany are additive, the combination of double discrimination (from both lecturers and peers) and gender-diverse identity represents a multiplicative risk factor. This highlights how systemic discrimination can exacerbate mental health challenges for marginalised groups, particularly during crises like COVID-19. Similarly, Moreno-Agostino et al. (2023) identifies unique intersectional vulnerabilities, such as South Asian heterosexual men reporting lower-than-expected life satisfaction despite otherwise privileged identities. These findings underscore the importance of considering how specific combinations of social identities can create unique risks, even when additive effects dominate overall disparities.

The role of socioeconomic factors, particularly financial hardship, is a recurring theme across studies. Lorthe et al. (2023) find that financial hardship is the strongest predictor of poor health-related quality of life (HRQoL) and mental health issues among children and adolescents in Geneva, with the highest risk observed among non-Swiss adolescent girls from financially disadvantaged families. Similarly, Balloo et al. (2022) highlight that low-income status consistently predicts higher depression scores

across all racial and gender groups, reinforcing the profound impact of socioeconomic disadvantage on mental health.

Generational and age-related differences also play a significant role in shaping mental health outcomes. Bell et al. (2024) highlighted that Generation Z (born 1995 onwards) shows a steep decline in mental health compared to Generation Y, while Baby Boomers exhibit unique improvements, suggesting that the pandemic (amongst other factors) has disproportionately affected younger generations.

2.5 Social Identity Theory

While intersectionality provides a valuable framework for understanding how structural inequalities shape lived experience, it does not always fully explain the processes through which individuals understand and construct their identities in everyday social contexts. For this reason, it is useful to also consider insights from Social Identity Theory (SIT), which offers a complementary perspective on identity formation and group belonging.

Social Identity Theory, originally developed by Tajfel and Turner (1979), proposes that individuals derive part of their sense of self from membership of social groups. These groups may include categories such as gender, ethnicity, nationality, occupation, or age cohort. Through processes of social categorisation, identification, and comparison, individuals locate themselves within social structures and develop a sense of belonging to particular groups. Membership of these groups can shape attitudes, behaviours, and emotional responses, particularly when group boundaries become salient or contested (Tajfel and Turner, 1979; Brown & Larson, 2009).

Building on this tradition, Jenkins (2014) emphasises that social identity is not simply an internal psychological process but is produced through ongoing social interaction. Identity emerges through the interplay between how individuals define themselves and how they are defined by others. Jenkins refers to this as the relationship between internal identification (how individuals see themselves) and external categorisation (how others classify them) (Jenkins, 2014). Social identity therefore develops within specific social contexts and is continually negotiated through every day experiences. This perspective is particularly relevant during adolescence and early adulthood, periods in which identity formation is a central developmental task (Erikson, 1968; Arnett, 2000; Steinberg, 2014). As young people navigate transitions between educational settings, peer groups, and emerging adult roles, they actively construct and reconstruct their sense of self. During adolescence, peer groups and social contexts become increasingly influential, with adolescents frequently evaluating themselves in relation to peers, shaping belonging and perceptions of status (Brown & Larson, 2009; Viner, 2012).

The COVID-19 pandemic disrupted many of the environments in which these processes normally occur. School closures, restrictions on social interaction and interruptions to educational progression

significantly reduced opportunities for young people to engage with peers and institutions that typically support identity development (Lee, 2020; Loades et al., 2020; Viner et al., 2022). Emerging literature has described this disruption as a form of "pandemic skip" (Schneider, 2023), where young people felt that a meaningful period of adolescence had effectively been lost or bypassed due to pandemic restrictions. Rather than progressing through expected social transitions and shared milestones, many young people experienced a sudden interruption to these developmental processes. Viewed through SIT, these disruptions are significant because identity develops through participation in shared social practices and interaction with others (Jenkins, 2014). When opportunities for social participation and group membership are reduced, young people may lose access to important psychological resources associated with belonging, continuity, and recognition (Jetten et al., 2012; Cruwys et al., 2014). For those whose educational transitions, examinations, peer relationships, and social milestones were interrupted during the pandemic, this may have contributed to feelings of dislocation or a sense that a phase of adolescence had been cut short.

In this thesis, SIT is used as a supplementary perspective alongside the intersectional framework that primarily guides the analysis. While intersectionality remains central to understanding how structural inequalities shape mental health outcomes across social groups, SIT helps interpret those aspects of young people's accounts concerned with belonging, peer comparison, and disrupted developmental transitions. It is particularly helpful in considering how the interruption of shared social experiences during the COVID-19 pandemic may have shaped young people's sense of identity and progression through adolescence. As discussed later in the thesis, participants' descriptions of lost milestones and disrupted transitions resonate with the idea of a "pandemic skip", where a period of expected adolescent development appeared to have been curtailed by pandemic restrictions.

2.6 Conclusion

This chapter has outlined the historical, social, and structural contexts that shape adolescent mental health, with a particular focus on how social inequalities influence young people's experiences. It traced the emergence of adolescence as a socially constructed life stage, shaped by industrialisation and dominant psychological theories, and highlighted how race, class, and gender have historically influenced access to opportunities and support.

Adolescence was presented as a critical developmental period, one profoundly shaped by social determinants such as education, family relationships, and socioeconomic status. These factors interact to influence mental health trajectories, particularly for those from marginalised backgrounds. The chapter also explored how structural barriers including discrimination, economic disadvantage, and limited access to culturally appropriate services contribute to persistent health inequalities. Intersectionality was introduced as a central conceptual and analytical framework, offering a more nuanced understanding of how overlapping systems of oppression shape adolescent mental health

outcomes. The limitations of single-axis approaches were noted, and the case was made for intersectionality as essential to both research and policy aimed at addressing these complexities.

The next chapter outlines the methodological approach used in this study, detailing the pragmatic paradigm and the theoretical frameworks of intersectionality and the social determinants of health. It introduces the exploratory sequential mixed methods design, encompassing both qualitative and quantitative methodologies, and describes how these were applied to explore young people’s lived experiences and broader structural patterns. The chapter also discusses data collection, analysis, and integration strategies, alongside ethical and reflexive considerations that underpin the research process.

CHAPTER 3 METHODOLOGY

3.1 Outline of chapter

This chapter outlines the methodological foundations and research strategies used in this research. It begins by describing the research paradigm of pragmatism, detailing the ontological and epistemological assumptions underpinning the research. Following this, it introduces the theoretical frameworks of intersectionality and the social determinants of health that guided the research design. The chapter then describes the rationale for adopting an exploratory sequential mixed methods design, which integrates both qualitative and quantitative approaches to address the multidimensional research questions. The qualitative component is outlined first, detailing participant recruitment, data collection via interviews and a focus group, and data analysis. This is followed by the quantitative component which includes an overview of the secondary dataset used from the UK Household Longitudinal Study (UKHLS), key variables, and statistical analysis techniques (e.g., MAIHDA). Attention is then given to how integration of findings was achieved between components, aligning with the principles of mixed methods research. The chapter concludes by discussing ethical considerations, reflexivity, and the strategies employed to ensure rigour and quality across all stages of the research process.

3.2 Research paradigm

Prior to making decisions regarding the methodology used in any research, it is important that the researcher has a clear perspective about reality (Lohse, 2017). In this PhD, I approached the research through a pragmatist paradigm, reflecting my focus on addressing the real-world issue of young people’s mental health during and after the COVID-19 pandemic, through practical, flexible, and ethically grounded inquiry. Pragmatism advocates that philosophical and methodological strategies should be determined by the nature of the research problem, with emphasis placed on the practical consequences of ideas rather than rigid adherence to abstract truths (Capps, 2023; Tashakkori & Teddlie, 1998; Yefimov, 2004). Emerging in the late 19th-century U.S. as a response to idealism and positivism (Pansiri, 2005), pragmatism, as developed by Charles Sanders Peirce, William James, and John Dewey, emphasised action, experience, and the contextual grounding of knowledge (Creswell & Plano Clark, 2018; Johnson & Christensen, 2016; Johnson & Onwuegbuzie, 2004; Morgan, 2007; Tashakkori & Teddlie, 1998; Teddlie & Tashakkori, 2009). Dewey’s concept of ‘inquiry’ as a dynamic process of reflection and action resonates strongly with this research design, which sought to adapt methodologically to the complex and evolving understandings of young people's lived experiences (Biesta, 2010). In adopting a pragmatist stance, I was guided not only by practical considerations but also by deeply held beliefs about responsible and ethical research. I believe that research should be transparent, fair, and faithful to the realities of those whose experiences are

studied. This commitment shaped decisions throughout the research process: from the selection of outcomes and methods through to analysis and interpretation. It informed my determination to represent contradictions and complexity within the data, rather than simplifying findings to fit predetermined narratives. It also underpinned my reflexive stance as a researcher, recognising my responsibilities both to participants and to the integrity of the knowledge produced. Morgan (2014) description of pragmatism identifies three widely shared assumptions, which align closely with my research values: -

1. Actions cannot be separated from the situations and contexts in which they occur.
2. Actions are linked to consequences in ways that are open to change.
3. Actions depend on worldviews that are socially shared sets of beliefs.

(Morgan, 2014, p. 26)

These assumptions were particularly pertinent in examining young people's mental health during the pandemic. Mental health outcomes could not be understood independently of the social and structural contexts in which young people were living, including educational disruption, financial insecurity, and shifting social relationships. Nor could these outcomes be treated as static; they were shaped by evolving conditions and mediated by coping strategies, support systems, and identity.

3.2.1 Strengths of a pragmatist approach

A central strength of pragmatism in this research was its capacity to legitimise methodological pluralism. The research questions required engagement with both subjective lived experience and measurable structural inequalities in order to generate meaningful, contextually grounded insights. The qualitative phase, based on interviews and the focus group, enabled an in-depth exploration of how young people experienced, interpreted, and negotiated their mental health during and after the COVID-19 pandemic. Building on these insights, quantitative analysis of UKHLS data enabled the identification of patterned disparities in psychological distress across intersecting social categories. A rigid adherence to either positivist or interpretivist paradigms would have constrained this dual engagement. Pragmatism instead provided a coherent philosophical justification for integrating both approaches within a single inquiry (Morgan, 2007; Kaushik & Walsh, 2019).

Pragmatism also aligned closely with the intersectional framework adopted in this thesis. Intersectionality demands attention to structural power relations while recognising situated and embodied experience (Collins & Bilge, 2020). Pragmatism's acceptance that both objective structures and subjective interpretations are consequential enabled the exploration of material inequalities (e.g., household income, ethnicity, urbanicity) alongside the diverse meanings young people attached to their experiences. In this way, pragmatism was not simply a methodological convenience but a stance consistent with the justice-oriented aims of the research.

A further strength lies in pragmatism's embrace of abductive reasoning. As Morgan (2007) suggests, inquiry moves iteratively between theory and data, with interpretations refined as new insights

emerge. Throughout this research, early qualitative findings, including accounts of disruption, lost time, and unequal access to support, sensitised the subsequent quantitative analysis to issues of socioeconomic difference, social context, and change over time. In turn, the quantitative analysis enabled these qualitative insights to be considered in relation to broader pre- and post-pandemic patterns within a nationally representative sample. This iterative movement exemplifies pragmatism in practice: not philosophical neutrality, but reflective engagement with emerging evidence.

3.2.2 Limitations and critical engagement

Despite its strengths, pragmatism is not without critique. It is often presented as a resolution to the "paradigm wars" between positivism and interpretivism (Johnson & Onwuegbuzie, 2004). However, Guba and Lincoln (2005) argue that paradigmatic differences reflect deeper ontological and epistemological commitments, which cannot simply be reconciled through methodological compromise. From this perspective, pragmatism may risk smoothing over tensions rather than resolving them. A related concern centres on instrumentalism. Biesta (2010) cautions that reducing pragmatism to "what works" can privilege technical effectiveness over normative reflection. Hammersley (2016) further argues that inquiry and practice operate according to different goals and cannot be fully fused without generating tensions; subordinating research to immediate practical demands may compromise its critical function. More recently, Hampson and McKinley (2023) question whether pragmatism always provides sufficient philosophical clarity, suggesting it can function as a convenient justification for methodological pluralism rather than a fully articulated paradigm.

These critiques are particularly salient in research addressing inequality. Decisions about measurement and modelling are not neutral; they carry epistemic and political implications. Operationalising intersectional identities within quantitative models necessarily simplifies complex lived realities, while statistical indicators cannot fully capture experiential nuance. Recognising this, the research avoided an uncritical "anything goes" pragmatism. The use of MAIHDA, for example, was theoretically motivated to move beyond single-axis approaches, and the qualitative component was designed not merely to add depth but to interrogate and contextualise quantitative patterns.

Engaging in mixed methods inquiry required navigating epistemological tensions. Quantitative analysis assumes comparability and generalisability, whereas qualitative inquiry foregrounds context and co-construction. Rather than collapsing these differences, they were treated as productive tensions. Convergence strengthened interpretation; divergence prompted further analysis. In this sense, pragmatism functioned not as philosophical neutrality, but as reflexive engagement with multiple forms of evidence. Pragmatism was therefore adopted with an awareness of its limits. Being explicit about its strengths and tensions provides transparency about how methodological decisions were shaped throughout the study.

3.2.3 Epistemology

Aligned with a pragmatist paradigm, the epistemological stance underpinning this research is practical, situated, and pluralistic. Pragmatism views knowledge not as an abstract entity to be discovered but as something produced through processes of inquiry directed at solving real-world problems (Kaushik & Walsh, 2019; Ormerod, 2006). Dewey's 'Theory of Inquiry' is particularly relevant here, proposing that beliefs and actions are dynamically linked through reflective investigation of problematic situations (Biesta, 2010; Kaushik & Walsh, 2019; Ormerod, 2006). Throughout the research, I recognised that understanding young people's mental health experiences required engaging with multiple forms of knowledge: statistical patterns emerging from secondary data analysis and the rich, contextualised narratives from qualitative interviews and the focus group. Rather than privileging one form of knowledge, I integrated both, letting research questions - not rigid methodological allegiance - guide methods and interpretation (Revez & Calvão Borges, 2018).

Furthermore, my evolving understanding of mental health in young people and intersectionality during the research process reaffirmed that knowledge is partial, contingent, and shaped by both researcher and participant standpoints (Mertens, 2020). Consequently, I approached knowledge production as an interactive and context-sensitive endeavour, acknowledging my own positionality and reflexive development throughout the research.

3.2.4 Ontology

The ontological assumptions of this research are likewise grounded in pragmatic pluralism. Ontology, concerned with the nature of reality, is treated in pragmatism not as a question of choosing between realism or relativism, but rather as accepting that both objective structures and subjective experiences coexist and interact (Morgan, 2007, 2014; University of Warwick, 2017). I align with Morgan's (2007) view that reality is intersubjective: while there is a real world that exists independently, individuals' experiences and interpretations of this world are socially mediated and vary across contexts (Morgan, 2007). This position allowed me to appreciate that while the COVID-19 pandemic was a shared global event, its impact on young people's mental health was experienced differently depending on factors such as sex and ethnicity, a key insight identified through both the qualitative and quantitative elements of this research.

Maarouf (2019) aptly captures this duality by suggesting that pragmatism accepts both the existence of an external reality and the multiplicity of subjective realities 'subjective and objective at the same time, accepting both the existence of one reality and that individuals have multiple interpretations of this reality' (p. 6). This ontological flexibility was essential for my research aims, it enabled the exploration of structural patterns (e.g., additive effects of factors on mental health) while also valuing the individual and diverse lived experiences articulated by young people. As a researcher, I understand that my task was not to adjudicate between competing realities, but to highlight how

different realities are constructed, experienced, and navigated, particularly at the intersections of social identities during the COVID-19 pandemic.

My ontological stance acknowledges that while systemic inequalities (e.g., socioeconomic disadvantage, racial disparities) structure mental health risks, young people's subjective experiences of these structures are dynamic, contextual, and often mediated by individual coping strategies, social support, and resilience. Thus, the research embraces complexity, rejecting binary notions of reality in favour of a nuanced, pragmatic ontology suited to the intricacies of youth mental health during COVID-19.

3.2.5 Theoretical perspective

This thesis draws on two complementary theoretical frameworks, intersectionality and the social determinants of health. While intersectionality provides the primary theoretical framework guiding this research, insights from SIT (Jenkins, 2014) are occasionally drawn upon where helpful to interpret aspects of identity formation and belonging described by participants. These perspectives were selected not only for their conceptual relevance but also for their capacity to guide a mixed methods approach capable of analysing both structural inequalities and individual lived experiences. By situating mental health within its broader social context, these frameworks enable a nuanced exploration of how different forms of disadvantage interact to shape outcomes across diverse youth populations.

As discussed in the literature review, mental health is a complex and often contested concept, with debates surrounding its definition, measurement, and causes. A central problem within dominant biomedical approaches is their reduction of mental health to individual pathology, neglecting the wider social and structural conditions that contribute to emotional and psychological distress (Deacon, 2013; Engel, 1977). While the biomedical model remains dominant in both clinical and policy settings, its limitations have led to the emergence of more holistic approaches such as the biopsychosocial model (Engel, 1977), and subsequently, sociologically-informed frameworks that attend to the social production of mental health (Beresford et al., 2016; Tew, 2005).

The social determinants of health framework addresses precisely this limitation by recognising that health and illness are patterned by the conditions in which people are born, grow, live, work, and age (Marmot & Bell, 2012; WHO, 2022e). Mental health, from this perspective, is not merely a reflection of internal dysfunction, but a consequence of social processes such as poverty, discrimination, and marginalisation (Link & Phelan, 1995; Lund et al., 2011). This theoretical orientation aligns with evidence presented in Chapter 2 of this thesis, which documents how young people’s mental health outcomes are shaped by structural inequalities, including access to resources, education, employment, and healthcare.

Yet, while the social determinants of health framework is essential in illuminating the broad social landscape of mental health, it has been critiqued for insufficient attention to how these determinants are experienced differently across social identities (Alegría et al., 2025; Edyburn et al., 2023; Kammer-Kerwick et al., 2024). It is here that intersectionality plays a critical role. Originally developed by Black feminist scholars to challenge single-axis approaches to discrimination (Crenshaw, 1989), intersectionality examines how social categories such as sex, ethnicity, class, and sexuality do not operate independently but intersect to produce unique experiences of oppression and privilege. Intersectionality is not only a theory of identity but a structural analysis of how systems of power such as racism, sexism, and classism interact (Collins & Bilge, 2020).

Both frameworks offer complementary strengths for understanding young people's mental health in a post-pandemic context. The social determinants of health framework foregrounds macro-level factors such as income inequality, educational access, and employment status, which have become increasingly salient during COVID-19. For example, school closures, disruptions to higher education, and precarious labour market conditions have disproportionately affected young people, particularly those already facing disadvantage (Lund & Cois, 2018). Meanwhile, austerity and underfunding in mental health services have reduced the availability of timely and appropriate support, further compounding these risks (Gilburt & Mallorie, 2024; O'Shea & McHayle, 2021). Intersectionality, in contrast, highlights how the impacts of these structural conditions are not evenly distributed. While the social determinants framework identifies broad disparities, intersectionality reveals how overlapping factors such as low income, racism, and gendered norms, produce distinct vulnerabilities. Thus, intersectionality enables a layered understanding of mental health that moves beyond population averages and captures the heterogeneity of experience.

3.3 Research design

Although I did not initially recognise it as such, my approach to problem-solving has long reflected a pragmatic orientation, centred on addressing real-world challenges through careful deliberation and practical action. This aligns with Dewey's Five-Step Model of Inquiry (Dewey, 1933/1985; Morgan, 2014) (Figure 3.1), which emphasises reflective problem identification, formulation of hypotheses, and testing through action. In research, this process becomes more rigorous, requiring methodological choices guided by the research question and a consideration of what works in practice (Kelly & Cordeiro, 2020; Morgan, 2007).

Figure 3.1. Five-Step Model of Inquiry (Dewey, 1933/1985).

(Morgan, 2014, p. 30)

Dewey's model appears linear, but the actual research process is iterative, moving between theory and data in a way that constantly refines both. Morgan (2007) refers to this as *abductive reasoning*, where decisions are shaped not only by logic and evidence but also by the researcher's positionality and values (Kaushik & Walsh, 2019). Pragmatism acknowledges both objective realities and subjective experiences, prioritising practical solutions over methodological orthodoxy (Pansiri, 2005).

While epistemological and ontological positions are often underemphasised in quantitative research, they remain central to research design especially in qualitative and mixed methods traditions. In a pragmatist approach, methodology serves as the bridge between philosophical worldview and empirical inquiry (Revez & Calvão Borges, 2018). Rather than aligning strictly with positivist or interpretivist paradigms, pragmatism embraces both quantitative and qualitative methods, reflecting a methodological pluralism well suited to understanding complex phenomena (Creswell, 2003; Kaushik & Walsh, 2019; Morgan, 2007). This flexibility is particularly important when investigating the intersecting and multifaceted influences on young people's mental health. A single methodological lens cannot adequately capture both the structural conditions and subjective experiences involved. The intersectional lens adopted in this research necessitated a mixed methods design, integrating statistical analysis to identify patterns and disparities with qualitative inquiry to capture depth, context, and lived experience.

From a pragmatic standpoint, the use of mixed methods was not simply a practical choice but a philosophically grounded one. It reflected a commitment to selecting tools most appropriate for

answering the research question and engaging with complexity. As such, pragmatism has been widely recognised as the foundational paradigm for mixed methods research (Teddlie & Tashakkori, 2009), offering a coherent justification for methodological integration. The combination of qualitative and quantitative approaches facilitated a richer, more nuanced understanding of how intersecting social identities shape the mental health experiences of young people in the context of the pandemic.

3.4 Aims and objectives

Informed by a pragmatic research paradigm and employing a mixed methods approach, this research sought to generate a comprehensive understanding of young people's mental health during and after the COVID-19 pandemic. By drawing on both qualitative and quantitative data, and situating the analysis within an intersectional framework, the research aimed to explore not only statistical trends but also the nuanced lived experiences of young people. The questions this research aimed to address are: -

1. How have key social determinants shaped young people's mental health before and after COVID-19, and what patterns have emerged from this change over time?
2. What are the lived experiences of mental health in young people, during and post COVID-19?
3. To what extent can intersectionality aid the understanding of mental health in the young people population?
4. What do the findings suggest for improving mental health support and reducing inequalities among young people?

3.5 Mixed methods approach

While studies combining quantitative and qualitative approaches date back to the early 20th century (Lynd & Lynd, 1929, 1937; O'Connor, 2001), formal debates around mixed methods integration gained prominence in the late twentieth century (Johnson & Onwuegbuzie, 2004). Since then, mixed methods has gained widespread acceptance, underpinned by increased publication, professional endorsement, and foundational texts (Biddle & Schafft, 2015). Often referred to as the *third methodological tradition* (Johnson et al., 2007), the field is now most commonly labelled 'mixed methods' research (O'Cathain et al., 2007), though alternative terms include 'blended', 'integrative', and 'multiple methods' research (Castro et al., 2010; Fetters & Molina-Azorin, 2017; Thomas, 2003). Definitions of mixed methods vary in emphasis. Jennifer Greene, for instance, defines it as inquiry involving more than one methodological tradition and way of knowing (Johnson et al., 2007). For this research, Johnson et al.'s (2007, p. 123) synthesized definition is most appropriate:

> Mixed methods research is the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e.g., use of qualitative

> and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration.
>
> *(Johnson et al., 2007, p. 123)*

This definition reflects the theoretical and methodological integration at the core of mixed methods research (Creswell & Plano Clark, 2018; Dawadi et al., 2021), allowing researchers to combine strengths and mitigate weaknesses of each approach (Enosh et al., 2015; Johnson & Christensen, 2017). Quantitative research, traditionally dominant in health and social sciences, relies on deductive reasoning and large samples to explore patterns, generalisability, and causality (Browner et al., 2022; Fetters et al., 2013). In contrast, qualitative approaches are inductive, focusing on meaning, experience, and context through methods such as interviews and focus groups (Curry & Nunez-Smith, 2015; Dawadi et al., 2021; Fetters et al., 2013). Each contributes distinct insights: quantitative methods reveal breadth and patterns, while qualitative methods offer depth and nuance.

Beyond method selection, mixed methods also considers *timing* (concurrent vs. sequential implementation) and *purpose* (e.g., complementarity, triangulation) (Guest, 2013; Creswell & Plano Clark, 2018). A critical component is the integration of data, which should be planned from the outset and aligned with the research question (Curry & Nunez-Smith, 2015). Despite its strengths, integration is often critiqued for insufficient depth (Bryman, 2007; Skamagki et al., 2024). Approaches to integration include merging, embedding, connecting, or using frameworks to link datasets, commonly at the interpretation or results stage (Creswell & Plano Clark, 2018; Fetters et al., 2013; Schoonenboom & Johnson, 2017). Figure 3.2 summarises key mixed methods design types and their integration strategies.

Figure 3.2. Primary mixed methods research study design and integration types.

DESIGN

Convergent: QUAL, QUAN

Exploratory Sequential: QUAL → QUAN →

Explanatory Sequential: QUAN → QUAL →

INTEGRATION

Merged: Component 1, Component 2 → Results

Embedded: Component 1, Component 2 → Results

Connected: Component 1, Component 2 → Results

The left column represents how the various methodological components are mixed or sequenced.

The right column represents the integration of each component's results for final analysis.

QUAN = quantitative component; QUAL = qualitative component

Component: This represents either the qualitative or quantitative component, depending on their sequence in your research design.

(Curry & Nunez-Smith, 2015)

3.5.1 Justification of methods

The strengths of mixed methods research, and its philosophical alignment with pragmatism, provide a compelling rationale for its use in studying the complexity of young people's mental health. Influenced by intersecting social, psychological, and environmental factors, mental health cannot be fully understood through either quantitative or qualitative approaches alone. Mixed methods allows for deeper, more comprehensive insights by integrating both (Curry & Nunez-Smith, 2015). This integrative potential is illustrated in Cosma et al.'s (2017) sequential QUANT→QUAL study on adolescent well-being across countries during COVID-19. Quantitative survey findings showed deteriorating mental health in 30% of adolescents, and qualitative focus group data identified contributing pressures ranging from school to social media. Similarly, Neill et al. (2022) used a pragmatic, co-produced mixed methods study to inform an adolescent mental health intervention. Through qualitative and quantitative data collection, they found that test anxiety and differing teacher-student perspectives shaped students' mental health. Findings directly informed the development of the R.E.A.C.T. programme demonstrating the action-oriented nature of mixed methods within a pragmatic framework.

During the pandemic, many studies used surveys combining closed (quantitative) and open-ended (qualitative) questions, reflecting practical constraints on data collection (Bell et al., 2023; Kaya & McCabe, 2022; Rogers et al., 2021). Open responses offered context to quantitative patterns but were limited by brevity and interpretive challenges (Postigo-Zegarra et al., 2021). Nonetheless, these studies exemplify how mixed methods can enrich understanding during complex and evolving circumstances.

While mixed methods research offers considerable advantages, it is not without challenges. A key strength lies in its ability to address complex social phenomena by drawing on multiple forms of evidence, allowing researchers to explore both broad structural patterns and the lived experiences that underpin them (Creswell & Plano Clark, 2018; Tashakkori & Teddlie, 1998). However, scholars have also highlighted methodological tensions associated with combining approaches that are rooted in different epistemological traditions (Bryman, 2007). Mixed methods studies can be resource intensive, requiring researchers to develop competence across distinct methodological traditions and to allocate additional time for data collection, analysis and interpretation. A particularly significant and widely recognised challenge concerns integration, as mixed methods studies often fail to move beyond parallel analyses, limiting the extent to which qualitative and quantitative findings meaningfully inform one another (Fetters et al., 2013). Achieving meaningful integration requires careful consideration of when and how datasets are connected during the research process.

In line with this logic, and consistent with an intersectional perspective that seeks to illuminate how inequalities intersect (Bowleg, 2008), this study adopted a sequential exploratory mixed methods design (QUAL→QUANT) (Fetters et al., 2013) (see Figure 3.3.). The qualitative phase was undertaken first and informed the subsequent quantitative analysis. Although there was some temporal overlap in the wider research process between February 2023 and September 2024, the design logic remained sequential, with integration occurring at the interpretation and reporting stage using two strategies: narrative weaving - organising findings by themes across both datasets, and a joint display, which visually presents integrated results and enables meta-inference (Fetters et al., 2013; Tashakkori & Teddlie, 2008). To ensure transparency and rigour, O'Cathain et al.'s (2008) quality guidelines for mixed methods studies was followed.

Figure 3.3. Flow chart of mixed methods design used in this research.

QUALITATIVE
Aim: To explore young people's lived experiences of mental health during and after COVID-19

Data collection: Semi-structured interviews and a focus group with young people in Sheffield
Data analysis: inductive-deductive approach using RREAL Sheets

QUANTITATIVE
Aim: To analyse secondary data (UKHLS) to see if intersectionality can aid the understanding of mental health in young people

Data collection: Secondary data analysis of Understanding Society Study data, Wave 7 (2015-2017) and Wave 13 (2021-2023)
Data analysis: descriptive, bi-variate, multivariate and MAIHDA

INTEGRATION OF FINDINGS

Qualitative and Quantitative connected and presented using a narrative weaving approach and joint display

Building on the qualitative phase, the quantitative component provided descriptive and comparative analyses of young people's mental health over time, including during and after COVID-19 lockdowns. It captured patterns by sex, ethnicity, and socioeconomic background, revealing consistent disparities particularly among young women, White adolescents, and those from lower-income households (Brooks et al., 2020; Grimm et al., 2022; Patalay & Fitzsimons, 2020). However, while these patterns are informative, they lack the nuance needed to understand why certain groups reported worse outcomes. The qualitative data addressed this gap by capturing young people's lived experiences, allowing for richer interpretations and exploration of how intersecting identities shaped their mental health during the pandemic (Jackson et al., 2021; Bowleg, 2012). Through interviews and a focus group, participants reflected on the emotional and social dimensions of lockdown and their perceptions of identity-related disadvantage. This depth added complexity to the quantitative findings and aligned with the study's intersectional aims.

The qualitative fieldwork was situated in Sheffield and developed in collaboration with Sheffield City Council's Public Health department. Engagement with the Sheffield Youth Cabinet during the design

phase facilitated recruitment and ensured the research remained grounded in the priorities of local young people.

3.6 Qualitative approach

Data collection for the qualitative part of the research involved the use of two methods: semi-structured interviews and a focus group. These were undertaken with young people in Sheffield to learn about their lived mental health experiences during and post-COVID-19, and to understand how they feel their identity may have played a role in their experience.

3.6.1 Semi-structured interviews

3.6.1.1 Developing the research materials

The purpose of the interviews was to gain an understanding of what young people experienced during the COVID-19 pandemic in terms of their mental health and their insights regarding how and who they are, might have impacted their experience. It was important that all materials were designed with the target audience in mind (16-24 year olds), ensuring the layout, formatting, content, language and readability were appropriate. This helped to ensure the materials were accessible to young people and optimise recruitment (Coleman et al., 2021; Fleming et al., 2015; Negrin et al., 2022). As the poster was a key signpost to the research, it clearly outlined the purpose, what participants were expected to do, eligibility criteria to take part and contact details for registration and further information. Two information sheets were also produced - one included detailed information about the research and the second information sheet was shorter, an abridged version of the original. The shorter information sheet used images and colour, aimed for the younger aged participants. As an added sense check, the consent form, information sheets and poster were also reviewed by a group of young people from the Sheffield Youth Cabinet who provided comments including: -

- The poster is eye catching however I think some of the writing is not bold enough so a bit lost in the very bright yellow on the page and also the title is not clear from it alone or afar that it's wanting people to take part in the study. I'm not sure how but it needs to invite people in to take part whereas it looks more like a mental health information poster which is quite often overlooked
- I think the information is good however there is a lot of it so perhaps key figures or words or phrases should be made bold as it might be a turn off for anyone seeing it as they can't be bothered
- I like the picture and the colour it's good

The documentation was updated to reflect this feedback (Appendices 1-5).

In addition to these materials, a standardised data collection form was developed (Appendix 6). This was initially drafted in Microsoft Word format and then created in Qualtrics, an online survey software (Qualtrics, 2020). This had multiple purposes, to act as a screening tool for eligible young

people, and to collect data about young people and their mental health. To be able to take part, young people had to meet the following eligibility criteria: -

- Aged between 16-24 years
- Lived in Sheffield (at some point) during the COVID-19 pandemic, and
- Felt their mental health was impacted during COVID-19 pandemic

All young people that were interested in participating were directed to the homepage set-up online in Qualtrics. This displayed the same information as the poster and explained that some information was required to check if the young person could take part. Young people were taken through a set of questions to determine their eligibility using question-specific validation so that automatic identification of eligibility could be undertaken. Further data including contact details, demographics (sex, ethnicity, occupation during COVID-19; living situation) and their current mental health were collected only from those young people that had met the eligibility criteria. In line with ensuring the research materials were as accessible as possible to all young people, all of the documents were available in paper format including the data collection form.

Similarly, the topic guide was developed to capture young people's mental health experiences - pre, during and post COVID-19, and how they understood that their identity may have influenced their experiences (Appendix 8). Mental health is intricately connected to the broader social context, influenced by various social, economic, and environmental factors (Public Health England., 2018), thus it also contained broader questions to understand the lives of young people such as 'what did a normal week in your life look like, pre-COVID?' and 'what did you do with your friends/ family?'. In addition to preventing the interviews from taking too long, the topic guide was kept as brief as possible to promote more in-depth answers to the questions and prevent the interviewing process from being overly prescriptive.

While the concept of intersectionality is powerful, it can be challenging to grasp due to its complexity (Thomas et al., 2021). This became especially evident during the first few interviews as the young people were asked questions about how they felt their sex and ethnicity (for example), may have impacted their experience of mental health. The participants appeared to struggle with answering the question, and at that time, it was difficult to rephrase it in a way that provided better clarification. Refining questions as the research progresses is recognised as important and can help to create high-quality topic guides. This is a reflection of increased understanding of the phenomena but may also be through researcher observations of biases and viewpoints (Agee, 2009; Charmaz, 2014; Creswell & Plano Clark, 2007). Following discussions with supervisors, the questions exploring individual social identities were made more explicit and prior to asking the questions, a narrative story was told to set the scene, for example: -

> During COVID, I witnessed friends who through their individual circumstances, had many different experiences in terms of their mental health. One friend could work at home - they had a big house so they could work without being disturbed by the children, and all the children had computers so they could do their school work OK. She found COVID OK, actually enjoyed it! However, I had other friends, one in a similar situation with children but they lived in a flat, really struggled due to lack of space and privacy; another couldn't work from home, they worked in a supermarket - both of these friends struggled, often talked about feeling down…….

This adaptation to the topic guide really helped participants to understand what was being asked and elicit more in-depth responses.

3.6.1.2 Recruitment

Recruiting young people for interview-based research presented significant challenges, many of which were not fully anticipated at the outset. Despite a strong initial commitment to engaging an underrepresented group in an important area of study, the realities of access, communication barriers, and stigma around mental health complicated recruitment efforts. Such challenges are well-documented in youth mental health research (Hoffmann et al., 2022; Liu et al., 2018; Moreno et al., 2017), with stigma continuing to deter participation in both research and support services (Sheikhan et al., 2023; Woodall et al., 2010). Multiple recruitment strategies were employed to maximise reach and inclusivity among 16–24-year olds in Sheffield. An initial assumption was that online methods, particularly social media, would be the most effective route. This assumption was based on both professional experience within higher education, and personal observations as a parent of a teenager, where frequent phone use and engagement with platforms such as Instagram, Facebook, and Twitter (now X) are common, and thus familiar spaces for the target population. Indeed, online recruitment has seen growing popularity due to its cost-effectiveness, wide reach, and accessibility for hard-to-reach populations (Murray & Xie, 2024; Parker et al., 2021). Social media also surged in usage during the pandemic, becoming a preferred recruitment method in some youth studies (Jong et al., 2023).

However, the reality proved more complex. Although posts were shared through personal and institutional accounts with accompanying research posters, visibility was limited. The oversaturation of online platforms, combined with limited algorithmic reach for accounts without large followings, meant posts rarely extended beyond immediate networks. As Abaddi et al. (2011) argue, social media is a noisy and fragmented environment, and without established presence or influencers to amplify messaging, organic recruitment is often ineffective. Furthermore, while young people make up around a quarter of UK social media users (Statista, 2023), this does not necessarily translate into engagement with academic or research-focused content. To overcome these barriers, the recruitment strategy was expanded to include offline and community-based approaches. Educational settings such as schools, colleges, and universities were logical access points but presented their own challenges, particularly in terms of gatekeeping and timing. A desktop mapping exercise identified Sheffield-based sixth forms,

colleges, youth organisations, and community programmes through the Sheffield City Council directory and the StartProfile platform (https://southyorkshire.startprofile.com/page/home-page). These were supplemented by further searches for youth-oriented groups. Where possible, individual contacts (e.g., heads of sixth forms, programme managers) were identified and sent tailored emails containing a concise explanation of the study, a recruitment poster, and ethical assurances. These messages used professional formatting and included university logos and identifiers to enhance legitimacy and build trust (Ross, 2009; Atkins & Huang, 2013). The first round of emails was sent in late March 2023 but coincided with school Easter holidays, prompting a second round of follow-ups after the school term resumed. Despite these efforts, direct responses remained limited. Prior experience had highlighted the critical role of gatekeepers, those individuals or organisations in a position to facilitate or restrict access to participants (Bryman, 2016; Lune & Berg, 2017). This is especially evident for young people, who are often surrounded by multiple formal and informal gatekeepers such as parents, teachers, youth workers, and service providers (Kay, 2019; Tinson, 2009). These figures serve protective roles but can unintentionally limit opportunities for participation. Contacting individuals directly allowed for some access in this research, but relationship-building was often constrained by time and lack of pre-existing connections.

A key breakthrough came unexpectedly through a personal contact. During a conversation about recruitment challenges, a friend who was both a Head of Year in a local sixth form and a long-standing member of a netball team, volunteered to assist. She shared recruitment materials through her professional networks and advocated for the study. This exemplifies the role of an informal 'guide' (Lune & Berg, 2017), someone embedded within the participant community who believes in the research and is willing to extend their credibility to the researcher. Her involvement added a layer of trust and familiarity that institutional outreach had struggled to establish. While the initial research plan had consciously avoided drawing on personal contacts to maintain boundaries, this unplanned support proved vital in expanding access.

To engage young people outside formal education such as those in employment, apprenticeships, or not in work or training, other public-facing spaces were targeted. Posters were displayed in local gyms, supermarkets, and community centres, particularly those involved in initiatives like the Big Sister project. This programme, aimed at increasing girls' participation in sport, was familiar through personal experience and widely recognised among young people locally. While the programme itself was not open to boys, gyms where it operated had increasing engagement from young men. These sites offered communal noticeboards and reception areas where posters and leaflets could be placed, potentially reaching young people indirectly or through peer sharing (Manohar et al., 2019).

Soon after the social media posts went live in early March 2023, 20 registrations were received through the Qualtrics screening form. Interested participants were sent personalised follow-up emails with the information sheet, consent form, and available time slots. Although many returned consent

forms promptly, scheduling proved difficult. Initial enthusiasm often faded during this phase, with emails going unanswered. Switching to WhatsApp for scheduling helped improve responsiveness, suggesting that more informal, instant messaging platforms may offer advantages for participant retention in youth research. To further support recruitment, a snowball sampling strategy was adopted. At the end of each interview, participants were asked to share the study with friends who might be eligible and interested. While this generated only a few additional registrations, it was a valuable supplement to the broader strategy.

3.6.1.3 Data collection

Data collection was designed to maximise accessibility, flexibility, and participant comfort while ensuring methodological rigour. Given the ongoing legacy of COVID-19 on research practices, participants were offered the choice of in-person, online (via Google Meet), or telephone interviews. This multi-modal approach aimed to reduce participation barriers such as travel, scheduling constraints, and personal preference for privacy. While traditional methodological literature has emphasised the benefits of in-person interviewing for building rapport and capturing non-verbal cues (Gillham, 2005; Rubin & Rubin, 2011), remote methods have increasingly been recognised for their advantages, particularly in sensitive-topic research, by offering greater anonymity and control to the participant (Jenner & Myers, 2019; Kähäri & Edelman, 2024). The use of multiple modalities also reflects broader shifts in qualitative research practice since the COVID-19 pandemic, where digital and telephone interviewing have become more widely adopted (Keen et al., 2022; Lobe et al., 2020). In this study, offering different interview formats allowed participants to select the format with which they felt most comfortable, which was particularly important when discussing personal experiences of mental health. To maintain consistency across modalities, the same interview guide and conversational interview approach was used in all interviews.

In-person interviews were held in pre-booked rooms at the University of Sheffield. To reduce logistical difficulties, participants were met at a central and easily accessible city location (a local Boots chemist) served by main bus and tram routes, and walked to the interview venue together. This short walk provided an opportunity for informal conversation, often about the journey or local landmarks, which helped ease nerves and build rapport before the formal interview began. A visible university identification badge was consistently worn while waiting for participants and was intentionally presented during introductions for reassurance and legitimacy. Remote interviews were conducted via Google Meet (video) or telephone. Participants were provided with detailed joining instructions, including equipment requirements, expected duration, and researcher contact details. Telephone interviews were scheduled with the same preparatory guidance and were useful for participants with unstable internet access or a preference for audio-only communication.

Preparation for each interview began 30 minutes prior to the scheduled start. This included checking technical equipment (speakers, microphone, digital recorder) and reviewing the participant's registration details such as age, sex, ethnicity, and COVID-19 experiences, captured during the Qualtrics screening process. This was particularly important, firstly to present myself as someone who cared but also because several of the interview questions specifically included this information that the participant had provided in the eligibility survey. Consent was re-confirmed verbally before any recording commenced. A reflexive approach was adopted throughout the data collection process, informed by principles of 'caring reflexivity' (Ross, 2017). Particular attention was given to the researcher–participant relationship and the potential influence of positionality on the research encounter. At the beginning of each interview, I made a conscious effort to build rapport, introducing myself not only as a researcher but also acknowledging my position as a parent of a teenager who had experienced mental health challenges during the pandemic. While I did not assume shared experiences, this approach was intended to foster openness and acknowledge the partial perspective from which I approached the research (Abrams et al., 2020).

All interviews were recorded using either the encrypted voice recorder or Google Meet's recording function, as approved in the study's ethics protocol. Audio recording during interviews enabled greater attentiveness to participants, minimised distractions, and provided reassurance that an accurate record of the discussion would be available for later analysis (Bryman, 2016). Data were transcribed verbatim, and then quality checked against the original recording for accuracy. Brief notes were still taken during and after interviews to capture initial analytic ideas, clarify points for follow-up, and record contextual observations.

Following each interview, initial insights were documented and organised using a RREAL (Rapid Research Evaluation and Appraisal Lab) Sheet (Appendix 10), a practical and adaptable tool typically structured as a table to support the collection, synthesis, and interpretation of qualitative data (Vindrola-Padros et al., 2022). This method supports early engagement with the data and allows analysis to progress in parallel with data collection (Vindrola-Padros et al., 2020; Vindrola-Padros et al., 2022). A preliminary version of the RREAL Sheet was created based on the interview guide, and adjustments were made after piloting it in the first few interviews to ensure it captured relevant information effectively. Key points were recorded directly after each interview through real-time note-taking, and recordings were revisited when clarification or further detail was required. The structure of the table remained flexible, with categories revised as new themes or patterns were developed throughout the research process. Ultimately, the RREAL Sheet played a central role in supporting the thematic analysis and acted as a first step in familiarisation of the data as part of developing familiarity with the data within a reflexive thematic analysis (RTA) approach (Braun & Clarke, 2021).

A total of 120 expressions of interest were received via the registration system. Of these, 29 interviews were scheduled, and 16 were completed successfully and included in the analysis. Interviews lasted an average of 54 minutes (range: 33–90 minutes) and were distributed as follows: online (n=8)**,** in-person (n=6), and telephone (n=2)**.** The number of completed interviews was guided by considerations of depth, diversity, and the richness of the dataset, rather than a predefined notion of saturation, consistent with RTA (Braun & Clarke, 2021). This ensured sufficient depth and diversity of experience to address the research questions while balancing resource constraints and ethical considerations.

Five interviews were excluded as 'imposter participants' (Ridge et al., 2023), individuals whose responses suggested they were not genuine members of the study's target group. This decision was based on multiple red flags: use of recruitment websites not linked to the study (e.g. Craigslist), inconsistencies between eligibility data and interview narratives (e.g. location, age), reluctance to turn on a camera without plausible reason, and vague or generic descriptions of living in Sheffield during the pandemic. Similar patterns have been documented in online qualitative research, where financial incentives, identity misrepresentation, or automated responses may drive false participation; it appears to be a rapidly emerging phenomenon (O'Donnell et al., 2023; Pullen Sansfaçon et al., 2024; Roehl & Harland, 2022; Sharma et al., 2024). Their removal was essential to maintain data integrity.

3.6.2 Focus group

3.6.2.1 Recruitment

One of the organisations contacted to raise awareness of the research was CHILYPEP (https://chilypep.org.uk/). CHILYPEP (Children and Young People's Empowerment Project) is a youth-led organisation based in Sheffield and Barnsley that empowers young people, especially those from marginalised or vulnerable backgrounds, to have a voice and influence decisions, and services affecting their lives. It focuses on mental health, social justice, youth rights, and community engagement through participation and advocacy (CHILYPEP, n.d.). A Project Worker from the STAMP (Support, Think, Act, Motivate, Participate) group, an initiative within CHILYPEP aimed at improving the mental health and emotional wellbeing of young people, responded with interest and requested a further discussion. Following a meeting, it was agreed that attendance at a STAMP session (held fortnightly in the evening) would be arranged initially for observation, with a subsequent session to be facilitated as a focus group for the research. The observation session provided an opportunity to introduce the research, answer any questions, and distribute printed information sheets and consent forms. With this material, attendees were given the time and autonomy to decide whether they wished to participate in the upcoming session that would serve as a focus group for the research.

3.6.2.2 Development of focus group schedule

Focus groups are a qualitative research method involving guided group discussions designed to explore participants' perceptions, experiences, and attitudes in relation to a specific topic (Wilkinson, 2004). They are particularly well-suited to exploring sensitive and complex issues such as mental health, as they enable participants to reflect on their experiences in a collective setting and build on each other's contributions (Frith, 2000; Lauri, 2019; Smith, 2003). With this in mind, the initial plan was to structure the focus group around the interview schedule, posing questions and recording responses and ensuing discussions. However, this approach shifted significantly following the observation of the STAMP session, which proved highly valuable in reshaping the structure of the focus group.

During the observation session, another researcher was observed presenting their study in an effort to gain feedback from a group of young people. The researcher brought along study documentation and posed questions about accessing mental health services. The response from the young people was disengaged; a few commented on formatting, some talked among themselves, and others paid little attention to the materials. When prompted to discuss their own experiences, interaction was limited, and one participant dominated the conversation. The session did not appear to generate substantive feedback, and the overall impression was that the opportunity had been largely unproductive. Determined to avoid a similar outcome, a different approach was deliberately adopted in preparation for the focus group session. Based on feedback from the young people, adjustments were made to enhance accessibility and engagement. One immediate change involved printing materials on coloured paper, directly as a result of comments from the young people about the difficulty of reading text on white backgrounds, a modification supported by research suggesting that coloured backgrounds can aid readability, particularly for individuals with dyslexia (Rello & Bigham, 2017). Plans were also made to include coloured pens, pencils, and stickers to foster a more creative and inclusive environment. More fundamentally, the structure of the focus group session was reimagined, with a shift towards creative methodologies to promote accessibility, expression, and participant-led discussion (McPherson et al., 2025).

Creative approaches such as storytelling, drama, photography, and drawing have been shown to facilitate engagement and self-expression, particularly among young people who may lack confidence or find traditional verbal methods restrictive (Darbyshire et al., 2005; Lomax et al., 2022; Mannay, 2010). These methods can be especially effective when exploring sensitive subjects like mental health, as they allow participants to communicate complex emotions and experiences in non-verbal or symbolic ways. They align well with a pragmatic paradigm and Dewey's emphasis on learning through doing (Dewey, 1944), and are most effective when employed in inclusive, youth-friendly settings that foster trust and co-production (Clark & Morriss, 2017; Holland et al., 2010). In response to these insights, two structured creative activities were developed to anchor the focus group

discussion, both based on visual approaches used by Bagnoli (2009) in their research on young people. The first was a participatory diagram (Jackson, 2013) where the young people were asked to draw a timeline of the COVID-19 period, illustrating their emotional and mental health journey. A rollercoaster metaphor was provided as an example to capture potential highs and lows experienced during this time. The second task invited the young people to draw a self-portrait, which did not need to be a realistic likeness, but rather a visual representation of their identities, i.e. who they are, what is important to them, and what factors shape their experiences. As highlighted by Bagnoli (2009), the aim of the self-portrait was to encourage reflexivity and to help the young people think holistically about their identities which aligned closely with the aim of this research. Both of these visual methods provided a participatory and flexible framework, enabling deeper reflection and encouraging a broader range of responses than standard questioning might allow (Jackson, 2013; Mohajeri & Malaney-Brown, 2025). They provided the basis for further discussion, allowing the young people to use what they had drawn as a 'scaffold' and talk more about their experiences during the pandemic.

Prior to the focus group session, a preparatory meeting was held with the STAMP Project Worker to review the session plan and ensure their approval of the proposed approach. During this discussion, the Project Worker raised a concern voiced by a young person regarding the use of recording equipment (Dictaphone). In response, it was agreed that the focus group session would not be audio-recorded. To enable full attention to be given to the young people in the facilitation of the focus group session, the STAMP Project Worker agreed to take written notes.

3.6.2.3 Data collection

The focus group session, which lasted approximately two hours, was held in the usual location for STAMP meetings, a room at Sheffield Hallam University in Sheffield City Centre. The focus group session began with introductions facilitated by the STAMP Project Worker. To help establish a relaxed and inclusive atmosphere, and to reduce perceived hierarchies between the facilitators and young people (Gibson, 2007), an ice breaker activity was undertaken which everyone participated in. Following this, the STAMP Project Worker handed over the focus group session. A brief recap of the research was provided and it was confirmed that all the young people had read the information sheet. Consent forms were then distributed, alongside printed copies of the data collection sheet (identical to the online Qualtrics version). These were completed before the focus group session progressed.

To structure the session effectively, the time was noted before introducing the first activity: a visual timeline exercise in which the young people were invited to draw their experiences before, during, and after the COVID-19 pandemic. To support understanding, an example timeline was shared, created during the session as a demonstration. After approximately 15-20 minutes, the young people were invited to discuss their drawings. This organically initiated a group discussion around their experiences. The second activity followed a similar format and involved drawing a self-portrait to

represent personal identities. Participants were encouraged to interpret the task broadly; the portraits did not need to be realistic depictions but rather symbolic representations of who they are and what shapes their sense of self. To contextualise this activity, a short narrative was provided explaining how identity intersects with experiences and mental health. Once the young people had completed their drawings, discussion resumed, prompted by questions such as: ‘Do you think your identity may have influenced how you felt or how your mental health was affected during COVID? If so, how?’. As the drawings and any accompanying written text formed part of the data generated within the focus group, the young people were asked verbally at the end of the session whether they were happy for these materials to be retained and used within the research, and verbal consent was obtained before the drawings were collected.

At the end of the focus group session, reflective notes and key discussion points were recorded, which were later collated with the notes taken by the STAMP Project Worker to form a comprehensive record of the focus group session.

3.6.3 Data analysis

The qualitative element of this research generated a rich dataset comprising semi-structured interviews and one focus group with young people, centred primarily on their mental health experiences during the COVID-19 pandemic. Analysis started alongside data collection and continued throughout the research process, allowing early insights to inform ongoing engagement with the dataset. In line with an intersectional framework, attention was given not only to what was said but also to how different aspects of participants’ identities and social contexts shaped their experiences. The data were analysed using RTA, following the approach developed by Braun and Clarke (2006, 2019, 2021). RTA provides a flexible method for identifying patterns of meaning across qualitative datasets while recognising the active interpretive role of the researcher in the analytic process. The analysis was guided by the six phases of RTA outlined by Braun and Clarke (2006, 2019, 2021): familiarisation with the data, generating initial codes, constructing candidate themes, reviewing and refining themes, defining and naming themes, and producing the final written analysis. These phases are presented below for clarity; however consistent with RTA, the process was iterative rather than strictly linear, involving ongoing movement between coding, interpretation and theme development. To ensure rigour and trustworthiness which are key considerations in qualitative analysis (Nowell et al., 2017), the analytical process was carried out in a systematic, consistent, and transparent manner across all stages of interpretation.

3.6.3.1 Familiarisation with the data

The initial phase of familiarisation involved transcription, repeated reading of interview and focus group transcripts, and systematic engagement with the RREAL sheets and notes. Reflexivity during this stage was constant, as I reflected not only on what the young people said but also on how their

accounts related to the broader social and contextual factors shaping their experience. This process supported the development of a deep familiarity with the dataset and the identification of patterns of meaning, including how young people spoke about their mental health and the wider social factors influencing their experiences. These early analytic reflections informed the subsequent coding and interpretive development of themes.

3.6.3.2 Generating codes and constructing candidate themes

Once all interviews and the focus group had been completed, the completed RREAL Sheets and notes were reviewed collectively. The data was compared across participants to identify important patterns of meaning. Initial codes were generated through close engagement with the dataset and were informed by the theoretical framing of the research, including intersectionality and existing literature on young people's mental health. Through iterative coding and interpretation, candidate themes were actively constructed through iterative engagement with the data and explored using thematic maps. Quotes from the interviews and the focus group notes were selected to illustrate and enrich each theme (Appendix 11).

3.6.3.3 Reviewing, refining and defining themes

Consistent with RTA, these processes did not occur as discrete or linear stages. Reviewing, refining, defining, and naming themes were undertaken iteratively, with movement back and forth between phases, as patterns of meaning were developed and clarified (Braun & Clarke, 2021). Candidate themes were reviewed for coherence and distinctiveness through continued engagement with the transcripts, notes and thematic maps. This involved considering whether the themes meaningfully captured patterns across the dataset, refining their boundaries, and clarifying their focus. Themes were then defined and named to ensure that each theme had a clear analytic purpose and contributed to the overall interpretation of the data (Braun & Clarke, 2021).

3.6.3.4 Final analysis and writing

The final phase involved producing the written analysis, in which themes were presented in relation to the research questions and situated within the broader theoretical and empirical literature. In keeping with RTA, writing was understood not simply as reporting findings, but as part of the analytic process through which themes were finalised and interpreted.

3.7 Quantitative approach

3.7.1 Data

The quantitative component of this research used secondary data to access large-scale, longitudinal population datasets that would have been impractical to collect independently. Specifically, data were drawn from the UK Household Longitudinal Study (UKHLS), a prominent UK household panel survey designed to examine the long-term effects of social change and policy interventions on well-being (Ellis et al., 2011). Established in 2009 as an extension of the British Household Panel Study, UKHLS collects annual data from approximately 40,000 households. The main survey includes interviews with household members aged 16 and above, complemented by self-completion questionnaires covering diverse topics such as health, education, employment, income, family dynamics, and social life (Buck & McFall, 2012; Institute for Social and Economic Research, 2024). Additionally, UKHLS administers supplementary surveys, including a youth self-completion questionnaire targeting individuals aged 10–15 years, subject to parental consent. This gathers data specific to young people's lives and was incorporated into this research using data from Wave 7 only (2015/16). The comprehensiveness and methodological rigor of UKHLS ensure its datasets are high quality, nationally representative, and freely accessible after registration (Fisher et al., 2019). The representativeness of UKHLS data has been widely acknowledged, making it a valuable resource for research on social inequality, health outcomes, and policy impacts in the UK (Lynn, 2009; Platt et al., 2020).

For the purposes of this research, Waves 7 and 13 of the UKHLS, spanning 2015/16 to 2021/22, were employed to investigate intersections of sex, ethnicity, household income, and urbanicity on mental health indicators among young people in the UK. These datasets reported response rates of 81.5% and 78.7%, respectively, ensuring robust statistical reliability (University of Essex Institute for Social and Economic Research, 2022). Furthermore, the longitudinal design of UKHLS facilitates the examination of changes over time, which is critical for understanding the evolving impact of COVID-19 on mental health (Buck & McFall, 2012).

The quantitative data were downloaded in R format from the UKHLS web site (https://www.understandingsociety.ac.uk/documentation/data-releases) and the associated R computer program was used for manipulation and analysis (R Core Team, 2023). Prior to the analysis stage, it was vitally important to prepare the data to help ensure validity (Osborne, 2013) and create highly efficient data (@GeeksforGeeks, n.d.). This pre-analysis stage involved several steps with the first understanding the coding patterns and missing data profiles of the datasets (Cheng & Phillips, 2014). Frequency tables, cross-tabulations and basic summary statistics (mean, mode, median, range) were also generated to explore all of the variables.

3.7.2 Data preparation and sample structure

The aim of using MAIHDA was to try to unpick some of the complexity of the various factors (social inequalities, biological, developmental processes, sociocultural) that influence mental health, and aid the understanding of mental health in young people. The UKHLS analysis involved reviewing literature focused on young people and their mental health, and how this may be impacted by different dimensions of inequality. Prior to the COVID-19 pandemic, the mental health of young people was reported as being in decline, with amongst others, poverty, ethnic group, low parental education and neighbourhood identified as being risk factors (Callaghan et al., 2021; Marquez et al., 2022; Reiss, 2013; Visser et al., 2021). Research has suggested that these social inequalities may have been exacerbated during the pandemic, impacting mental health further (Lorthe et al., 2023; Serrano-Alarcón et al., 2022; The Health Foundation, 2022). To follow on from the evidence, a range of variables were included in the downloaded UKHLS datasets based on two key points as suggested by Evans, Leckie, et al. (2024). Firstly, from a practical point of view, the information needed to be available for use in the UKHLS source data and be well completed. Secondly, from an intersectional perspective, the variables needed to capture and reflect the complex interplay of various social identities and be recognised as potential risk factors that impact mental health in young people. Appendix 12 displays all of the considered variables and whether they met the criteria for inclusion of being well completed. It was decided to include four variables as intersectional strata– sex, ethnic group, household income and urban. Additionally, the outcomes of the qualitative analysis with young people were also considered and played a role in the intersectional strata variables selected, particularly household income (as a proxy of socioeconomic status) and to a lesser extent, urbanicity. The young people discussed restricted access to computers and lack of space in the home as negatively impacting mental health. Conversely, being able to go outside and having access to open green spaces was felt to help mental health.

While the wider research focuses on young people aged 16–24 years, the UKHLS analysis drew on data from two broader age ranges: 10-30 years in Wave 7 (2015/16) and 16-30 years in Wave 13 (2021/22), to align with the ages those individuals would have been during the COVID-19 pandemic. Specifically, individuals who were aged 16-24 years during the pandemic would have been between 10 and 15 years old in 2015/16, and between 24 and 30 years old by 2021/22. These age bands were therefore selected to ensure the analysis captured the same age cohort of young people at two relevant time points: pre-pandemic and during/ post-pandemic.

Table 3.1 displays the structure of the individual datasets from Waves 7 (Youth and Adult), and Wave 13 Adult, outliers and missing data. After removal of individuals that were not within the age range of interest (10-30 years), the availability and quality of responses to the key outcome measures and intersectional strata variables were examined.

Table 3.1. Sample structure and missing data.

	Wave		
	7 youth (10 -15 years)	7 Adult (16-30 years)	13 Adult (16-30 years)
Initial sample total, N	3630	42170	27,998
Deletions, n			
Outside age range of interest (10-30 years)	138	36464	22983
Missing, n (%)			
Sex	0	0	1 (0.02)
Ethnic group	5 (0.14)	50 (0.86)	8 (0.16)
Urban	2 (0.06)	6 (0.10)	3 (0.06)
Household income	28 (0.80)	120 (2.07)	281 (5.60)
SDQ	23 (0.66)	-	-
GHQ-12	-	1263 (21.8)	243 (4.85)
Final sample total, n	**3434**	**4789**	**4496**

3.7.2.1 Missing data

Most of the intersectional strata variables had some missing data in all three datasets with the proportions relatively small, between 0.02% and 5.60%. The main outcome variable (GHQ-12) in the Wave 7 Adult dataset did have a substantial proportion of missing data (21.8%), with 269 (4.65%) responses coded as inapplicable, 942 (16.3%) coded as proxy and 52 (0.90%) coded as missing. This indicates that the majority of the missing responses (coded as inapplicable and proxy) for GHQ-12 were due to an individual not being asked the question either because they were not eligible (inapplicable) or someone else in the household answered on behalf of the participant (proxy) (University of Essex Institute for Social and Economic Research, 2024a). To understand the potential impact of the missing data in the Wave 7 Adult dataset, a comparison of the data samples with and without missing GHQ-12 responses for all of the intersectional strata variables was performed (Appendix 13).

Within the W7 Adult sample, aged 16-30 years (n=5706), 14.4% had a missing GHQ-12 response. On examination, the two cohorts were relatively similar with only small differences between them when stratified by the strata variables. The cohort with missing GHQ-12 responses had a higher mean age (difference of 0.11), a greater proportion of young men (57.5% versus 53.1%) and a smaller proportion of young people with a White, Pakistani or Mixed ethnic group background. There was greater representation in the missing cohort for the remaining ethnic groups - Black, Other and Asian, with the latter having the largest difference (3.8%). The missing cohort included a smaller proportion of young people that lived in a rural setting (17.7% versus 18.1%) and had a higher mean household

income by £14. The findings of the group comparison tests (χ_2 or t-tests) between the missing and non-missing cohorts were significant ($p<0.05$) for age, sex and ethnic group.

The comparison of the two cohorts indicates that there were only slight differences between those with and without a GHQ-12 response, mainly that those with a missing GHQ-12 response were more likely to be slightly older, male and from a non-White ethnic background. This suggests that the final sample is biased particularly towards those from a White or Pakistani ethnic background, as well as those who are female and younger.

In any real world data, missing data is a widespread problem. The optimal approach to handle the issue is to use multiple imputation (Van Ginkel et al., 2020), recognised as being flexible but computationally intensive and requiring careful application (Sterne et al., 2009). After exploration of the missing data in GHQ-12, and taking into consideration the low numbers of missing data in the strata variables, it was decided to use list wise deletion to deal with the missing data. Although this method can be considered wasteful and potentially introduces bias depending on the mechanism of missingness, it remains widely used and is straightforward to implement. In this context, given the low rates of missingness in key variables, list wise deletion was chosen over simple imputation, which, while sometimes used, may underestimate variability and can introduce its own biases (Van Ginkel et al., 2020).

Survey weights were not applied in this analysis. While survey weighting is often used to improve population-level representativeness, current implementations of MAIHDA do not accommodate survey weights directly within the multilevel model structure (Evans, Leckie, et al., 2024; Merlo, 2018). This limitation is noted in the literature and reflects a broader methodological challenge in intersectional quantitative research.

3.7.2.2 Outliers

As a continuous variable, household income was interrogated to identify any potential outlying values. The process of Winsorization was applied where the extreme values (small and large) are replaced with the next closest value, slightly modifying the data in a symmetrical fashion (Blaine, 2018; Thomas & Ward, 2006). Performing Winsorization has the advantage of being able to keep household income values (rather than recoding to missing) and their weight in the tails of the distribution of household income. Consequently, they have a lesser effect on estimates of scale and 'robustify' the sample mean (Wicklin, 2017). As per Weichle et al. (2013), household income was sorted from lowest to highest and values falling in the 0.1% quantile (lowest threshold) and 99.9% (upper threshold) were identified. A household income considered extreme was identified for 5, 12 and 8 participants in the W7 Youth, W7 Adult and W13 Adult cohorts respectively. These values were replaced with the next closest values and the cohort means and standard deviations compared pre- and post-Winsorization. Test of difference were also performed comparing above and below the

means of household income, pre- and post- Winsorization. The results suggest the Winsorization process has led to more stable means demonstrated by the decreased variability caused by the outliers, indicated by the standard deviations, whilst also maintaining the statistical significance of the results (Appendix 14).

3.7.2.3 Outcome variables

3.7.2.3.1 Strengths and Difficulties Questionnaire (SDQ)

The Strengths and Difficulties Questionnaire (SDQ) is a widely used and validated tool for assessing the mental health of young people aged 4-17 (Goodman, 1997). It is a brief, self-, parent- or teacher-report measure, with good reliability and validity demonstrated across various populations and settings (Hall et al., 2019; Mieloo et al., 2012; Muris et al., 2003). The tool assesses a broad range of health and behaviour domains:

- Emotional symptoms: anxiety, depression, and low mood
- Conduct problems: aggression, antisocial behaviour, and rule-breaking
- Hyperactivity/inattention: restlessness, impulsivity, and difficulty concentrating
- Peer problems: difficulties with peers, social withdrawal, and bullying
- Prosocial behaviour: helpfulness, empathy, and cooperation

It provides a comprehensive approach allowing for a balanced evaluation of both difficulties and strengths (as per its name), which is essential in identifying not only areas of concern but also resilience factors in young people. Some examples of how the SDQ has been used include screening for child psychiatric disorders (Goodman et al., 2000), screening of emotional and behavioural problems in Spanish children and adolescents (Ortuño-Sierra et al., 2018) and analysing dynamic change in children's socioemotional development in a UK cohort (Speyer et al., 2022).

The SDQ variable used in this dataset was based on responses from questions covering four areas (emotional symptoms, conduct problems, hyperactivity or inattention and peer relationship problems) outlined in Appendix 15 and is completed by respondents aged between 10 and 15 years, measured in Wave 7. The SDQ score is reported as an average (mean) score (range 0-40), with higher scores indicating higher levels of abnormal behaviour. Scores >=18 are recognised as an indication of mental ill-health in young people (ONS, 2015). The SDQ score has been found to perform well in various different formats (Keilow et al., 2019) and it is often utilised as a categorical variable, most recently based on up to four pre-defined thresholds - close to average, slightly raised, high, and very high (Boyer et al., 2016). It is utilised as a continuous scale in this research, with a mean of 10.7 (SD=5.84) across the Wave 7 youth cohort.

3.7.2.3.2 General Health Questionnaire (GHQ-12)

Similar to the SDQ, the General Health Questionnaire (GHQ-12) is an effective tool for measuring mental health in adults, aged 16 years and above. A self-administered questionnaire consisting of 12 questions, the GHQ-12 has the ability to detect a range of mental health issues early, before they escalate into more severe conditions including anxiety, depression, social dysfunction and loss of confidence (Centofanti et al., 2019). All of which are often seen in young people as they experience stress from education/ employment pressures and social relationships, in the transition to young adulthood. Research has shown the GHQ-12 to have strong psychometric properties including good reliability and validity across different populations, demonstrating its adaptability (Baksheev et al., 2011; French & Tait, 2004; Mann et al., 2011; Politi et al., 1994). For instance, Goldberg et al. (1997) validated the GHQ-12 in numerous countries, showing its applicability to young people of diverse backgrounds. The versatility of the GHQ-12 means it is extensively used in both research and clinical practice exploring mental health (Callender et al., 2021; Holt-White et al., 2023; Stevelink et al., 2018).

For this analysis, the GHQ-12 is derived based on 12-question responses of GHQ-12 (Appendix 16), completed by respondents aged 16 years and older, measured in Waves 7 and 13. The GHQ-12 is reported as a sum value, ranging from 0 (least distressed) to 36 (most distressed), with higher values indicating more severe impairment. Values >=13 indicate psychological distress and suggests further investigation for potential mental disorders (Goldberg et al., 1997). The GHQ-12 scale may be transformed into different formats; in this research the GHQ-12 scale was applied in a continuous form to minimise information loss and align with other studies (Bell et al., 2024). The mean GHQ-12 scores in the Adult cohorts aged 16 years and over are 10.8 (SD=5.71) and 12.3 (SD=6.14) for Waves 7 and 13 respectively.

3.7.2.4 Intersectional strata

3.7.2.4.1 Sex

Biological and physiological differences between males and females have been shown to influence mental health. Hormonal variation and sex-specific brain structures may contribute to differences in symptom expression and disorder prevalence (Day & Stevenson, 2020; Donner & Lowry, 2013; Kuehner, 2017; Li & Graham, 2017). Research consistently shows that females are more likely to experience internalising disorders (e.g., anxiety, depression), while males are more prone to externalising problems (e.g., conduct disorder, substance misuse) (Eaton et al., 2012; Kessler et al., 2005). Recent UK data suggest that young women (aged 18-24 years) are over 1.6 times more likely than young men to experience common mental disorders, with this gap widening over time (McCurdy & Murphy, 2024). While young women report higher rates of self-harm and suicide attempts, young men remain at greater risk of suicide death (Miranda-Mendizabal et al., 2019).

3.7.2.4.2 Gender

Gendered social roles and expectations also shape mental health outcomes. Qualitative research has found that young women experience more stress related to social interaction, responsibility, and gendered power dynamics than young men (Landstedt et al., 2009). These pressures contribute to greater vulnerability, particularly among those who do not conform to traditional gender norms (Xu et al., 2024).

In comparison to cis-gender and heterosexual young people, individuals who identify as lesbian, gay, bisexual, transgender, queer, plus other sexual orientations and gender identities (LGBTQ+) experience significantly higher rates of depression, self-harm, and suicidality. International and UK studies report elevated risks, especially among bisexual youth and sexual minorities (Di Giacomo et al., 2018; Irish et al., 2019; Marchi et al., 2022; McDermott et al., 2024).

The UKHLS collects respondents' self-reported sex. Only two response categories were allowed in the measurement of this survey, thus sex and gender are conflated and the labels of *male* and *female* are used (1=Male, 2=female).

3.7.2.4.3 Ethnic group

Ethnic minority groups often face unique stressors such as racism, socioeconomic disadvantage, and cultural dissonance, that can shape mental health outcomes and influence access to services (Bhui et al., 2003; The Synergi Collaborative Centre., 2018). Evidence consistently shows variation in mental health across ethnic groups, with some groups experiencing elevated risks for certain conditions, and others showing better outcomes despite greater adversity (Bourque et al., 2011; Goodman et al., 2008; Harding et al., 2015). Racism and discrimination have been directly linked to poorer mental health outcomes and are frequently reported by young people from Black, Asian and Mixed ethnic backgrounds in the UK (Ghezae et al., 2022; Mind, 2021). Access to care also differs: ethnic minority young people are less likely to enter services through primary care and more likely through social care or youth justice systems, suggesting inequities in how support is reached (Edbrooke-Childs & Patalay, 2019; Grimm, Alcock, et al., 2022). Cultural stigma, mistrust, and differences in symptom presentation may further discourage voluntary help-seeking (Bradby et al., 2007; Silva et al., 2016). However, research in this area faces interpretive challenges. Ethnic groups are often aggregated into broad categories that mask within-group differences, leading to an oversimplified picture of mental health disparities (Kauh et al., 2021; Lam et al., 2023). Ethnicity is a multidimensional construct, and disaggregation is necessary to identify specific patterns and risks.

In the UKHLS, ethnicity is self-reported using 18 categories aligned with the Government Statistical Service (GSS) harmonised standards (GSS Harmonisation Team, 2011). After preliminary exploration of this variable, the majority of these categories (16) contained less than 5% of individuals with the largest being White (66.1%) followed by Pakistani (8.5%). Following guidance produced by The

Cabinet Office Equality Hub, when it is not feasible to use the full harmonised set of 18 classifications, they recommend using aggregated ethnic groups with reference to those used in the 2021 England and Wales Census (Asian, Black, Mixed, White, and Other) (Cabinet Office Equality Hub, 2023). However, if more detailed ethnic groups can be used, they should be but these should link to the harmonised standards. For the purposes of this analysis, the 18 response categories have been collapsed into six (1=White, 2=Pakistani, 3=Asian, 4=Mixed, 5=Black, 6=Other) (Table 3.2), keeping Pakistani as a separate ethnic group due to the large number of young people in this group. While this approach helps ensure analytical feasibility, this aggregation does have limitations that must be noted and reflected on. It may obscure within-group differences, and broad categories may not reflect the full diversity of experiences across the UK's regions and communities (Haelle, 2022; Kauh et al., 2021).

Table 3.2. Ethnic group categories.

UKHLS ethnic group	Aggregated ethnic group
White British/ English/ Scottish/ Welsh/Northern Irish	White
White Irish	White
White Gypsy or Irish Traveller	White
Any other White background	White
White and black Caribbean	Mixed
White and Black African	Mixed
White and Asian	Mixed
Any other Mixed background	Mixed
Indian	Asian
Pakistani	Pakistani
Bangladeshi	Asian
Chinese	Asian
Any other Asian background	Asian
Black Caribbean	Black
Black African	Black
Any other Black background	Black
Arab	Other
Any other ethnic group	Other

3.7.2.4.4 Household income

Household income was chosen to assess how economic resources and related stressors contribute to mental health, loosely acting as a proxy for socioeconomic status (SES). Ideally an SES proxy contains a combination of indicators such as social class, educational attainment and household income (Jerrim, 2020), recognising that SES is a 'measure of one's combined economic and social status' (Baker, 2014). However, social class is not collected in the UKHLS survey and parental educational attainment contained a high proportion of missing data in all of the Wave cohorts (Appendix 12). Similarly, the Index of Multiple Deprivation, an area-based measure, was also poorly

completed. This is a typical finding in many administrative databases and as such, the use of alternatives such as household income is often used instead (Galobardes et al., 2007).

Household income is recognised as a primary social determinant of health, having a fundamental impact, particularly on mental health in many ways being both a cause and a consequence (Benzeval et al., 2014; Hagell et al., 2018; Public Health England, 2019; Ridley et al., 2020). There are wide socioeconomic disparities and for those young people living in low-income households, this is the most significant disadvantage. Low income influences the physical environment in which people live (i.e. housing, neighbourhood) and access to material resources (food, clothing, transport), as well as having negative psychosocial and behavioural impacts over the life course. For example, young people in low income or debt-ridden households are four times more likely to experience severe mental health problems (Gutman et al., 2015), more likely to be unhappy, and experience bullying (associated with low income) than peers in higher income households (The Children's Society, 2023). A comprehensive review by the World Health Organisation (2008) found strong evidence linking low SES to increased psychiatric symptoms in children, with these disparities becoming more pronounced as children transition from early childhood to adolescence (WHO, 2008). The impact of living in such circumstances (low income) can affect family dynamics; parents are more likely to have poor physical and mental health (The Children's Society, 2023) and the home environment is likely to be stressful (Yang et al., 2023). Consequently, parents' behaviour may be affected which in turn impacts children and young people, and their mental health. This is supported with data from the Office for National Statistics where higher rates of mental disorders are found in children of families that struggle to function well (unhealthly functioning) and who have a parent with a mental disorder (ONS, 2019c). Young people reported that living in a low-income household and experiencing associated stigma led to feelings of 'shame, embarrassment, social isolation, and low self-esteem' (Rainer et al., 2024, p. 9). These negative emotions can create a downward spiral, impacting confidence, mental health, education and employment with long-term consequences (Tilleczek & Campbell, 2013). For some groups of individuals living in low income households, mental health outcomes are worse due to other combined factors. In particular, single parents, women, living with a long-term health condition, disability, experiencing adverse events or being part of a marginalised community such as those of non-White ethnicity or LGBTQ+, are all associated with increased poor mental health (Kirkbride et al., 2024; Mental Health Foundation, 2020).

The household income variable used in this analyses was OECD equivalised enabling incomes for households of different size and composition to be compared. Firstly, extreme values that were not missing were substituted with the next values moving inwards from the extremes in both tails of the income distribution (Winsorization) (Kromydas et al., 2021). Secondly, the sum of the monthly total net personal income (no deductions) received by all household members was divided by the modified equivalence scale for each household (University of Essex Institute for Social and Economic

Research, 2024b). The age group of interest in this research includes 31.2% (n=2730) and 26.3 (n=1312) who reported their status as full-time students in Wave 7 and 13 respectively. Therefore, it is important to note that income from student loans and/ or tuition fee loans are included as a component of personal income and thus in the derived household income. To help with interpretation, the derived household income was stratified into quintiles (1-5).

3.7.2.4.5 Urban

The surrounding environment plays an important role in the lives of young people. Urban and rural environments offer vastly different living conditions, resources, and stressors that influence everyday life, both directly and indirectly effecting mental health (Public Health England and Local Government Association, 2017). The urban/rural divide often correlates with differences in socioeconomic conditions and access to services, which can directly affect mental health outcomes (Gordon et al., 2023; Wilkinson & Pickett, 2009). Young people in rural areas may face more significant barriers to healthcare access, fewer mental health professionals and diverse social support networks (Public Health England and Local Government Association, 2017) due to geographical location and inadequate transport (Commission for Rural Communities, 2006, 2012). Opportunities in education and employment may be reduced having a broader and long-term impact on young people's lives, and in turn, their mental health (Commission for Rural Communities, 2012; Levin, 2014; National Youth Agency, 2021). On the other hand, urban young people may have better access to mental health services but might suffer from stress related to crime or socioeconomic competition (Hiepko et al., 2024; Okkels et al., 2018). For example, Mueller et al. (2019) explored the role of the physical environment in adolescent mental health and found a strong consistent association between fear of crime, mental health and behaviour. The higher levels of noise, pollution and potentially overcrowding, can contribute to anxiety, depression, and other mental health issues (Weich et al., 2006). Conversely, while rural areas may offer more tranquillity and close knit communities, young people in particular may feel isolated and may experience higher levels of social stigma around mental health problems (Glass et al., 2020), as there are distinct cultural and social norms for the different environments. For example, Cartmel and Furlong (2000) highlighted how issues such as mental health or substance abuse led some families in small communities to feeling stigmatised, isolating the most vulnerable young people.

Urban indicator (urban), (Dickinson, 2005)) was derived from the ONS Rural and Urban Classification of Output Areas based on the respondent's address falling into an urban or rural area (University of Essex Institute for Social and Economic Research, 2024c). Binary indicator (1=Urban, 0=Rural).

3.7.2.5 Age

Age is a critical factor in mental health, particularly during adolescence and early adulthood, a life stage associated with rapid biological, psychological, and social development. Research shows that mental health problems often emerge during this period, with risk patterns and symptom profiles varying significantly by age (Kessler et al., 2007; Patel et al., 2007). Mental health trajectories may also interact with other factors such as socioeconomic status, sex, and ethnicity over time, making it essential to account for age-related variation when exploring intersectional patterns. In this analysis, age was centred to the mean within each wave and included as a covariate in the final adjusted models. This was done to control for the potential confounding effects of age-related differences across groups, especially as the sample spans a wide age range (10-30 years across waves). Including age helps to account for heterogeneity in mental health that may be due to developmental stage rather than other intersecting social characteristics.

3.7.2.6 Social strata

A social strata table was constructed in order to nest respondents in intersectional social strata. Each of the four interacting dimensions, sex, ethnic group, household income quintile and urbanicity, were combined resulting in a maximum number of 2x6x5x2=120 social strata. This is further outlined in the next section.

3.7.3 Data analysis

A structured, multi-step quantitative analytical strategy was employed in this research to explore the intersectional patterning of mental health outcomes in young people pre- and post-pandemic. The analysis included four key stages: descriptive, bivariate, multivariate (multilevel modelling), and MAIHDA. Each step served a specific analytic function, enabling the identification of basic associations, assessing potential confounding, and examining variation both within and between intersectional strata before progressing to the more complex, cross-classified framework of MAIHDA (Bauer & Scheim, 2019). Conducting multilevel models prior to MAIHDA helped to unpack the distribution of variance and examine whether additive effects or interactions warranted deeper intersectional modelling. This tiered approach ensured methodological rigour and transparency, and supported a nuanced understanding of how social inequalities in mental health are structured, insights that may be lost in more aggregated or single-step models (Bowleg, 2012; Evans et al., 2018).

3.7.3.1 Descriptive analysis

The first step involved generating descriptive statistics. Describing and summarising the data collected is fundamental; it provides an overview of the distribution of the data, enables patterns to be detected and outliers to be identified (Cooksey, 2020). To make conclusions about the young people population, inferential statistics were used which centred around the chosen outcome measures (SDQ

and GHQ-12). This included frequencies and percentages for categorical variables (e.g., sex, ethnic group, urban), and means and standard deviations for continuous variables (e.g., age, household income, SDQ and GHQ-12). Descriptive statistics were stratified by survey wave to reflect the different outcomes, SDQ for children aged 10-15 years (Wave 7), and GHQ-12 for young people aged 16-30 years (Wave 7) and 16-30 years (Wave 13). This step not only provided an empirical grounding for the dataset but also highlighted the distributional features of key independent and outcome variables (Cooksey, 2020).

3.7.3.2 Bivariate analysis

In the second step, bivariate associations between independent variables and mental health outcomes were explored using cross-tabulations as well as formal statistical tests such as the Mann-Whitney U Test and Kruskal-Wallis H Test. The significance level of 0.05 and 95% CI were used. This stage identified potential main effects and interactions between social categories (e.g., ethnic group and sex, or household income and urbanicity), providing preliminary evidence of intersectional disparities. Bivariate analysis also allowed assessment of whether there were sufficient data across the different intersecting categories, allowing for the anticipation of any potential issues with low sample sizes in specific groups (Evans et al., 2018).

3.7.3.3 Multilevel modelling

To investigate the additive effects of intersectional variables on mental health outcomes (SDQ and GHQ-12 scores), multilevel linear regression models were estimated. The modelling process began with simple specifications containing only the outcome variable (SDQ or GHQ-12) and a single strata variable. Complexity was gradually introduced by incorporating two-way, three-way, and finally four-way interactions involving sex, ethnic group, household income, and urbanicity. This resulted in a total of 15 models for each Wave. The initial multilevel models employed random intercepts to capture baseline differences across strata groups while accounting for individual-level variability. This allowed for each intersectional group to have its own average mental health score, representing distinct baseline differences in outcomes. The models were structured to reflect the nested nature of the data, with individuals (Level 1) nested within intersectional strata group (Level 2): -

- Level 1 (Individual Level; within group variation): represented by individual respondents with their associated mental health scores (SDQ or GHQ-12) and specific characteristics. The variability in mental health outcomes within each intersectional group (e.g., sex, ethnicity, household income and urbanicity) was captured in this stage, accounting for differences among individuals within the same stratum group (Goldstein, 2011; Snijders & Bosker, 2012).
- Level 2 (Group Level; between group variation): captures the differences in average mental health outcomes across the intersectional strata defined by combinations of sex, ethnic group,

household income, and urbanicity. The model estimates how these intersectional strata groupings contribute to variations in SDQ and GHQ-12 scores, reflecting structural and social inequalities (Goldstein, 2011; Snijders & Bosker, 2012).

The equation for the linear Level 1 null model can be expressed as: -

$$Y_{ij} = \beta_{0j} + e_{ij} \qquad e_{ij} \sim \mathrm{N}(0, \sigma_e^2) \qquad (1)$$

Where Y_{ij} is the mental health score (SDQ or GHQ-12) for individual i in stratum group j, β_{0j} is the average mental health score for stratum group j (random intercept). The individual residual error term e_{ij} measures the deviation of the observed outcome for individual i in stratum group j from their stratum mean β_{0j}, and is assumed to be normally distributed with a mean of zero and a constant Level 1 variance, σ_e^2 (Dickinson, 2005; Evans, Leckie, et al., 2024). The Level 2 (group-specific) intercept β_{0j}, can be expressed as:-

$$B_{0j} = \beta_0 + u_j \qquad u_j \sim \mathrm{N}(0, \sigma_u^2) \qquad (2)$$

In equation 2, β_0 represents the overall intercept (average mental health score across strata groups), and u_j is a stratum group random effect that is the deviation of group j from the overall average intercept. The u_j are assumed to be normally distributed with mean of 0 and variance σ_u^2 (Evans, Borrell, et al., 2024). Combining the Level 1 and 2 equations, the model can be expressed as: -

$$Y_{ij} = \beta_0 + u_j + e_{ij} \qquad (3)$$

Where $u_j \sim \mathrm{N}(0, \sigma_u^2)$ and $e_{ij} \sim \mathrm{N}(0, \sigma_e^2)$

To explore whether the effects of specific predictors vary across levels of a grouping variable, random slopes were introduced during the multilevel modelling stage. This extension enabled an initial assessment of whether variables such as household income or sex had differing impacts on mental health outcomes across social categories (e.g. ethnic group), prior to applying MAIHDA. While MAIHDA itself traditionally employs a random intercept-only specification to estimate intersectional group-level variance (Evans et al., 2018; Merlo, 2018), this earlier use of random slopes allowed for additional exploration of heterogeneity in associations that could inform later modelling. Emerging literature suggests that integrating random slopes within intersectional multilevel models may offer valuable extensions to current approaches (Evans et al., 2023). The random slopes model is as follows: -

$$Y_{ij} = (\gamma_{00} + u_{0j}) + (\gamma_{10} + u_{1j})X_{ij} + e_{ij} \qquad (4)$$

Where $u_{0\mathrm{j}}$ is the random intercept for the group variable, capturing group-specific deviations from the overall mean, γ_{10} is the fixed effect of the predictor variable, and u_{1j} is the random slope for the predictor within group j, capturing how the effect of the predictor variable on the mental health score

varies across groups (Leyland & Groenewegen, 2020). An example of the random slope model assessing the effect of sex on SDQ score within ethnic group is expressed as: -

$$SDQ_{ijk} = (\gamma_{00} + u_{0k}) + (\gamma_{10} + u_{1k})Sex_{ijk} + e_{ijk} \quad (5)$$

Where SDQ_{ijk} is the SDQ score for individual i within ethnic group k , u_{0k} is the random intercept for ethnic group k, γ_{10} is the fixed effect of sex on the SDQ score, and u_{1k} is the random slope for sex within ethnic group k.

The relative fit of the random intercept and random slope models was assessed using Likelihood Ratio Tests (LRTs), which provided a statistical comparison of model complexity and fit (James et al., 2011).

Progressing from simple to complex multilevel models in such a structured way ensured that the analysis could systematically capture both individual and group-level variability, whilst also allowing for the identification of critical intersectional effects before proceeding to the more statistically complex MAIHDA models. This helped to ensure robustness and interpretability in the analysis (Gelman & Hill, 2006; Snijders & Bosker, 2012).

3.7.3.4 Multilevel Analysis of Individual Heterogeneity and Discriminatory Accuracy

The final step in the quantitative analysis involved applying MAIHDA to model how mental health outcomes are patterned across intersectional strata. This approach extends multilevel regression modelling, a method widely used in fields such as education and public health to address nested data structures (Goldstein, 2011). Traditionally, individuals (Level 1) are clustered within larger contextual units (Level 2), such as schools or neighbourhoods, to account for within-group similarity and between-group variability. For example, a multilevel study of primary school children in the UK found that mental health difficulties varied significantly between schools, with school-level factors such as the quality of personal development provision and the proportion of students with special educational needs accounting for over 11% of the variance in outcomes (Humphrey & Wigelsworth, 2012). Multilevel modelling effectively partitions this variance, capturing both individual and contextual effects on health outcomes. MAIHDA builds on this logic but replaces physical or institutional clusters with social ones. Individuals are nested within combinations of social positions defined in this research by sex, ethnic group, household income, and urbanicity, termed *intersectional strata* (Evans et al., 2018; Nieves et al., 2023). These strata serve as the Level 2 units, representing multidimensional configurations of identity and structural position. This structure is particularly well suited to large-scale secondary datasets, such as national health surveys, where the focus is on understanding how intersecting social positions influence outcomes (Bell et al., 2024; Evans et al., 2018; Holman et al., 2020).

This advanced quantitative approach aligns closely with intersectionality theory by recognising that individuals experience structural inequality not through singular axes of identity but through their intersections (Crenshaw, 1991; Evans et al., 2018). An *inter-categorical* approach was adopted (McCall, 2005), using existing social categories as 'anchor points' for analysis (Glenn, 2002, p. 14). In this framework, hierarchical models allow Level 1 individuals to be situated within Level 2 strata defined by 'all dimensions of identity, social status/power and resources under consideration' (Evans & Erickson, 2019, p. 2). This structure enables the exploration of both marginalisation and mixed privilege without assigning primacy to any single social axis, thereby avoiding one of the key limitations of traditional regression models (Bauer et al., 2021; Evans et al., 2018).

3.7.3.4.1 Model estimation and interpretation

MAIHDA models are typically estimated using random-intercept multilevel models thus the null MAIHDA model (Model A) is the same as (3) (Evans, Leckie, et al., 2024). In Model B, the mental health outcomes (SDQ and GHQ-12) were modelled as a function of individual-level covariates, stratum-level random effects, and individual error terms. This additive main effects model can be expressed as: -

$$Y_{ij} = \beta_0 + \beta_1 x_{1j} + \cdots + \beta_{\mathrm{p}} x_{pj} + u_j + e_{ij} \tag{6}$$

Where $u_j \sim \mathrm{N}(0, \sigma_u^2)$ and $e_{ij} \sim \mathrm{N}(0, \sigma_e^2)$

Where $x_{1j}, \dots x_{pj}$ are the dummy variables and $\beta_1, \dots \beta_p$ are their associated regression coefficients. This model includes no fixed interaction terms; instead, interaction effects are captured by the stratum-level random intercept u_{j}, which reflects the deviation of each stratum's mean from what is expected based on additive effects alone. The random effect u_{j} is assumed normally distributed with mean zero and variance σ_e^2 representing residual between-stratum variance. The residual e_{ij} remains the within-stratum, between-individual variance. Covariates are assumed independent of u_{j} (Evans, Borrell, et al., 2024).

A central strength of MAIHDA lies in its ability to decompose variance into within- and between-stratum components. In the null MAIHDA model, the Variance Partition Coefficient (VPC) quantifies the proportion of total variance attributable to differences between strata, after adjusting for additive effects, thereby measuring the *discriminatory accuracy* of the strata in explaining the outcome (Merlo, 2018). It is often expressed as a percentage and is calculated using: -

$$VPC = \frac{\sigma_u^2}{\sigma_u^2 + \sigma_e^2} \tag{7}$$

A higher VPC suggests that social position plays a substantial role in structuring mental health outcomes and thus greater practical significance. However the interpretation of the VPC changes in Model B due to the redefinition of the between-stratum variance (σ_u^2) in this model (Evans, Leckie, et

al., 2024), where it now reflects the proportion of variance attributable specifically to interaction effects after accounting for additive effects. This represents differences between strata that are not explained by simple additive patterns. Typically, much of the between-stratum variance seen in the null model (Model A) is reduced in Model B with the inclusion of additive effects. This reduction is measured by the Proportional Change in Variance (PCV) (Moreno-Agostino et al., 2023):-

$$PCV = \frac{\sigma_{u1}^2 - \sigma_{u2}^2}{\sigma_{u1}^2} \quad (8)$$

Where σ_{u1}^2 and σ_{u2}^2 are the between-stratum variances in Model A and Model B respectively (Evans, Leckie, et al., 2024). The PCV is also typically expressed as a percentage, with interaction effects regarded as essential if the PCV is significantly below 100% to accurately capture inequalities between strata.

3.7.3.4.2 Advantages of MAIHDA

MAIHDA's ability to quantify both additive and interactive effects across social strata provides crucial insights into how structural inequalities influence mental health outcomes during the pandemic. Unlike single-level models, which estimate interactions only for pre-specified combinations and often default to privileged groups (e.g., high-income White men) as references, MAIHDA considers all strata collectively, reducing reliance on reference categories and enhancing inclusivity (Choo & Ferree, 2010; Evans et al., 2018). This is particularly valuable for understanding disparities in mental health among diverse groups of young people during COVID-19, where intersecting disadvantages may have amplified mental health risks.

Methodologically, MAIHDA is also more parsimonious and scalable than traditional single-level models. While single-level approaches require exponentially increasing interaction terms, MAIHDA's complexity grows linearly (Bell et al., 2019). For instance, capturing all main effects and interactions in a single-level model may require hundreds of coefficients, whereas MAIHDA achieves this with far fewer parameters, maintaining interpretability and managing high-dimensional interactions more effectively. In large-scale datasets like UKHLS, this efficiency allows for exploring complex intersectional patterns without excessive model complexity. Additionally, MAIHDA’s multilevel structure enables precision weighting, stabilising estimates for small or underrepresented strata, which is critical when examining mental health disparities among minority or rural populations (Bell et al., 2019). This reduces small-sample bias and allows for more robust exploration of inequalities.

3.7.3.5 Importance of sequential analytic steps

Each stage in this strategy served as both a standalone examination and a preparatory phase for MAIHDA. Descriptive and bivariate analyses offered foundational insights and helped to refine the conceptualisation of the strata. Multilevel linear regression models established benchmark associations, against which the additional variance explained in MAIHDA could be evaluated.

Skipping these steps would have obscured preliminary trends, increased the risk of model mis-specification, and undermined the ability to interpret MAIHDA's output within the broader epidemiological context. Moreover, by building incrementally, the analysis remained theoretically grounded and empirically transparent, aligning with calls in intersectionality research to avoid 'black box' modelling approaches and instead centre the interpretive significance of social structure (Bauer & Scheim, 2019; Bowleg, 2012).

3.8 Credibility and validity

Credibility and validity are critical considerations in mixed methods research, requiring careful attention to the integrity and trustworthiness of both qualitative and quantitative components (Onwuegbuzie & Johnson, 2006; Teddlie & Tashakkori, 2009). Mixed methods designs are uniquely positioned to enhance research quality through the integration of different types of data, yet they also present challenges in maintaining rigor across distinct methodologies (Creswell & Plano Clark, 2018). Assessing quality in mixed methods research is inherently complex and has been widely debated in the literature, evidenced by the different standards, frameworks and language used (Creswell & Plano Clark, 2018; Leech et al., 2010; O'Cathain, 2010). Researchers use various terms to describe quality in this context, including validity, legitimation, and inference quality (Onwuegbuzie & Johnson, 2006; Tashakkori & Teddlie, 2003) and various frameworks have been suggested based on different conceptual approaches and typologies (Ivankova, 2014). Importantly, as O'Cathain (2010) highlights, it is not always about achieving perfection in every criterion; rather, the focus is often on whether the quality of the research is considered 'good enough' to meet the purpose and expectations of its users. This perspective acknowledges that practical standards for quality may differ based on the research aims and the intended audience. Some authors argue that the 'traditional approaches to validity should not be minimised in mixed methods research' (Creswell & Plano Clark, 2007, p. 146) believing that qualitative and quantitative methods should be assessed for quality individually in mixed methods research. For quantitative research, the traditional criteria for social policy researchers includes validity, reliability, replicability and generalisability (Bryman et al., 2008). The criteria used to assess the quality of qualitative research is more controversial with the most recognised being that suggested by Lincoln and Guba (1985) of credibility, confirmability, transferability and dependability. Applying so many criteria is not only time consuming and difficult but does not address the fact that mixed methods research is more than just its qualitative and quantitative components (Creswell & Plano Clark, 2007).

Creswell and Poth (2018) outline five critical elements that underpin high-quality mixed methods research: clear justification for the mixed methods approach, detailed methodological descriptions, transparent integration of findings, appropriate use of mixed methods terminology, and logical coherence across study components. These principles were carefully embedded within the research

design to enhance the understanding of mental health among young people during the COVID-19 pandemic. A mixed methods design was justified by the need to capture both contextualised insights through qualitative interviews and a focus group with young people in Sheffield, and general patterns, through quantitative analysis of a national dataset. This dual approach enabled the exploration of lived experiences alongside population-level trends, offering a more comprehensive view of mental health disparities.

Methodological transparency was maintained by clearly describing sampling, data collection, and analysis procedures across both components. The integration of data was explicitly structured using joint display tables, which allowed for comparison between statistical patterns and participant narratives. This helped identify areas of convergence and divergence, particularly in how mental health outcomes intersected with dimensions of identity such as sex, ethnic group, household income, and urbanicity. Appropriate mixed methods terminology was used consistently to explain analytical choices and data integration processes. Logical coherence was achieved by aligning research questions, methods, and analysis strategies with the research's overarching intersectional framework.

Building on the work of Creswell (2003), O'Cathain et al. (2008) developed guidance for Good Reporting of A Mixed Methods Study (GRAMMS) to aid with transparency. Table 3.3 outlines how this guidance has been followed in this research further enhancing quality and rigour.

Table 3.3. Good Reporting of A Mixed Methods Study (GRAMMS).

		Thesis chapter and section
1	Describe the justification for using a mixed methods approach to the research question	3.5.1
2	Describe the design in terms of the purpose, priority and sequence of methods	3.3-3.5
3	Describe each method in terms of sampling, data collection and analysis	3.6-3.7
4	Describe where integration has occurred, how it has occurred and who has participated in it	3.8; 7.4; 8.2
5	Describe any limitation of one method associated with the presence of the other method	3.11; 3.5; 7.4; 8.2; 8.6
6	Describe any insights gained from mixing or integrating methods	3.5; 7.4; 8.2

3.8.1 Credibility and validity in practice

As well as working to the guidance by Creswell and Poth (2018) and O'Cathain et al. (2008), credibility and validity in this research was enhanced by employing several practical strategies. In the qualitative component, an audit trail was maintained to document each stage of data collection and analysis, clearly outlining the logic applied as the research progressed. This process enhanced transparency and replicability. Throughout the interviews and focus group, participant views were fed back during discussions to verify understanding and gather further relevant details, strengthening

validity. This was further supported by the inclusion of verbatim quotes within the qualitative findings, which provided authenticity and a direct connection to participant voices.

The quantitative component used the UKHLS dataset, a nationally representative longitudinal study of UK households. The breadth and diversity of this dataset allowed for robust analysis across various socio-economic, ethnic, and regional groups, supporting the generalisability of findings. Methodological strategies, including statistical controls for key variables and rigorous analytical techniques, were employed to enhance the reliability of the results. Established measures of mental health and socio-demographic factors were used to ensure alignment with theoretical constructs, providing a solid empirical foundation.

The Sheffield Youth Cabinet was also consulted in the early stages of the research to provide feedback on the research design and advise on materials, including the consent form, information sheets and recruitment posters. This consultation helped ensure the research was accessible and appropriate for its intended audience, enhancing its acceptability and relevance.

3.8.2 Reflexivity

Reflexivity is a foundational element in qualitative research, necessitating continuous self-awareness and critical self-reflection by the researcher on their potential biases, preconceptions, and relationship to the research (Finlay, 2017). As Finlay (2002, p. 532) articulates, 'reflexive analysis in research encompasses continual evaluation of subjective responses, intersubjective dynamics, and the research process itself'. This process acknowledges that researchers inevitably influence, and are influenced by their research process and findings. The goal of reflexivity is not to eliminate researcher influence which is impossible in qualitative research, but rather to embrace and account for it, thereby enhancing the trustworthiness and credibility of the research (Olmos-Vega et al., 2023).

As a mature, White, heterosexual, able-bodied woman with a professional career in health services research spanning nearly three decades, I approached this research with both privilege and insight. Growing up in a working-class family on a council estate in Sheffield, I am the first in my family to attend university and to move away from my hometown, living and working in London for ten years before returning to Sheffield. My personal background instilled in me an awareness of socioeconomic disparities, which was further amplified during the COVID-19 lockdowns as I observed the impact on my two daughters, aged 8 and 15. While my family had the advantage of space, technology, and stability to navigate the pandemic relatively comfortably, I became acutely aware that this was not the experience for many. My reflections during this time, coupled with discussions with friends and family, highlighted the varying impacts of lockdown measures on young people, particularly those in more precarious circumstances.

My decision to pursue this PhD was influenced by my professional environment at the Centre for Urgent and Emergency Care Research (CURE) at the University of Sheffield, where I am surrounded

by academics actively engaged in impactful research. Although I had long aspired to undertake doctoral research, it was only when I encountered this particular PhD opportunity characterised by its focus on the social determinants of health, and supported by an exemplary supervisory team that I found a research area that resonated deeply with both my personal observations and professional commitments.

Throughout the research process, I engaged in continuous reflexive practice. This included sharing topic guides and thematic developments with my supervisory team to ensure that the analysis remained a true representation of participants' voices, rather than being unduly influenced by my own experiences and assumptions. Following each interview and focus group, I recorded personal reflections, deliberately questioning my interpretations and actively considering how my background and positionality might shape the findings. This iterative process of reflection and dialogue helped maintain analytic rigour and authenticity in representing the diverse experiences of the participants.

The intersectional perspective adopted in this research further demanded a conscious awareness of how my positionality could impact the interpretation of participants' experiences. I was mindful of the privileges associated with my socio-economic stability and professional standing, recognising how these factors could influence my understanding of vulnerability and resilience in the context of pandemic-related mental health challenges. By maintaining a reflexive stance, I aimed to foreground participants' lived experiences and narratives, ensuring their perspectives were authentically represented in the analysis.

3.9 Ethical considerations

The UK's national ethical research framework emphasises the importance of ethical considerations in research, with key principles including respecting the rights and dignity of individuals, ensuring voluntary and informed participation, conducting research with integrity and transparency, and clearly defining lines of responsibility (UKRI, 2023). UK Research and Innovation (UKRI) also outlines specific ethical guidelines for research, emphasising the need to maximise benefits and minimise risks, and to consider equality, diversity, and inclusion in all research activities. These principles align with the core ethical considerations outlined in the Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979) and the British Sociological Society Guidelines (British Sociological Association, 2017), which underpin the design of this research. Ethical approval for this research was not merely a procedural requirement but was considered a moral obligation to ensure participant safety, dignity, and respect. Meeting these high ethical standards was critical not only for ethical approval but also as a commitment to ethical integrity as a researcher (Patton, 1990). The ethical considerations for this research which employed a mixed-methods design, incorporating both qualitative and quantitative methods, are outlined below. These were structured around the principles of autonomy, beneficence, and justice, as defined by both

UKRI guidelines and the Belmont Report, and further informed by best practices in mixed-methods research (Creswell & Plano Clark, 2018).

3.9.1 Autonomy: informed consent

The principle of autonomy emphasises the right of individuals to make informed, uncoerced decisions regarding their participation in research. To uphold this principle, robust informed consent procedures were implemented in the qualitative component of this research. Participants were provided with detailed information sheets (available in short and long formats) outlining the research aims, methods, potential risks, and anticipated benefits (Appendices 2 and 3). These documents were written in accessible language to ensure clarity and comprehension, and with feedback from young people (Coleman et al., 2021; Goodwin, 2008).

For the semi-structured interviews, individuals interested in participating were provided with the information sheet and consent form, and were then asked to get in touch if they would like to proceed with an interview. The attendees from the Support, Think, Act, Motivate, Participate (STAMP) group within CHILYPEP were informed two weeks prior to the focus group taking place through a short verbal presentation and the research documentation, they were also given time to ask questions. Those who wished to participate then had the choice to attend the focus group or not.

Ethical considerations for participants aged 16 and over were initially aligned with the Gillick competence framework, which allows young people deemed competent to consent to participate without parental permission if they are capable of understanding the nature, purpose, and potential risks of the research (Griffith, 2016). However, following discussions with the University Research Ethics Committee, it was decided that parental consent would be required for participants aged 16 to 18 years. This decision was made to further ensure participant safety and adherence to ethical standards, acknowledging that while young people can demonstrate competence, additional safeguarding was deemed appropriate (Alderson & Morrow, 2020; Powell et al., 2012). As a result, informed consent for these younger participants involved a dual process where both the participant and their parent or guardian provided consent. Information sheets were designed to be clear and accessible for both audiences, ensuring mutual understanding of the research's aims and potential risks (Alderson & Morrow, 2020). This measure aimed to uphold ethical principles while also respecting the protective role of guardianship in research involving adolescents.

Informed consent is viewed as a continuous process, not a single event (Kadam, 2017), particularly given the semi-structured nature of interviews and focus groups, where discussions could evolve organically and potentially touch on sensitive mental health experiences. To mitigate concerns of coercion and preserve participant autonomy, individuals were informed that they could refuse to answer any question or withdraw from the interview or focus group at any point without justification (Richards, 2002). A verbal reminder of these rights was provided at the start of each interview and

focus group to reinforce their voluntary participation. Furthermore, the ongoing nature of consent was emphasised, with participants being encouraged to express any discomfort or desire to withdraw at any stage of the research process (Alderson & Morrow, 2020). Efforts were also made to ensure that participation was truly voluntary and free from coercion. Recruitment strategies emphasised that involvement was entirely the choice of the participant, and there were no consequences for declining to participate. This is particularly significant in research involving young people, where power dynamics can inadvertently influence participation (Gallagher, 2009). To address this, clear communication strategies were implemented, ensuring participants understood their rights fully and were not pressured to participate by peers or authority figures, particularly relevant in relation to the focus group (Powell et al., 2012).

3.9.2 Beneficence: risk-benefit assessment

The principle of beneficence requires researchers to act in ways that enhance the well-being of participants while prioritising their safety and overall welfare (Beauchamp, 1990). In research involving young people, this principle is particularly significant given the ethical debates surrounding their participation in research. These debates often centre on two contrasting perspectives: one advocating for heightened protection from potential risks, and the other emphasising the importance of including young people in research and respecting their right to express their views on matters that directly affect them (Dixon-Woods et al., 2006). This ethical tension highlights the complexity of assessing risk in research with young populations. Researchers acknowledge that perceptions of harm are inherently subjective, influenced by various stakeholders such as parents, researchers, and young people themselves (Spriggs, 2007). As a result, risk assessments must be carefully balanced to safeguard participants while also recognising their capacity to contribute valuable insights to research. In addition to informed consent, Powell et al. (2012) discusses three key ethical issues for conducting research with young people: protection of children and young people (anxiety/ distress), anonymity and confidentiality, and payment of participants. These issues are addressed in the context of this research in the following sub-sections.

3.9.2.1 Protection of children and young people

From the perspective of qualitative research, one of the most significant risks with young people is the potential for anxiety and emotional distress, particularly when discussing sensitive or potentially traumatic topics. Social research is often intrusive, exploring personal experiences that can evoke strong emotional reactions (Dickson-Swift et al., 2008). Alderson and Morrow (2020) identify anxiety, embarrassment, and emotional discomfort as common risks, particularly in studies addressing mental health, family dynamics, or trauma. Given the focus on mental health in this research, particular attention was given to the potential for distress. To mitigate these risks, protective measures were implemented including informing participants, both verbally and through information sheets,

that they could skip questions or withdraw from the research at any point without consequence. All participants were also provided with information about local mental health support services (Appendix 17) at the end of the interview or focus group as part of debriefing process (Shaw et al., 2011), ensuring they had access to assistance if participation triggered anxiety or distress (Ahmed, 2024). By adopting a flexible, participant-led approach to data collection, the research aimed to empower young people to share their experiences in a manner and pace that felt safe and comfortable for them (Alderson & Morrow, 2020).

3.9.2.2 Anonymity and confidentiality

Anonymity and confidentiality was a primary concern in this research, particularly as it focused on a potentially sensitive topic. To safeguard privacy, a multi-layered approach was adopted, reflecting best practices in research ethics (Greene & Hogan, 2011; Valentine et al., 2001). Ensuring that participants felt safe and comfortable during the interviews was a priority. Research indicates that privacy during data collection is crucial for participants to feel secure enough to share sensitive information (Valentine et al., 2001) thus, participants were encouraged to select environments where they felt comfortable speaking openly. Various dates, times and methods were offered for the interviews including online, face-to-face, and by telephone to give the participants an element of control over the interview (Greene & Hogan, 2011). Online interviews were held using Google Meet, a platform trusted and recommended for use by the University of Sheffield IT Services, and participants were encouraged to choose private locations to prevent interruptions or eavesdropping (Edwards & Holland, 2013). Face-to-face interviews were held in confidential settings (pre-booked meeting rooms) on the University of Sheffield campus, and telephone interviews allowed participants the privacy of their own environment (Valentine, 1999).

All collected data were handled with strict confidentiality. Digital data were collected using an encrypted Dictaphone and securely stored in compliance with UK GDPR (Council directive 2016/679 [2018]) with access restricted to the researcher only to prevent unauthorised disclosure (Powell et al., 2012). Identifiable information, such as names and locations, were removed from interview transcripts to prevent identification. Similarly, the focus group drawings and any accompanying written text were anonymised prior to analysis; verbal consent was obtained from the young people at the end of the session for these materials to be retained and used as research data. All of the participants have been assigned pseudonyms (Kaiser, 2009).

3.9.2.3 Payment of participants

Offering payment to young participants requires careful ethical consideration to balance appreciation for their time and effort with the need to avoid undue influence. Compensation serves to acknowledge the inconvenience and commitment involved in participation, promoting inclusivity and empowerment by valuing young people's contributions (Alderson & Morrow, 2020; Powell & Smith,

2009). Furthermore, appropriate incentives can enhance participation rates, thereby supporting the research's overall success (Rice & Broome, 2004). However, payments must be proportionate and not so substantial as to coerce participation or overshadow the voluntary nature of consent. To mitigate potential coercion, non-monetary tokens such as gift vouchers, certificates, or small gifts are often preferred to monetary payments for young people (NIHR, 2024; Powell et al., 2012). These forms of appreciation can reduce the risk of undue inducement while still recognising participants' contributions (NIHR, 2024).

Clear communication about the nature and purpose of these payments is crucial to maintaining ethical standards. Participants must be informed that their involvement is entirely voluntary, that they have the right to withdraw without penalty, and when and how they can expect to receive their payment (UKRI, 2023). In this research, participants in the qualitative component received a £20 Amazon voucher as a token of appreciation. This was clearly communicated in all materials, specifying when participants would receive the voucher (immediately following the interview or focus group) and in what format (electronic voucher via email). To ensure transparency and accountability, participants were asked to confirm receipt of their vouchers, and an audit trail was maintained to document all vouchers issued.

3.9.3 Justice: fair participant selection and access

Achieving fair selection and equitable treatment of participants is a core aspect of the principle of justice in research ethics, ensuring that the benefits and burdens of research are distributed without bias (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). This research aimed to recruit a diverse cohort of young people, intentionally targeting variation across socio-economic, racial, and sex identities in line with its intersectional framework (Crenshaw, 1991). Outreach efforts included contacting youth organisations supporting non-White ethnic minorities and disadvantaged young people. This strategy was designed to counteract historical patterns of exclusion in mental health research and amplify marginalised voices (Reed & Rudman, 2023). Despite these targeted efforts, challenges emerged in recruiting marginalised individuals. Additional barriers included the lack of provision for non-English speaking young people due to resource constraints and digital access limitations. While efforts were made to mitigate these barriers such as offering face to face and telephone interviews, limited internet access reduced the visibility of recruitment advertisements, potentially affecting participation. Moreover, young people unable to provide informed consent independently were not included in the research. These exclusions highlight an ethical tension between practical limitations and the commitment to equitable representation (Hammersley & Traianou, 2012). Although these constraints were necessary, they underscore an ethical obligation to identify and address barriers to inclusion in future research (Morrow & Richards, 1996).

To uphold the principle of justice, dissemination of research findings was considered early in the research design. Discussions with the youth organisation CHILYPEP, which supported recruitment, focused on creating the results in an accessible format and establishing a timeline for sharing results. This was intended to demonstrate to young participants the impact of their contributions and to raise awareness of the mental health challenges faced by young people during the pandemic. Participants were also informed during the debriefing process, with arrangements made to send the findings once ready. This commitment to transparent and inclusive dissemination aligns with best practices in community-based research, supporting the ethical obligation to ensure participants benefit from the knowledge generated through their involvement (Alderson & Morrow, 2020; Powell et al., 2012)

3.10 Application for ethical approval

The research was submitted for ethical approval on 27th July 2022 to the Department of Sociological Studies Research Ethics Committee (SCS REC, University of Sheffield), and this was approved on 27th October 2022 (REC no. 049340) (Appendix 18). Prior to obtaining approval, the SCS REC raised some concerns requiring minor amendments to the application. The main concerns and how they were addressed are summarised in Table 3.4.

Table 3.4. REC comments and responses

Reviewers comments	Researcher response
The use of a more targeted recruitment strategy may be required, rather than just using social media. The recruitment of young people is difficult generally, and this research ideally needs to recruit demographically diverse individuals	The recruitment strategy was revised to a more targeted approach including directly contacting specific youth groups, use of gatekeepers and screening of potential participants using a brief questionnaire.
In the quantitative component, consider the use of the UKHLS COVID-19 specific datasets	The main UKHLS datasets to be used covered the COVID-19 pandemic period (pre- and post-) and included more depth and breadth in relation to the questions asked and responses. The smaller specific COVID-19 datasets were considered but the responses from the population of interest were small.
Provision of information for parents and carers including draft email wording, participant information sheet and consent	Additional documents for parents and carers were created, along with a shorter, easy-to-read, modified version of the information sheet.

3.11 Strengths and limitations

This study has several methodological strengths and limitations, which are important to consider in interpreting the findings. Adopting a mixed methods approach to examine the national picture of young people's mental health pre and post COVID-19, while incorporating their views and lived experiences, represents a key strength of this research, particularly given the limited prior work in this area (Ford et al., 2024; Holding et al., 2022; Tinner & Alonso Curbelo, 2024). This thesis makes a

distinctive contribution by employing an intersectional perspective to explore how intersecting social identities and structural inequalities shape mental health outcomes for young people in the UK. Although interest in intersectionality within quantitative research has grown in recent years (Bauer et al., 2021), much of the existing literature remains limited in its scope, often focusing on single dimensions of inequality or treating multiple dimensions additively (Evans & Erickson, 2019; Patil et al., 2018). The use of MAIHDA in this research addresses these limitations, offering both methodological and theoretical advantages over conventional regression techniques (Bell et al., 2019; Evans et al., 2018). MAIHDA facilitates the integration of an intersectional framework and is increasingly recognised as a leading methodological innovation in 'exploring health disparities within social epidemiology' (Merlo, 2018, p. 74), as it allows for the analysis of both between-group differences and within-group heterogeneity. While the recognition of heterogeneity among young people is a strength of the quantitative approach used, inherent limitations remain, as not all experiences, cultures, or perspectives can be fully captured, potentially obscuring important influences on mental health (Moreno-Agostino et al., 2023). This is particularly evident in the categorisation of ethnicity, where 19 groups were aggregated into five for analytical purposes, potentially overlooking within-group variation. A further limitation of the MAIHDA analysis is that findings are confined to the specific dimensions of identity and social position included in the model (sex, ethnic group, household income, and urbanicity). For instance, sexual orientation, an important determinant of mental health especially during the COVID-19 pandemic (Griffin et al., 2023; Jones et al., 2023), was excluded due to data unavailability. In the case of household income as an indicator for socioeconomic status, it captures only one dimension of socioeconomic status and may not reflect other important factors such as education, occupational status, wealth, or material deprivation (Galobardes et al., 2007). Additionally, income can be subject to reporting bias, fluctuate over time, and may not accurately represent the economic resources available to individuals within the household, particularly in research focused on young people (Daly et al., 2002; Galobardes et al., 2006).

This thesis is among the first to integrate qualitative inquiry with MAIHDA in the study of young people's mental health. This mixed methods design provides a more holistic understanding of mental health inequalities by capturing both the nuanced, lived experiences of young people and broader population level patterns. While MAIHDA is a powerful tool for modelling additive and interactional effects across intersecting social identities, it remains primarily exploratory and best viewed as a starting point for understanding intersectional disadvantage (Bell et al., 2024). When combined with in-depth qualitative investigation however, the mixed methods approach has been described as approaching 'gold standard' for intersectional health research (Bell et al., 2024).

The qualitative element of the research was grounded in a specific local context, focusing on young people aged 16 to 24 residing in Sheffield. Young people's perspectives were sought in relation to the

research and in the development of the material used, which contributed to the relevance of the research. However, the research would have been further strengthened if young people had been involved throughout the research process in a co-participatory role (Purdy & Spears, 2020). The interviews and focus group provided a valuable depth of understanding about how local social, economic and support networks influenced mental health during the pandemic, and how they potentially intersected with individual identities to shape mental health experiences. They generated detailed narratives about isolation, social connection, mental health and support-seeking which were crucial in situating the analysis within the lived realities of young people and provide some context to the quantitative findings. Intersectionality is a complex theory for most people to grasp, and thus there was no surprise that the young people that participated struggled to understand and articulate how their identities may have impacted their mental health. Different stories were used to try to help explain the concept as suggested by other researchers (Kia, 2024; Rizvi, 2019), tailoring them to the young person being interviewed, but with muted success.

A number of other limitations are associated with the qualitative component of the research. The qualitative data were collected and analysed by a single researcher, which introduces potential concerns regarding interpretive bias and limits opportunities for analyst triangulation (Patton, 1999). Although reflexive practices were employed to enhance rigour (Braun & Clarke, 2021; Johnson et al., 2020), the absence of multiple analysts may have constrained the breadth of interpretive insight. Additionally, the sample of interviewees, while age diverse, was predominantly White, middle class and based in a single city. These demographic and geographic factors limit the generalisability of the qualitative findings, particularly in relation to racialised experiences and national level variations in service access and provision. Participant recruitment for the qualitative strand also encountered practical constraints, resulting in a modest number of interviews and some uncertainty regarding the depth and breadth of the dataset. As a result, while the themes developed are grounded in participants' narratives, there may be additional dimensions of experience that were not fully explored.

3.12 Conclusion

This chapter outlined the methodological framework underpinning the research and detailed the rationale, design, and implementation of a mixed methods approach to examining young people's mental health during and after the COVID-19 pandemic. Guided by a pragmatic paradigm, the study employed an exploratory sequential mixed methods design, beginning with qualitative data collection and followed by quantitative analysis. This structure enabled the integration of in-depth narrative accounts with broader structural patterns to explore how social identities and contextual factors intersect to shape young people's mental health experiences.

The chapter first introduced the philosophical and theoretical foundations of the study, highlighting the influence of pragmatism and the central role of intersectionality and the social determinants of

health in shaping the research questions and methodological decisions. These frameworks provided both the lens and structure for exploring complexity, relationality, and inequity across the qualitative and quantitative components. The mixed methods design was explained in detail, beginning with the collection of qualitative data through semi-structured interviews and a focus group with young people. These accounts were analysed to identify key experiences, challenges, and coping strategies during the pandemic. Insights from the qualitative phase informed the subsequent quantitative analysis using longitudinal data from the UKHLS. MAIHDA was applied to explore how intersecting social identities, particularly sex, ethnic group, household income, and urbanicity shaped patterns of psychological distress over time. The chapter also discussed the strategies used to ensure ethical integrity, reflexivity, and methodological rigour. These included attention to power dynamics in research with young people, transparent documentation of analytic decisions, and the use of integration techniques such as narrative weaving and joint display to synthesise findings across methods.

The next chapter presents the first of two chapters reporting findings from the qualitative component of the research. It provides an overview of participants' backgrounds and explores how the COVID-19 pandemic disrupted their daily lives, routines, and social identities.

CHAPTER 4 YOUNG PEOPLE'S PERSPECTIVES: SOCIAL DISCONNECTION AND DISRUPTED LIVES

4.1 Outline of chapter

Chapters 4 and 5 present findings from the qualitative analysis, based on interviews and a focus group conducted with young people. This chapter begins with a descriptive overview of the participants, providing context by outlining their backgrounds and daily lives prior to the COVID-19 pandemic. It then explores how the pandemic disrupted their everyday routines and social identities, with a focus on living arrangements, loss of structure, social isolation, and shifting relational dynamics. These findings highlight the profound effects of disconnection and uncertainty during a formative life stage.

4.2 Overview

The interviews and focus group with young people provided a glimpse into their lives, their mental health and perspectives before, during and after the COVID-19 pandemic and associated lockdowns. Remarkably, many of the participants shared similar experiences and feelings and highlighted the importance of social connections. This emphasis on connection reflects the central role that peer groups and shared social environments play in shaping identity and belonging during adolescence and early adulthood (Jenkins, 2014; Jetten et al., 2012). Table 4.1 provides an overview of the participant characteristics, where they lived and what they did during the COVID-19 pandemic, their GHQ-12 score and interview method.

The average age of the young people that participated in the interviews and focus group was 20 years and the majority were female (58%) and White British (73%). During the COVID-19 pandemic, they mostly lived with family in eight different Sheffield postcodes and studied full time. At the time of the interviews and focus group (post-COVID-19), only two of the 26 young people that participated had a GCS-12 score regarded as normal. Most had GCS-12 scores indicating psychological distress (>=13).

Table 4.1. Overview of participant characteristics, where they lived and what they did during the COVID-19 pandemic, their GHQ-12 score and interview method.

Name[1]	Age	Sex/ Gender	Ethnic group	During COVID-19: Resided (Postcode)	Live with[2]	Do[3]	GHQ-12 score[4]	Interview method[5]
INTERVIEWS								
Emily	17	Female	White British	S17	Family	Study FT +	**23**	I
Oliver	16	Male	White British	S17	Family	Study FT	**14**	I
Charlotte	17	Female	Any other White background	S17	Family	Study PT +	**22**	I
Amelia	18	Female	White British	S17	Family	Study FT	**31**	O
Soraya	19	Female	Pakistani	S7	Family	Study FT +	**23**	O
Will	21	Demiboy	English	S2	Family +	Vol PT	**27**	I
Lucas	23	Male	White British	S2	Family	Work FT/ PT	**29**	T
Rehan	20	Male	Indian	S3	Family	Study FT +	**17**	O
Imogen	21	Female	Any other White background	S1	Family +	Study FT	**19**	O
Zayan	22	Male	Pakistani	S4	Family	Study PT +	**21**	O
Florence	21	Female	White English	S10	Family +	Study FT	**18**	O
Sophia	24	Female	White British	S10	Family +	Study FT +	**21**	I
Lily	22	Female	British Chinese	S10	Family +	Study FT	**19**	T
Martha	23	Female	White British	S1	Alone	Study FT +	**34**	O
Elena	23	Female	Any other White background	S6	Friends +	Study FT +	11	O
James	23	Male	White British	S17	Family +	Study FT +	12	I
FOCUS GROUP								
Grace	16	Female	White British	S8	Family	Study FT	18	
Mia	18	Female	White British	S6	Family	Study FT	30	
Taylor	20	Non-binary	White British	S13	Family	Study FT +	22	
Alex	20	Male	White British	S6	Family	Study FT	29	
Zoe	22	Female	White British	S8	Family +	Vol PT	30	
Ben	21	Male	White British	S6	Family +	Study FT +	24	
Quinn	22	Non-binary	White British	S20	Family	Work PT	30	
Emery	22	Non-binary	White British	S13	Family	Study PT +	29	
Lucy	16	Female	White British	S10	Family	Study PT	31	
Natalie	24	Female	White British	S11	Other	Work FT	22	

Notes:

[1] Pseudonym names used

[2] Family + and Friends + indicate that the young person lived in more than one different situation during COVID-19, with the primary living situation either family or friends

[3] FT=full-time; PT=part-time; Vol=volunteered; Study FT/PT+ indicates that the young person undertook multiple different occupations during COVID-19, with the primary occupation being study

[4] GHQ-12 score= 0 (least distressed) to 36 (most distressed); >=13 indicate psychological distress (bold)

[5] Interviews only - I=in-person; O=online; T=telephone

4.2.1 Life prior to COVID-19 pandemic

As a baseline it was important to have some general understanding about the young people who participated in the interviews and focus group, and what their lives were like before the COVID-19 pandemic. Thus, one of the first questions asked was ‘can you tell me about your life prior to COVID-19, for example, describe a normal week?’, which was purposely left open so that they could share whatever they wished. The aim was to capture information about their daily routines, the activities they enjoyed and their relationships, as well as some indications about their mental health (Appendix 8]. It also would provide an insight into what the they lost when restrictions were introduced. Exploring lives prior to COVID-19, then over 3 years ago, it was perhaps unsurprising that few of the young people contributed. The details provided were often sparse, requiring probing to gather information, which was important in building a picture of them as individuals, and an insight into their personality, behaviours and social networks.

There are particularly distinctive differences in the lives of young people between the ages of 16 and 24 years. The majority of younger people (18 years and under) are dependent on family and in full-time education or apprenticeships, whereas those aged above 18 years generally have much more independence. They can choose the direction which they want to go in in relation to their occupation, living circumstances. For this reason, the following sections separates these age groups when describing what their lives were like before COVID -19.

4.2.2 Younger age group (18 years or below)

Participants who were aged 18 years or under described a routine primarily centred around the school day, with social dynamics focused within that relatively structured environment. The youngest were in years 9-11 at school at the start of the COVID-19 restrictions, and the remainder were either attending sixth form or College. Two young people (Emily and Amelia) mentioned that they sometimes struggled with school describing it as ‘hard’ and experiencing ‘off days’ but they did not understand why.

> So before [COVID-19], I would say that I was struggling quite a bit because I didn't really, because I didn't really understand like, why I was the way I was, but I'd say I was a lot more like sociable but it, it was really draining. Like I didn't know why I was so drained from like all the socialising and stuff. [continues] I was in Year 10 when lockdown happened and I

> wouldn't…., sometimes I'd have off days, so I wouldn't go into lessons or I'd leave school sort of thing.
>
> *(Amelia, female, 18 years)*

Identity formation and the strengthening of peer relationships is crucial in this age group (Arnett, 2000; Erikson, 1968), this was witnessed when the participants talked about how they spent their time outside of school or college. All the young people except one discussed being part of small friendship groups, spending evenings and weekends together either just 'hanging around' in friends' houses or in the local area, and shopping. Soraya described experiencing friendship problems, and that despite being part of a group of 3-4 friends, she did not really have any friends she felt she could talk to.

> I did have less friends, I didn't really have a big friendship group. I had like three or four friends, but even then I felt like it was quite difficult. [continues] It felt even more like lonely in a way because I didn't have like, because obviously you have family support but that's a bit different to having friends who are your age and you know, you can talk to about anything.
>
> *(Soraya, female, 19 years)*

When discussing what they did in their free time, drinking alcohol appeared to be a regular occurrence for only one young person, Florence, possibly reflecting that young people are less likely to have tried alcohol compared to their counterparts 20 years ago (Twenge & Park, 2019). This formed part of Florence's social routine, spending an evening with friends at the weekend, visiting local bars and nightclubs. Extracurricular activities once or twice a week were common and included sports (badminton, gymnastics, gym, dance) or hobbies (choir, music, drama). Florence was particularly active, competing every weekend around the UK as a competitive sports person in events around the UK as well as regularly attending a gym. Three participants reported taking part in no formal physical activities at all.

Some of the young people were involved in part-time work, paid and unpaid. The type of work and reasons for undertaking it varied from volunteering in a veterinary hospital to gain experience for a possible future career, to more formal employment roles in areas such as childcare and outdoor activities.

All the school/ college-aged participants lived with their immediate family. For the majority, their immediate family included both parents (mother and father) and at least one sibling. Only two young people had parents that were separated and lived with a single parent, and two did not have any siblings. The family home was often described as 'nice', with everyone having their own bedrooms and private space. Four participants did not live in Sheffield prior to the COVID-19 restrictions, living in other regions in England or abroad, in their European country of origin. Each of these young people moved to Sheffield to attend higher education within six months of the COVID-19 restrictions being introduced.

Only one participant, Soraya, in this age group talked about religion, stating that she regularly visited her local Mosque as a practising Muslim.

In this small cohort of 7 younger people, at least six revealed they had pre-existing health issues. These were wide ranging from anxiety, OCD and eating disorders to suicidal thoughts and depression. One participant also reported living with a chronic condition which often left them in physical pain. Some were aware of their health issues and were receiving support to help manage them at the time of the COVID-19 restrictions, but this was not the case for all of them.

4.2.3 Older age group (19-24 years)

As would be expected, the lives of the older individuals differed from those of the younger ones due to the various developmental shifts, characterised by significant life transitions such as starting higher education, entering the workforce, or exploring other post-secondary paths. This stage demands a more independent approach to life, often involving relocation, financial autonomy, and a deeper exploration of personal values and career aspirations. This was reflected in six participants within this age range, who were living independently in shared accommodation and attending higher education. Two of these students were not UK-born, with their family based abroad. The remaining participants lived in the family home and studied. Five young people were in employment, two of whom were full-time meaning they had a formal routine of working Monday to Friday, 9-5pm unlike those who were studying and whose routine was structured around classes, which for some included only a few hours a week.

The students were all at different stages in their academic learning (years 1-3), mostly based in Sheffield. One student was on placement in Asia as part of their degree course when the COVID-19 lockdowns were introduced. Except one individual (Zayan), discussions with all the participants about their life at that time appeared to indicate that they were typical for that age group, i.e. outside of studying and employment they would spend their time with friends and family regularly socialising and visiting places such as cafes, bars, restaurants and cinemas. Several students were members of various societies and described their lives at that time as always being busy.

> I was in my third year as an undergraduate at [university], it was kind of quite student life. I'd spend time with my housemates, I spent a fair bit of time on campus, going to lectures and doing assignments and stuff like that, and I was quite active with student societies. I spent quite a lot of time running the [sports] Club, and going on trips with them and things like that on the weekends and in my evenings as well. [continues] I was away quite a lot of the weekend and if I wasn't away, I'd be either hanging out with my housemates, hanging out with my friends or catching up on the coursework I hadn't done in the week, because I was [playing sport].
>
> *(Sophia, female, 24 years)*

> I had a very, very busy life. Like, I basically had every single hour of my day booked, like, there was something going on all the time. And that's kind of how I used to live my life [before COVID-19]. [continues] To kind of give you a picture of what it looks like, I would have breakfast in the morning, go to lectures, have lunch with friends, go to - if I had any lectures left or any like seminars or anything, and then go back home, maybe go to the gym,

> or maybe meet with friends, go to a society event, visit my boyfriend who was living in, he was a student as well. He was living in a different neighbourhood, so kind of going from my place to his, and yeah, that was kind of just what was like a normal day.
>
> *(Elena, female, 23 years)*

> I was studying at University, I was in [city] doing communication and media. So all my teaching was in person at that time, obviously. I had a mix of lectures, seminars, that sort of thing. Nothing, nothing too exciting in my degree, and then outside of that, I was involved in various societies. I was involved in the Christian Union, I was very involved in my local church which filled up various evenings and days a week. I would also go to the theatre a lot, which was my other big thing.
>
> *(James, male, 23 years)*

Regular physical exercise was reported by three people in this age group. The exception to this lifestyle was Zayan, a male student in his second year at university, who lived in the family home and worked part-time alongside his studies. Zayan described himself as an introvert and did not feel he had any friends from his course, thus his spare time was often spent with family members.

As with the younger age group, only one participant spoke about religion being an important part of their life, with several of their social activities linked with their local Christian Church.

More than half of the interview and focus group individuals aged 19 to 24 reported living with a pre-existing condition prior to the COVID-19 restrictions, most related to anxiety, stress, and depression. Additionally, two participants disclosed experiences with eating-related issues, though only one had received a formal diagnosis and was in recovery at the time. A further two individuals discussed living with autism, and one participant reported struggling with drug and alcohol addiction, which began in 2019.

As the researcher, a university student and a mother of two children, much of what I heard about the lives of the young people prior to COVID-19 was not surprising. Irrespective of their usual daily routine, their lives were structured around this, i.e. school, college, university and/ or employment with a regular daily routine. For most, spare time was spent in the company of family and friends doing things that they enjoy. Although habits such as eating, sleeping, drinking and exercise were generally described as 'normal', there was a small proportion who felt they struggled with sleeping and eating, which some had received a formal diagnosis for. It was the number of participants that reported pre-existing health issues that was unexpected. Over half of them reported living with various conditions, disorders, or addictions, both diagnosed and undiagnosed, at the time COVID-19 restrictions were introduced. This included anxiety, stress, depression, eating disorders, neurodevelopmental conditions, and chronic physical illnesses.

4.3 Key themes

Following an explanation about their lives pre-COVID-19, most young people appeared relaxed, and both the interviews and focus group proceeded to feel more like discussions. Talking about their 'former lives' seemed like nostalgic reminiscing for many of the participants, with them often smiling as they described the 'normality' of their life at that time. Moving forward to then explore their lives following the Prime Minister's announcement and the commencement of the COVID-19 lockdowns with the question 'how did your life change when COVID-19 arrived?', facial expressions changed quickly, and smiles were replaced with more solemn expressions. For those being interviewed, the broad nature of this question allowed them to go in any direction they felt comfortable with, and as their response progressed, I would gently bring them back to fill in gaps about particular elements. For those in the focus group, I allowed them time to think and draw, followed by a discussion. This initially focused on what they had drawn and then organically grew into a group discussion about individual experiences and feelings.

In the preceding conversations, several overarching themes were identified in the analysis of the interviews, focus group discussion and drawings with young people. Restricted movement and social contact due to the COVID-19 lockdowns significantly impacted the experiences of participants, and more importantly their mental health with consequences continuing to the present day. These findings are presented in five key themes - experiencing social disconnection and disruption to everyday life, negotiating and making sense of mental health during COVID-19, living with uncertainty and its impact on mental health, experiencing disruption to life transitions and a sense of lost time and experiences of accessing and engaging with mental health support. An overview of these key themes and sub-themes is provided in Table 4.2. For the purposes of analysis, the findings presented represent those from all participants involved in the interviews and focus group, irrespective of age.

Table 4.2. Key themes and sub-themes.

Key themes	Sub-themes
Experiencing social disconnection and disruption to everyday life	Loss of routine and disruption to daily life: Absence of daily routine, in-person interactions and connections; inability to simply hang together had significant impact Social relationships as sources of support: Importance of strong social networks, family and friends; Supportive relationships offering a buffer against negative impact; ability to share experiences, offer/ receive emotional support and just talk to someone Periods of reflection and re-evaluation of priorities: Unexpected reflection on life and in particular, health including priorities, values and future goals; positive impact
Negotiating and making sense of mental health during COVID-19	Worsening of existing mental health challenges: pre-existing issues (mental and physical) magnified at a time when mental health was generally in decline due to restrictions Questioning the validity of personal distress: legitimacy of own mental health struggles; others more worthy of support; further internal layer of conflict Experiences of dismissal and the need for validation: not being believed by adults about mental health struggles; lack of validation exacerbating feelings of isolation and frustration Developing self-awareness and reframing mental health: heightened awareness of own mental health and physical health, positive impact
Living with uncertainty and its impact on mental health	Ever-present uncertainty, 'the unknown' was major source of anxiety and worry; pervasive feeling of not knowing when normalcy might return significantly impacted overall well-being
Experiencing disruption to life transitions and a sense of lost time	Missed milestones (significant birthdays), reduced opportunities for adolescent exploration, sense of lost time and being set back, contributing to frustration and loss. Disrupted transitions into adulthood, feeling between childhood and adulthood, limited opportunities for independence, experience and stability, increasing vulnerability and impacting confidence and self-worth.
Experiences of accessing and engaging with mental health support	Mental health support often perceived as misaligned with individual needs, with limited and repetitive approaches reducing engagement and uptake. Remote support, while convenient, experienced as less emotionally engaging, with reduced connection, difficulty expressing feelings, and greater scope to avoid sensitive discussions.

4.3.1 Experiencing social disconnection and disruption in everyday life

4.3.1.1 Loss of routine and disruption to daily life

When the COVID-19 lockdown restrictions were put in place, all but one of the participants were living with other people either in their family home or shared accommodation. For the latter group, mostly students living either in student houses or flats, this quickly changed as their fellow house mates left, often to move back home. This initial period was viewed by many as a type of extended break, happening at the end of term and the start of the Easter holidays, and so most seemed to view it as an upbeat period. The young people moved their communication with family and friends outside of their home to online and began using apps such as FaceTime, Zoom, WhatsApp and Snapchat to regularly communicate. For those at school, this would often involve completing homework together virtually, for the older age group this would include more social activities such as quizzes, games and even virtual discos.

> I was actually quite like, oh, yeah, let's go for a few weeks. Little did I know. Yeah. I think it was quite nice to have a break. It just felt like a bit of a holiday at first. And it was quite fun, actually, at first, like, I would like get up every morning and go for a run, come back and do like a yoga class. And then like, I'd get on with my work for a few hours. And then I just have the rest of the day to just like, relax and stuff. Yeah, and it was quite fun.
>
> *(Oliver, male, 16 years)*

> So I was thinking this is great, this is an extended summer. [continues] talking about her move to different city for university] initially I was so excited. Like the novelty hadn't really worn off, my room was like really, really nice, it had a nice double bed, obviously it was quite new accommodation, made it look all nice, everything had been done out and got like fake plants, so I was loving it and like, I'd taught myself to cook and I was, I was really like, really happy.
>
> *(Florence, female, 21 years)*

> Yeah. We had quite big kind of lots of zoom quizzes. The pub, actually just around the corner from here, they started doing beer deliveries on Fridays and Saturdays. So there was a group of us that would like, it was my partner's office, like research group, would all normally go to the pub on a Friday. So instead, we all started getting a beer delivery on a Friday and then having like a disco call together to be like this.
>
> *(Sophia, female, 24 years)*

Where there was online contact with friends and family, they felt it was much less than before the COVID-19 lockdowns but a valuable source of support. Just the ability to have a connection with people outside of your immediate surroundings, being able to discuss individual experiences and feelings, and the realisation 'that you are not alone' provided substantial comfort at a time that was becoming increasingly hard to navigate.

> Yeah. So coming out of the pandemic, one of the things that surprised me, I think I mentioned this before was talking to other people and realising just how many other people felt like they were in a similar situation. So obviously, we've got the benefit of hindsight now. But I think if something similar were to happen again, I think having some kind of sessions run by the

> University or run by the hospital trust to be to sort of explain to everyone you know, that it's, it's normal to feel like this. And not only is it normal, a lot of people if not the, most people are feeling like this to some degree. And if I were to know that I wasn't alone, and that so many people on my course were feeling exactly the same. I think that would have helped me in a way because it wouldn't have made me felt like I was so falling behind so much, both you know, socially and academically and emotionally. So yeah, so I think just sort of, I'm not, I wasn't even looking for anything, any sort of specific counselling or anything like that. But if there was just a session, that was run, where we were all invited, you know, it was explained to us that this is normal. A lot of people are feeling like this. And we just spoke to the people on the course I think that would have helped.
>
> *(Zayan, male, 22 years)*

The importance of strong social networks became more evident where they were missing, highlighting the profound connection between loneliness and mental health. Three young people (Oliver, Soraya, and Zayan) lived in the family home but described a lack of communication with friends, which, despite arising from different circumstances, led to similar experiences of loneliness and emotional distress. Soraya and Zayan reported friendship difficulties and challenges in meeting new people, leaving them socially disconnected during lockdown and intensifying their sense of isolation. Oliver, despite having a friendship group, was restricted to online schooling as his access to social network apps and social media was not permitted, preventing direct interaction with friends. This social deprivation appeared to exacerbate his loneliness, which Oliver described as ‘struggling’ through, accompanied by growing anxiety and distress over the well-being of his friends. All three experienced heightened loneliness due to limited social contact, which in turn had a detrimental effect on their mental well-being. As the pandemic progressed and restrictions tightened, their sense of isolation deepened, further compounding negative psychological effects. In particular, the shift in Oliver’s daily routine, habits, and overall demeanour when discussing later lockdowns (compared to the first) was striking, suggesting that prolonged loneliness played a key role in his deteriorating mental health.

> Yeah, like in the first lockdown, I would like make myself really nice lunch every day and stuff and like, and then slowly that kind of turned into, I’ll just grab a like a pack of crisps or something from the cupboard. And that'll do me for today.
>
> *(Oliver, male, 16 years)*

> MK: And was that because you couldn't be bothered or your appetite kind of dropped...?
> I just wasn't that hungry at that point. Yeah, I just Yeah. I wasn't usually like feeling it.
>
> *(Oliver, male, 16 years)*

> But I can honestly say that was that that four weeks I spent at Doncaster, I think was the most difficult part of the course for me because it was our first placement and it was the loneliest, it was one of the loneliest experiences I had, because most of the students in Doncaster commuted, and the ones that didn't, were split across a number of hotels. So there weren't any other students I knew in my hotel and when I'd come back from placement, I was so lonely. And you know, there was, I'd have to eat out there was no cooking facilities. So I would just have to have takeout for every day, for four weeks, I came back on the weekend, so I'd go on

Sunday night, and then I'd come back on Friday. And then repeat that four times. But it was very, very lonely,… I just felt so lonely. I'm not sure if I saw any of the students. And if I did, it would just be bumping into them. And then I'd go back to a hotel room by myself, and then just wake up and do that, do the same the next day. So that yeah, that was really an awful experience.

(Zayan, male, 22 years)

So, in the first year, it was really, I think that was quite hard and especially, because in the first lockdown, I was at my other school and like, I had friendship problems at the time. So it felt even more like lonely in a way because I didn't have like, because obviously you have family support but that's a bit different to having friends who are your age and you know, you can talk to about anything and I think not having that was quite hard as well because like you had no one really to talk to you who understood the situation.

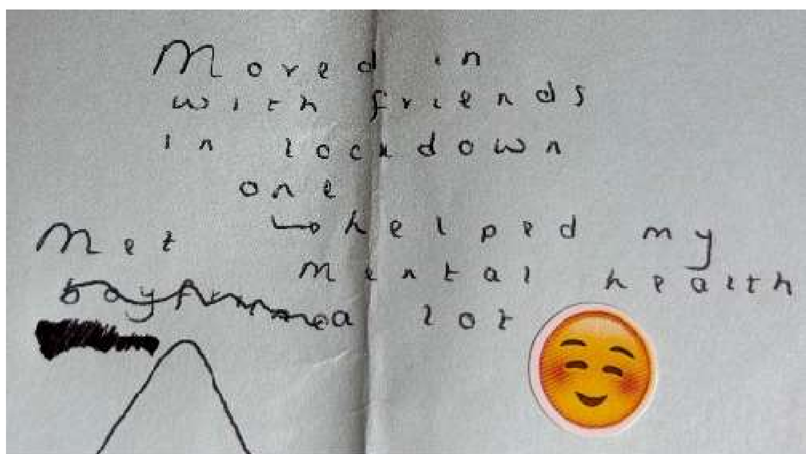
(Soraya, female, 19 years)

For one young person, remote contact with friends was not sufficient during the lockdowns. Living alone in student accommodation for seven months and with a history of depression, Martha described struggling due to the lack of personal contact. She noted that being in a block of student flats, she became increasingly aware of the lack of noise or movement around her. This isolation eventually took its toll, and consequently, Martha began meeting with friends both inside and outside regularly, despite knowing that this was not permitted under the COVID-19 lockdown restrictions. Her friends became her biggest support and a crucial factor in maintaining her mental health.

I talked to my friends about it, and they knew what I was going through. And obviously some of my friends were going through similar things too. And I did meet up with my friends sometimes even though you weren't supposed to, because I needed to, really. So I had a couple friends around quite a lot. [continues] If I hadn't done that I have no idea where I would have been.

(Martha, female, 23 years)

For Emery, the struggles with their mental health were so bad that Emery moved in with friends which became a big support.



(Emery, non-binary, 22 years)

The disruption of everyday social contact was not simply a temporary inconvenience, but a profound interruption to identity formation and relational development. For young people at a life stage characterised by peer connection, experimentation, and increasing autonomy, the enforced withdrawal from social spaces altered both their sense of belonging and their perception of self. Social isolation was experienced not only as physical separation, but as an emotional and developmental pause, the implications of which extended beyond the period of formal restrictions. From a SIT perspective, shared environments such as schools, universities and peer groups play an important role in shaping identity and belonging; when these spaces were removed, opportunities for young people to affirm and negotiate their social identities were also disrupted (Jenkins, 2014; Tajfel & Turner, 1979).

4.3.1.2 Social relationships as sources of support

The importance of this social network became apparent when Martha discussed meeting with her parents on her birthday during the lockdown restrictions, when you could meet with a restricted number of people outside.

> I did break the regulations by having friends over, but I wasn't alone in that. I'm not going to lie about that either. I met my parents on my birthday outside on a walk and we went to like a country park near my house and had a glass of champagne outside. So yeah, it was nice. My parents were really anxious about COVID at the time so that's why we did that, and because they knew I'd been seeing my friends, they didn't want me to come back like to the house. I would have gone back to the house but then I wouldn't been able to see, I wouldn't have been able to see my friends, so I had to think about that a little bit and then that's why I decided to stay in the student accommodation.
>
> *(Martha, female, 23 years)*

In terms of face-to-face contact, some of those living with their families were able to enhance their familial relationships as it provided a unique opportunity to spend more time with family members that they would not normally see much of due to working and other commitments. For others, co-habiting with people (family or friends) even with good relationships, was not sufficient to defend against feelings of loneliness and a decline in mental health. This was a common finding across the participants with nearly half of those in the research raising this as their experience.

I felt very isolated but also loved by family. It was a mixed time, but I

(Zoe, female, 22 years)

> I felt completely alone even though it's surrounded by family, I still felt so alone. I just, yeah, they obviously there's contact, it's not the same talking to friends over video chat or talking to your parents over video call than it is actually being with them. So yeah, I felt very, very alone.
>
> *(Lily, female, 22 years)*

> Okay, so, so even though I did live, I live in a household with four other people I did feel, I had my privacy, but I did feel quite isolated and I think that was because the other people were working. So we were all, we would all be in our own rooms, with our own laptops. Just and, even though we're in a household with other people, we still are at least I know, I felt very alone. And if I compare that to people who maybe did live alone, I don't think there was a huge difference. Because even though I was with other people, I still felt alone, if that makes sense.
>
> *(Zayan, male, 22 years)*

For those in shared accommodation, the lockdowns propelled relationships due to circumstances. Rather than live alone in large flats or houses, some took the decision to move in with their partners, something that they would not have considered otherwise. This was seen positively as they were able to share the experience with someone they were close too, and remain independent. For Sophia, she felt this experience fast forwarded her maturity, particularly when compared to her peers who had returned to the family home during the lockdowns.

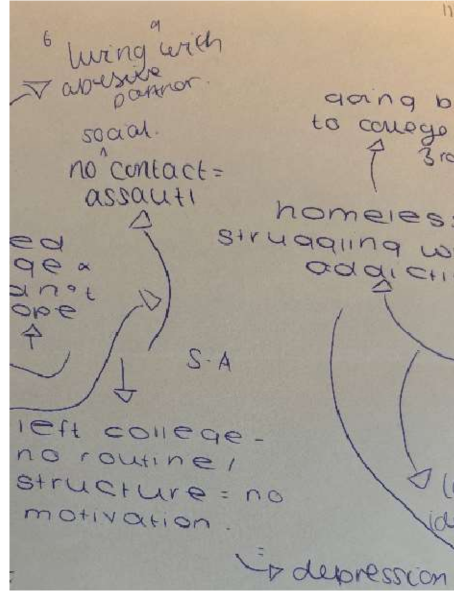
> I find it slightly odd actually, at Christmas one of my friends was like, 'when are you going home?' and I was like, probably about five o'clock and he was like 'no, for Christmas?' I was like 'oh I kind of feel like I live in Sheffield now'. And because I didn't go back to my mum's in that first part and then I moved back to Sheffield, I feel like it was very much kind of final moment of like no, home is my house now. I'm not sure everybody my age feels that [continues] If COVID hadn't been happening, I probably would have gone back to my mums for a bit in the summer and then I'd have like, I was slightly kind of moving along the process of moving more out as I got through university, but [COVID-19] definitely kind of, put a stop and accelerated it.
>
> *(Sophia, female, 24 years)*

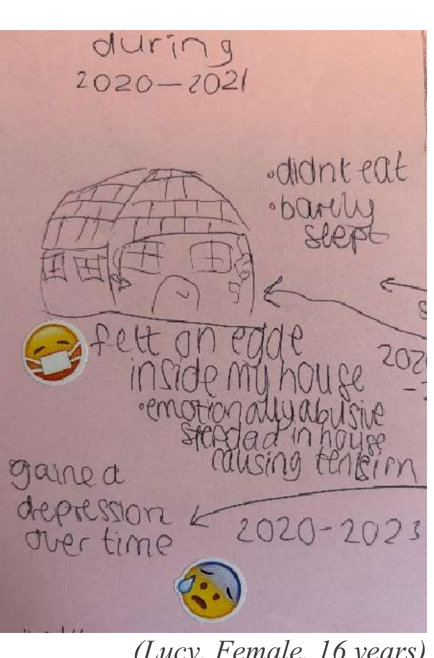
As the various lockdowns continued and the novelty of restricted personal freedoms wore off, communication online with other people appeared to reduce for all the participants, and relationships with those in the home for some became strained. Two individuals discussed how they actively started to avoid family members, with arguments occurring, tension increasing, and one young person eventually making the decision to move out into shared accommodation.

> *[Mental health]* got worse because I was all isolated and stuff. I went on meds, meds didn't really help that much. I moved out, that helped with the person I got together with during lockdown, it's nonbinary, it uses it pronoun. It's lease was about to go up, I was desperately wanting out of my parents house so we looked for a house together and also with its childhood best friend …I was feeling a bit happier after that but that was short lived because like a couple of weeks, maybe a month after we moved in, It realised it straight up just wasn't attracted to men like at all ... that was really confusing and heart-breaking for me because it still felt better than living with my parents but now I'm living with an ex and a stranger.
>
> *(Will, Demiboy, 21 years)*

> Still living with one half of the family. And, you know, we, we did have arguments, and obviously, I think, being in each other's space 24/7, as opposed to, you know, four to five hours a day, [?] took a bit of a strain on relationships and whatnot. But, you know, it just kind of got to the point where I would just stay in my room and not really go out on the side to eat or get something to drink. Because it just made more sense to me.
>
> *(Lucas, male, 23 years)*

For Mia and Lucy, the restrictions made home life particularly challenging. Lucy spoke of enduring emotional abuse from a stepparent, while Mia felt trapped in a relationship with an obsessive partner and suffered an assault. Both described how these traumatic experiences, combined with isolation, led to a gradual descent into depression.





(Mia, female, 18 years) *(Lucy, Female, 16 years)*

These accounts reinforce the centrality of relational connection during adolescence and early adulthood. Social ties functioned not simply as companionship, but as emotional regulation, validation, and continuity at a time of profound uncertainty. Where these lifelines were sustained, they appeared to buffer distress; where they were weakened or absent, vulnerability intensified.

4.3.1.3 Periods of reflection and re-evaluation of priorities

Nearly all the participants felt the imposed COVID-19 restrictions and in particular, social isolation, provided a time for reflection and introspection. This was not something that was prospectively planned by them but arose as they discussed their experiences during that time, and where they are now. These reflections appeared to fall into three categories: life trajectories, learning about themselves and health (physical and mental).

For several respondents, their isolation from their usual environment of school, college, university or employment and their wider social network, gave them time to think about what they wanted for themselves and in the future. Sometimes this was directly influenced by the COVID-19 pandemic that

was taking place at the time but for others it seemed that space gave them the freedom to make decisions they felt they would not normally be able to do.

Two participants changed their career trajectories as a consequence of their experiences during the COVID-19 pandemic. Both were attending school when the first restrictions were implemented and had set ideas of what they wanted to study at A-Level. After breaking down in class, Emily spoke to a senior teaching member at her school and received a lack of support at a time she felt she needed it the most. This not only negatively impacted Emily's mental health but also influenced her decisions on seeking support elsewhere. Reflecting on her experiences of school during the COVID-19 lockdowns, Emily described how these experiences shaped her future aspirations:

> It's also like, it changed completely what I wanted to do as a job now. I want to be a teacher, and part of that is so that, you know, I can help people sort of my age and things like that. I'd say, yeah, it basically changed everything that I wanted to do with my future. [continues] I think it was probably mostly because of the experience I had in school during the lockdowns, it just made me think I don't want to go to this school anymore because you know, they've let me down. I want to be able to work in a school so I can make change in the future.
>
> *(Emily, female, 17 years)*

For Charlotte, the treatment of her grandfather in a care home and increased exposure to different medical roles during the COVID-19 pandemic shaped her developing career aspirations, as she explained:

> I wanted a job before COVID but I think coming out of COVID, I was like dead set on, I wanted to work in a care home. That is what I really wanted to do, and I had always like, kind of wanted to cos my grandpa was in a care home, but I think cos we saw a lot more like footage of care homes during COVID, it made me realise more like, I really, really want to do this. I think had that not happened, I might have not done that [continues] I want to go into being a paramedic, I didn't even know what a paramedic was before COVID, like I thought people in ambulances like just drove people to hospital. So I think again, it's that thing of, even though it was sad, I think seeing like footage on the news made me discover things that I hadn't really thought of before and it has kind of, I think, cos I'm like a hundred percent sure that's what I want to do. So I feel like in a way it will almost change like the way that my life was gonna go. Which is kind of cool.
>
> *(Charlotte, female, 17 years)*

Emily and Charlotte are now pursuing careers in education and health (respectively).

There were a few participants that seemed to have experienced a more difficult time than others for various reasons including their pre-existing issues with mental health and living circumstances during the COVID-19 lockdowns, Martha was one of these. Living as a young person alone for long periods of time, and as a sufferer of depression, Martha described the COVID-19 period as 'most of the negative experiences I've ever had came during that time'. However, these experiences have, on reflection, also generated positive outcomes. Not only influencing the person Martha is today but also her studies and life going forward.

> I feel like in a lot of ways, it's made me more resilient than I might have been otherwise. Most of the negative experiences I've ever had came during that time. And I've still moved on despite that, and I feel like that now is sort of a big part of my identity, like moving on from difficult times. So it has shaped me as a person, I would say, and maybe I wouldn't be in the same place I am now maybe I wouldn't be as motivated. I might have just stayed on the same trajectory, as I was on before. Like, just putting in a slight bit of effort and not really caring about it.
>
> *(Martha, female, 23 years)*

> I had no idea what was going to happen next. And I had no idea in my head of where I wanted to be, or what I wanted to do. And I wonder whether that might have continued if I hadn't had that period of time where I had to say to myself, look, you need to get yourself in check and just finish this degree. I might have never have done that.
>
> *(Martha, female, 23 years)*

Another participant, Florence, strongly believed that the restrictions imposed due to COVID-19 set her life on a very different trajectory to what it should have been and that she is now a completely different person because of it. As a young outgoing and sociable person starting university with a wide group of friends, Florence was looking forward to the quintessential social experience that higher education students often partake in but this was not possible. On reflection, Florence feels this is a consequence of not being able to meet new people and socialise for nearly two years, not feeling like she is part of the student community or city where she studies, and significantly affecting her friendships ever since and how she lives her life.

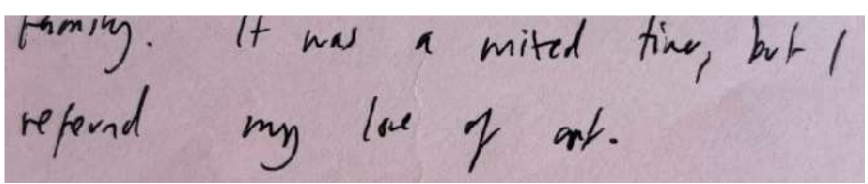
> I probably would have been in a complete different friendship group. I also live in the city [S1] like now so, most people live in [Sheffield S10] and stuff, I wonder whether like, … I like living here because it's easy to get home and stuff but I actually go home every weekend now which is like, a lot of people are surprised I do that, I just drive home and I wonder whether I would have settled in more, made more, so I don't actually have that many friends at uni because I always go home. I don't like maintain friendships well, apart from a few close ones because I go home at the weekend and I just end up saying no, it helps because how can you invite someone to do stuff. So yeah, I do wonder I always do sit and wonder 'Oh, I wonder what life would be like?', but it is what it is.
>
> *(Florence, female, 21 years)*

The introspective journey throughout the COVID-19 pandemic and associated restrictions appeared to be a unique experience for many of the participants. Although they acknowledge it was a challenging time, most young people had similar feelings to Martha and expressed negative as well as positive outcomes because of the experience. The extensive time alone allowed them to find things they were passionate about such as Zoe’s rekindling of love for art, whereas for Soraya, Lucas and Zayan it helped them to build resilience and to better understand themselves.

> Like I feel like COVID made me like grow as a person in a way, even though in that time, I don't know if I did, but looking back, I think everything that happened. was for me to like grow, and actually You know, find what I actually have a passion for.
>
> *(Soraya, female, 19 years)*

> In terms of resilience, that's a word that has been thrown around a fair few times during discussions of COVID. And every single time, I always have to say, Okay, there's resilience that's formed of one's own development, and one's own personal strides towards bettering themselves. And then there's, there's the other version of it, where you're thrown in circumstances, and you're not given, you know, you're not given much in terms of ways of dealing with it. And you develop your own resilience, but you do it out of necessity, and not necessarily of, not necessarily in ways that you're actually trying to benefit yourself in terms of your health, you're just doing it because if you don't, you would not be able to function. And so you know, it's a weird one, because, yes, there has been resilience that's formed, but it's not in a healthy way.
>
> *(Lucas, male, 23 years)*

> It was, it was a huge learning experience as well. I think going through those sort of emotions and experiences, has made me a better person at the risk of sounding cliché, but I think I learned a lot from it, about people around me and also myself, and now have, you know, reflecting on how I sort of reacted to that environment and those experiences, I think will help me sort of cope with anything, not if another pandemic hit, but just in sort of experiences are I'm uncomfortable, or feeling a little bit anxious.
>
> *(Zayan, male, 22 years)*



(Zoe, female, 22 years)

These reflections illustrate how enforced stillness created space for a deeper engagement with selfhood. While not universally positive, this period of introspection enabled some young people to reassess priorities, values, and aspects of identity that had previously been overshadowed by routine and social expectation. In this way, reflection became both a coping mechanism and a developmental process unfolding within the constraints of disruption.

4.4 Conclusion

This chapter has examined how the COVID-19 pandemic disrupted the everyday lives of young people at a formative stage of development. By first outlining participants' circumstances prior to the pandemic, it became clear that education, employment, peer relationships and routine social interaction formed an important framework for identity development and emotional stability. The sudden introduction of restrictions interrupted these structures, creating uncertainty and altering how young people related to others and to themselves.

The findings show that social isolation extended beyond physical separation. The loss of routine, reduced contact with peers, and changes in living arrangements affected young people's sense of belonging and progression. For younger participants, school provided structure and social connection; for older participants, university, employment and broader peer networks served similar roles. When

these spaces were removed, many described feeling unsettled or out of step with their expected life trajectory. These accounts suggest that the disruption of school, university, employment, and peer networks unsettled the shared social contexts through which young people ordinarily negotiate identity and belonging (Jenkins, 2014). At the same time, the period of reduced activity created space for reflection. Some young people described becoming more aware of their values, interests, and aspects of their identity that had previously been secondary to daily demands. These experiences were not uniformly positive, but they illustrate the complexity of disruption during adolescence and early adulthood.

CHAPTER 5 YOUNG PEOPLE'S PERSPECTIVES: NAVIGATING MENTAL HEALTH DURING CRISIS

5.1 Outline of chapter

This chapter continues the presentation of findings from the qualitative analysis, focusing on the emotional and psychological impact of the COVID-19 pandemic on young people. It examines how the crisis intensified existing vulnerabilities and mental health challenges, as well as the barriers encountered in accessing appropriate support. The chapter also explores how young people made sense of their experiences, including emerging self-awareness, resilience, and reconfigured understandings of identity and wellbeing in the aftermath of prolonged disruption.

5.2 Negotiating and making sense of mental health during COVID-19

5.2.1 Worsening of existing mental health challenges

It appeared from talking with the young people that they were proficient at managing their mental health, generally internalising mental health challenges they faced and just getting on with life. Sixteen participants reported that they had a pre-existing issue prior to COVID-19, mostly associated with mental health, however only three people had a formal diagnosis. When the restrictions were introduced, all of the participants with a diagnosis which included eating disorders, depression and suicidal thoughts, were receiving support in the form of therapy and/ or medication and were considered to be in recovery.

Among those without a formal diagnosis, low level anxiety was a common occurrence but something that was not constant in the participant's lives and so often dismissed. When it occurred, it was managed until the next time. Recognising mental health issues can be difficult for both the person experiencing them as well as to those around them, there are no tests and often no obvious signs. This came through in discussions with a couple of the young people about their mental health before COVID-19 who were aware that something was not quite right, but they did not understand it or could not explain it, even though for Amelia, it would affect her attendance in lessons and overall school attendance. These reflections suggest that young people often made sense of their feelings in relation to those around them. With reduced everyday interaction during lockdown, there were fewer opportunities to compare experiences with peers or to situate distress within a shared social context, a pattern consistent with SIT (Jenkins, 2014; Tajfel & Turner, 1979)

> So before that, I would say that I was struggling quite a bit because I didn't really, because I didn't really understand like why I was the way I was, but I'd say I was a lot more like sociable but it, it was really draining … [in relation to school] I would sometimes, I'd have off days, so I wouldn't go into lessons or I'd leave school sort of thing.
>
> *(Amelia, female, 18 years)*

Similarly, for Lucas, he described his mental health prior to COVID-19 as 'not necessarily perfect and pristine'; that there were issues but it was not clear exactly what the issues were. Lucas had visited a GP to seek help in the months prior to the COVID-19 restrictions being implemented, no diagnosis was offered but the GP did suggest undertaking lifestyle changes and returning after 12-months if things had not improved.

> So, prior to COVID I wouldn't necessarily say that my mental health was, you know, perfect and pristine. There was definitely there were definitely ongoing issues before COVID but it was mostly just to do with you, you know, I'd find myself stressed out over certain things, and then I would, you know, kind of stay in my head a little bit and it was manageable.
>
> *(Lucas, male, 23 years)*

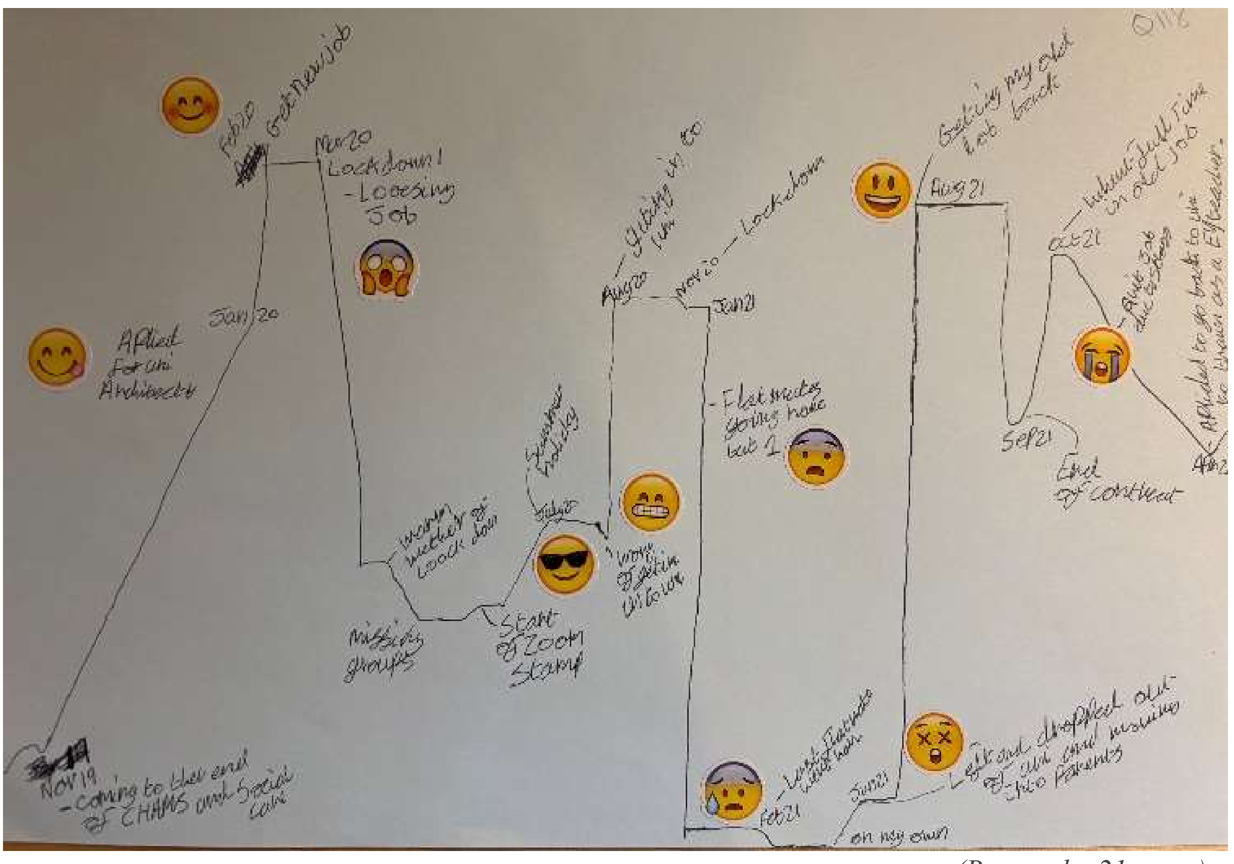
As would be expected, all the participants were in different places in terms of their health in March 2020, a reflection of their own lives and experiences to that point. Many of them describe entering the lockdowns positively, viewing the stay-at-home order as an extended holiday but the consequences of the continued restrictions to live their lives 'as usual' led to declines in mental health, particularly impacting motivation.

> I think it was very up and down. I think at times, it just felt, it was quite, quite quiet. I could just slow down a little bit. I almost just felt like we were in permanent holiday mode. But I think there were other times when it was like, you couldn't see the end. It kept going and kept going. There were the constant daily news briefings that we all sat in front of the telly to watch. It was just like, nothing's changing. what possibly could be the way out of this? Which I think does make you struggle a bit mentally, because it's just like, when you're told those things that I feel make me who I am, when can I start doing those again?
>
> *(James, male, 23 years)*

> Definitely yeah, like I find it really hard to kind of stay motivated. There's just it's really hard to kind of keep going with things when you don't know whether they're going to count for anything. What you're going to do, when everything is really uncertain. One of my housemates came back in June, to actually get all their stuff. And she was like really mad at me. She was like, 'why is the Hoover still in [friends] room where I left it when I left in March?', and I was like, '[friend] it's a miracle that I've like got out of bed and done my exams!'. The hoovering just didn't really factor in that time.
>
> *(Sophia, female, 24 years)*

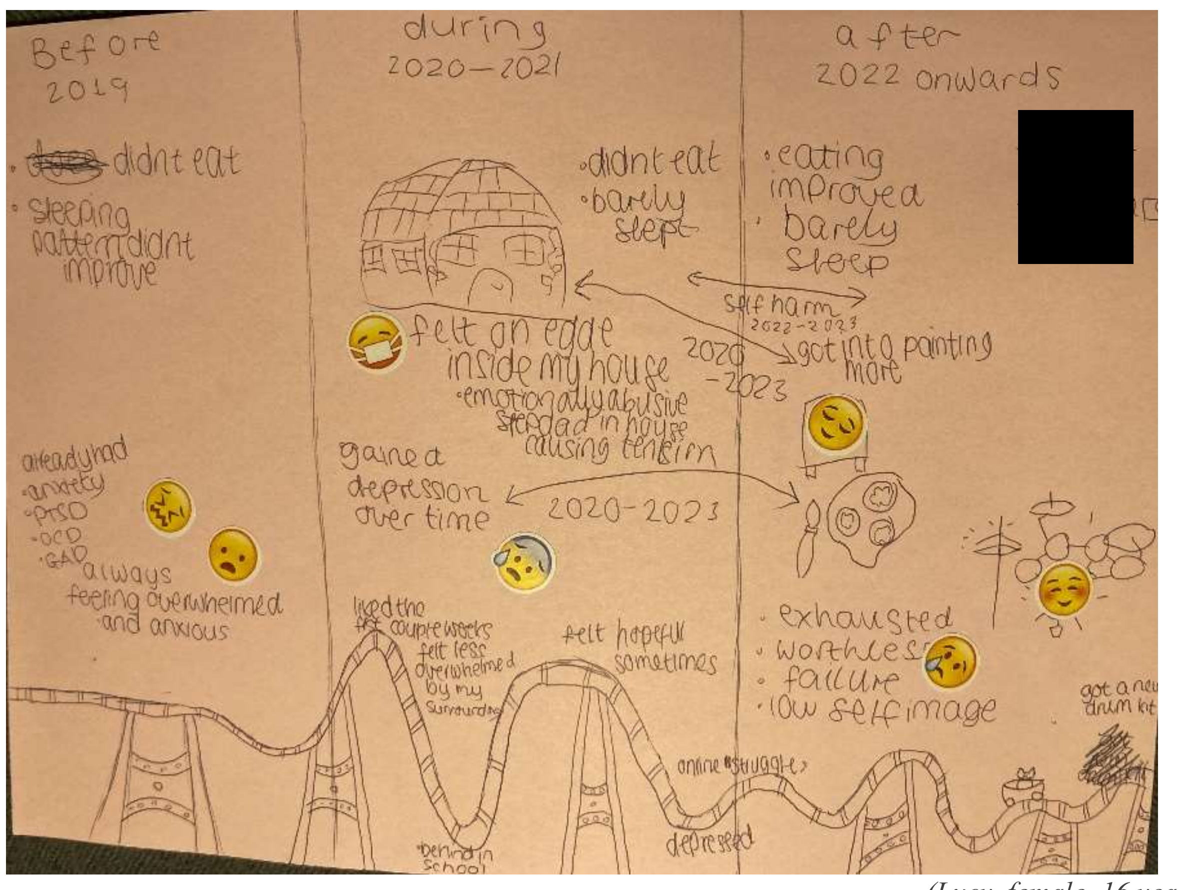
Declining mental health was especially evident in the discussions among the focus group participants and in their drawings. Many of the young people used lines to represent their feelings and experiences during this time, which seemed to fluctuate significantly, reflecting the impact of the multiple lockdowns. This is clearly illustrated in Ben's timeline. Prior to the onset of COVID-19, Ben was experiencing a period of increasing stability and optimism. He was moving out of CAMHS and social care, starting a new job, and applying for university, milestones that signalled a hopeful new chapter. However, the first national lockdown marked a significant disruption. Ben lost his job and found the isolation particularly difficult. The shift to online meetings with the STAMP group provided some support and contributed to an improvement in his wellbeing during this phase. The second national

lockdown in November 2020 had a profound impact. At this point, Ben was living alone following the departure of his flatmates, and the increased isolation contributed to a decline in his mental health. This culminated in him dropping out of university, which he identifies as a particularly low point. By the end of 2021, there were signs of recovery as Ben re-entered employment, which helped to stabilise his mental health. However, the positive trajectory did not fully continue, and as job-related stress increased, his wellbeing began to decline again. The timeline finishes with Ben's decision to reapply to university, suggesting a renewed effort to regain a sense of direction and purpose.



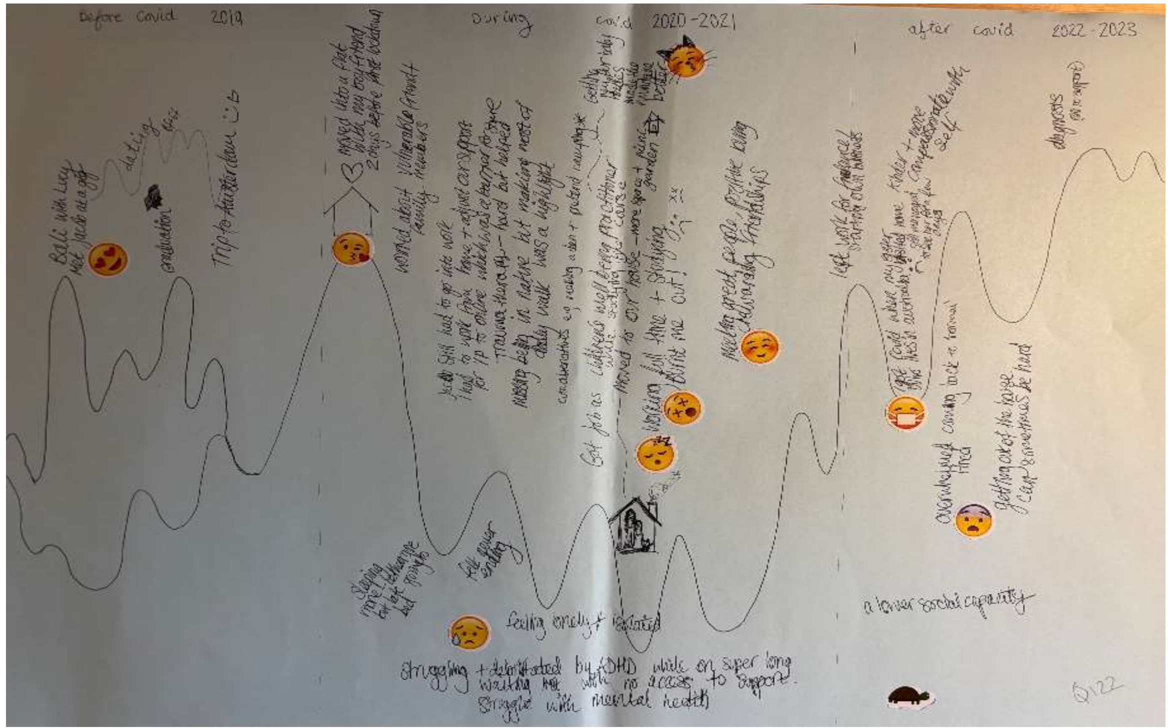
(Ben, male, 21 years)

Similarly, the lockdowns negatively impacted the lives and mental health of Lucy and Natalie. Lucy's timeline reflects a sustained period of distress beginning before COVID-19 and intensifying throughout. Lucy describes not eating or sleeping, and feeling constantly "on edge" due to emotional abuse from her stepfather during lockdown. This period, marked by isolation and tension, led to the onset of depression, which persisted from 2020 to 2023. In 2022 and 2023, Lucy reports self-harming, indicating a deepening of her mental health struggles. Although restrictions began to ease, she did not experience immediate improvement. Instead, the post-COVID period is characterised by exhaustion, low self-image, and feelings of worthlessness and failure. While there are signs of improvement beginning in 2022, Lucy's timeline powerfully illustrates the long-term impact of both the pandemic and her home environment on her mental wellbeing.



(Lucy, female, 16 years)

Natalie's timeline reflects a fluctuating yet reflective account of her mental health across the COVID-19 period. In the pre-pandemic phase, she notes experiencing ups and downs, which appear to mirror the typical emotional undulations of a 20-year-old navigating the demands of higher education alongside the highs of social life, including holidays with friends. A particular high point was moving in with her boyfriend, though this coincided with the onset of the first lockdown, leading to an abrupt downturn. The emotional toll of the pandemic is clearly marked across 2020–2021, with annotations such as "felt never ending," "struggling and debilitated by ADHD," and "feeling lonely and isolated." Nonetheless, moments of positivity also emerge, including the comfort of getting a cat, moving house and the highlight of the daily walks. From 2022 onwards, the timeline shows gradual improvement, though this is accompanied by challenges in adjusting to the 'new normal', with Natalie describing feelings of overwhelm and reduced social capacity. The timeline concludes with a self-directed intention to be "kinder and more compassionate with self," suggesting a movement towards self-acceptance and emotional resilience.



(Natalie, female, 24 years)

The commonality experienced across the whole cohort of participants was striking. The social isolation, change in daily routine and pervasive fear both from the virus and the associated restrictions combined and acted as a magnifying glass for pre-existing health conditions. Issues that were previously ambiguous, surfaced, and could no longer be ignored. Relapses occurred in eating disorders and depression.

> I did have some issues with eating and that, it was basically, I was diagnosed with an eating disorder even before all of lockdown and then I was in recovery when lockdown happened, but lockdown definitely did affect my whole progress and on multiple occasions caused me to relapse, or even though I felt like maybe it was helping me with my recovery, looking back on it I've realised it really wasn't. It was just putting more and more stress on me.
>
> *(Lily, female, 22 years)*

> I remember thinking at the time, like, there were lots of, lots of people were suddenly really anxious I remember going 'Oh, this is, this is what my life is as a person with anxiety'. It's kind of like every day, you know, obviously it wasn't it like it did also impact me, but it was, yeah, it was kind of like yeah, welcome to the world.
>
> *(Sophia, female, 24 years)*

> [in relation to depression] Like, it got a lot worse. It was already bad. And then it was even worse after [the lockdowns].
>
> *(Martha, female, 23 years)*

During

turned 18 in 2021, was difficult not knowing what would happen w/ exams going to uni etc was still under CAMHS but switching to another worker who didn't understand my need for in person appointments being autistic struggled w/ the drastic change in routine, college being online was a big support for me, struggled a lot more with my eating disorder again.

(Alex, male, 20 years)

When talking about this stage in his life, the impact on Will was apparent as he became emotional and described that time:

> So I was trapped at home, my parents were responding to their stress with anger, I'd gotten very used to getting near 20 cuddles from everyone around me but my parents aren't that physically affectionate. I spent a lot more time online I always already was spending time online anyway but I spend even more so online, I just felt very isolated for a bit I had to go back on anti-depressants they didn't really do anything other than help improve my sleep a bit, it was Mirtazapine [antidepressant] and you take that at night, so my sleep improved over lockdown but yeah that initial hit was bad.

(Will, Demiboy, 21 years)

For one participant, the increased isolation led to a severe mental event: -

> MK: So do you think that [COVID-19 restrictions] had any impact on your mental health at all?
> So, yeah, I think massively cos I, I like. I'm so extroverted, like all my energy comes from other people and that's what makes me really happy. And I just felt the whole lockdown, I felt so lonely. Like I was just so sad. And I was actually, um, uh, I did have a suicide attempt, so I was in the hospital as well, so it definite, at the time, I wasn't a hundred percent sure about it was lock down, but now I've come out of it, I was like, I just need other people. In hindsight, you can look back on that, yeah.

(Charlotte, female, 17 years)

Being in the same place for a long period of time in stressful circumstances also changed the perspective of the home for some. Their living spaces and in particular bedrooms, that were once viewed as places of sanctuary, became more like incarceration.

> I was saying I don't want to go in my bedroom. Like I didn't want to go back in it. So I think it definitely, like, I like peeled all the wallpaper off and like moved my desk to the other side and stuff just to try and make it feel different. So I think I didn't really like the space.
>
> *(Charlotte, female, 17 years)*

> I think things might have been easier if I'd had flatmates. Just someone to talk to every now and then in the kitchen, when you run into them, it just the everyday moments like that, it would have felt a bit more normal, if those kinds of things were still going on. But it's just whenever I went into the kitchen, it was just complete silence. And I was in there. And I looked out the window. And it was just so many empty apartments. And just that feeling was so surreal in a way. And I just almost never heard anything, any noise in the accommodation apart from me, really.
>
> *(Martha, female, 23 years)*

A further commonality experienced during this time and which intensified, was the challenges of remote learning. This became for some participants an additional burden on mental health that they had to manage. When discussing life prior to the COVID-19 lockdowns, six young people who were at different levels in their academic careers (school, college and university) spoke about how they found studying hard, two of these individuals had a diagnosis of the neurobehavioral disorder dyslexia. Following the lockdowns, there was a rapid transition from classroom to online, and everyone had to change the way that they worked. For these individuals, the difficulties with studying appeared to increase describing challenges such as difficulty in understanding the work, what they needed to do, issues with concentration and focus. Consequently, this had a significant knock-on effect not only on their academic learning where a few participants described falling behind in their studies (Taylor, Emery and Lucy), but also on their overall mental health, impacting habits such as sleeping and eating but also motivation, worries and anxiety.

> I was sort of left to my own devices that stressed me out, because sometimes I wouldn't do it. And then I would feel like I was gonna fail all my exams, basically. But yeah, I'd say, I definitely got more anxious. [in relation to motivation] That definitely was lower as well. Yeah, I struggled to concentrate with, because I was just so like, miserable effectively. It was just, yeah, I'd say my grades definitely went down, after the lockdown. Probably partly because, you know, teaching wasn't there, really. But also, probably a bit because of how I was feeling as well.
>
> *(Emily, female, 17 years)*

> I hated doing school at home cos I found it really hard. I didn't understand anything and I'm also one of those people, I just have no self-motivation. So if I don't want to do something, I just won't do it. So I used to, I think I was going to sleep at night not being able to relax because I was like, oh, and then I've got to do maths again tomorrow and I don't know how to do the thing we did last week. So I can't do it.
>
> *(Charlotte, female, 17 years)*

> With online school work, I just didn't do any of it because I couldn't. I couldn't like tie, I couldn't manage myself. Like I needed someone to tell me exactly what to do, and I couldn't like, follow the lesson plans, I didn't want to do lessons so I just wouldn't and I used to tell my parents that I, for Spanish class, it was watching Peppa pig in Spanish. So I could just do nothing or history. Watch history, documentaries sort of thing and because I just really, really found it difficult. [continues] In terms of the ADHD, like it became frustrating not being able to learn like, not being able to take in anything and it became ... I felt quite like upset with myself because I was just like 'why can't I do this?' Like, this should be easy. Everyone else loves online learning and I actually can't do it sort of thing.
>
> *(Amelia, female, 18 years).*

This period appeared to amplify the challenges which the young people had been experiencing prior to the COVID-19 lockdowns, and subsequently the four participants (without Dyslexia) have received diagnoses of ADHD.

5.2.2 Questioning the validity of personal distress

Another aspect that came to light in the theme of managing mental health was how some of the participants viewed their mental health struggles in respect to others. It was clear that many of the young people felt the COVID-19 lockdowns were challenging and described experiencing a roller-coaster of emotions that impacted them daily, influencing their working/ studying, habits and relationships. They were aware of this at the time it was happening, with increased recognition of the depth of their struggles as time progressed. Delving into how they managed what they were experiencing and the prospect of support, they appeared to be knowledgeable about what support was available and the various routes to access it. However, the young people surprisingly went on to quickly dismiss the legitimacy of their struggles, either normalising what they were experiencing with everyone facing similar issues, or that there were other people who were worse off and needed the support more.

> It definitely affected every single one of us … [my experiences] made it a little bit tougher for me, but I'm sort of person who I would always tell myself that other people had it worse, so, when my family members, for example, would say like 'oh yes it must be so hard, doing all these classes online and not having a university experience or student experience', I would always say 'yeah, well at least I'm not one of those who was maybe graduating or I'm not someone who's meant to be starting school, you know like a child or things like that', I'd always try and think of other people in worse situations.
>
> *(Lily, female, 22 years)*

> I think probably a big thing that I kind of realised about a lot of my friends with the kind of stuff that they're working through, they don't want to access support as much because they feel like their problem isn't quite big enough for, to kind of reach out for outside help.
>
> *(Oliver, male, 16 years)*

> I think, definitely, if I was like, in school with somebody who was like, doing it with me, just sort of validating that, you know, it was okay for me to reach out and like, do that, it would have been easier, especially because in the news all the time you hear about, you know, mental health services are really sort of overloaded with people who are asking for help. And

> so it makes you sort of go, is it really me that should be making it even worse? I think I probably would have just made it be like, for me that they [other people] were having a harder time than I was. So maybe it was, you know, I, I just kind of felt like there were people who were having a lot more difficult time than I was, and said, I should let them sort of get more support.
>
> *(Emily, female, 17 years)*

Feelings of illegitimacy and comparison were developed through the analysis as powerful psychological mechanisms shaping young people's accounts during this period. Many young people minimised their own distress by positioning it against perceived greater suffering elsewhere. This internal negotiation often functioned as both a coping strategy and a barrier to support, reinforcing silence and self-sufficiency. The imposter narrative, therefore, reflects not only individual cognition but also wider social discourses around resilience, productivity, and worth. Feelings of being an 'imposter' in relation to mental health struggles may also reflect processes described within SIT, where individuals evaluate their experiences against perceived norms within their social groups (Tajfel & Turner, 1979; Jenkins, 2014).

5.2.3 Experiences of dismissal and the need for validation

Feeding into the legitimacy of feelings was the fear of being dismissed, which was both perceived and real. Several of the participants discussed how they considered seeking some form of support but choose not to as they were concerned of the responses they might elicit. This reluctance to reach out was due to the expectation of not being believed, particularly when (in their minds) their lives appeared good on the outside. This links back to mental health and the lack of visibility of symptoms, and the fact that emotional experiences defy easy categorisation. If it is difficult for the person experiencing them to understand what they are going through, then how is anyone else going to, consequently leading to the conclusion that they will be disbelieved and receive a lack of validation for their feelings.

> So she gave me like this card with like a Youth Mental Health Service and she said because we were going back into another lockdown if, during that lockdown, I needed people to speak to there'd be, I could go online and do it there. I never did. But, you know, so there was the opportunity to at times, but I didn't. I wanted to, but I didn't want to actually have to go and seek it out and get some more formal, sort of ...
>
> *(Emily, female, 17 years)*

> MK: because you were a bit nervous about it?
> Yeah, I thought people would like, think I was being silly or like, not really believe me, and things like that, because it was in reality, my life was really not that difficult, you know, but it was just taking a bit of a toll on me. So I thought people might be like, come on, suck it up, like get on with it.
>
> *(Emily, female, 17 years)*

It seems the worries young people had about talking openly were not unfounded. Martha took the step of opening up about her mental health struggles to staff in her university department and rather than

receiving offers of support, she felt the response was indifference to her plight, that she was not believed and lying about her mental health. In the school environment, Amelia described being able to have someone to talk to and who did listen but they still felt unheard. She wanted the space and time to have her feelings acknowledged, where she could simply say ‘I am not okay’ without judgment but instead, there was a focus on solutions which felt dismissive and failed to address her underlying emotional state.

> I spoke to my department and the student access to mental health services, spoke to the University Health Service, but it wasn't that helpful. Just because the response times were really slow and it took a long time to get an appointment anywhere to speak to someone. Then I felt like the support that I did get wasn't actually very helpful for me, unfortunately. And I also felt like my department just thought that I was making it up because I couldn't be bothered to attend. I got that feeling. So I just didn't have a good year on that front.
>
> *(Martha, female, 23 years)*

> I think, especially in school, a lot of the way that they handle it is, they look for like, solutions. Instead of just accepting the way that I feel and accommodating for that, they look for ways to get rid of the sort of thing, and saying like, the external places. Where all I really wanted was for them to accommodate for it and let me have my like timeout sort of thing.
>
> *(Amelia, female, 18 years)*

For many, family provided the holistic support net during the time of COVID-19 but for some of those who wanted to talk about their mental health, family offered little solace. There was a perceived generational gap in attitudes towards mental health that created a barrier to communication with family members, increasing feelings of isolation. In particular, there was a fear for Florence, that her parents would provide judgement and dismissal of how she was feeling because of their perceptions of mental health, as well as the seemingly fortunate circumstances that her parents had provided for her.

> Obviously post COVID, mental health awareness and like online therapy I might have maybe considered it because I think if I had told my parents I needed it, I'm not sure. I think they, because we could have probably been able to afford to pay for it so it wouldn't be that, but then, I don't know whether they would, would have gone like, because they’re quite old fashioned. I mean, they're not like not that much. But I'm not sure they would have gone 'well why do you need that, like you've got such a nice life?' I mean, they would have been offended. I didn't really feel like I could ask them for that. And I probably could have paid for it out of my pocket but then I didn't want to because I’m a student … I wouldn't tell them and tell them after I've done it. Well, halfway through, like I'd probably tell them I've been having therapy and I feel great for it. Not that I do think they would judge me. Like it's like that sort of like, slight chance that they would and then that would like invalidate my feelings and they're not, they're not bad people, They're not like that far behind. And they talk about mental health, but I'm not sure whether they would because on paper, why should I have any problems? I've really not got any life problems. So I wouldn't want to also make them feel like I'm throwing everything back in their face that they've given me.
>
> *(Florence, female, 21 years)*

> I didn't really speak to my family about it because they wouldn't have believed me either. They don't have the best attitude towards mental health … So my family isn't very understanding, obviously, not every working class family is the same, but they have the kind of mentality where you just get on with it, my family, so they didn't really understand why I was struggling. And they still don't understand why I struggled so much.
>
> *(Martha, female, 23 years)*

Where the participants had struggled in seeking support, in some cases friends had filled that gap, offering validation and a safe space for sharing experiences and fostering understanding. Friends offered a sense of community and acceptance where others could not or would not offer support, demonstrating the importance of connection and belonging.

> I talked to my friends about it, and they knew what I was going through. And obviously some of my friends were going through similar things too. And I did meet up with My friends sometimes even though you weren't supposed to, because I needed to, really. So I had a couple friends around quite a lot.
>
> *(Martha, female, 23 years)*

This narrative underscores the critical role that validation plays in the mental well-being of young people. When individuals feel unheard and their experiences dismissed, it creates a climate of isolation that can exacerbate their struggles. Compared to years ago, open communication about mental well-being is encouraged with a sense that there is more acceptance for those who experience their own struggles, however this was not always reflected in the experiences of the participants in this research. More problematic is that when young people do seek support from those that advertise offering it, the response can sometimes be unsympathetic, invalidating emotional experiences and disempowering people from seeking help in the future.

5.2.4 Developing self-awareness and reframing mental health

The weight of the COVID-19 pandemic undeniably took a toll on mental health. However, the discussions with participants highlighted an unexpected benefit, a surge in self-awareness and a newfound appreciation for mental health among young people.

The pandemic appeared to serve as a catalyst for introspection, where personal resilience and new future directions were realised. Teenage years and young adulthood are often referred to as periods of self-discovery, this was certainly true for this cohort where the participants began to recognise emotional cues they may have previously ignored. This was highlighted by several individuals making statements such as 'become more in tune with the fact that I wasn't okay' (Lily) and 'I wasn't the best but I didn't realise that at the time' (Lily) capturing this newfound awareness. This introspection led to a deeper understanding of personal mental health thresholds, as indicated by Zayan: -

> I think it's helped me to identify where the threshold sort of is for seeking help, because I think that where I was at that point, where I was really, really low, and I did speak to a GP, I think, I think that was the right time and the right threshold. I think, anywhere before that, I

> don't think there would have been much to gain from speaking to, speaking to a professional. So yeah, I think it's helped me identify the threshold for reaching out.
>
> *(Zayan, male, 22 years)*

The pandemic not only fostered self-awareness but also a willingness to seek help. As previously discussed, this was not the case for all young people but for some it was a breakthrough, and a pragmatic approach to seeking help replaced the stigma of appearing 'weak'. Returning to the interview with Zayan, there was recognition that 'it's okay to ask for help' and a growing acceptance of seeking professional support.

> It was a bit of a roller coaster of emotions for me. And I think that's helped me develop my sort of emotional maturity. And understanding that a) it's okay to feel low sometimes but b) also that it's okay to ask for help and c) that a lot of people, that there will be other people in a similar situation, and I'm never the only one feeling like that.
>
> *(Zayan, male, 22 years)*

The newfound knowledge about mental health appeared to extend beyond personal well-being. Sophia discussed considering her own mental health in a wider context, for example when considering applying for jobs.

> It has made me ask a lot more questions when applying for jobs and just a little bit more conscious of like, health related risks.
>
> *(Sophia, female, 24 years)*

In addition to fostering increased self-awareness, a further positive aspect that the participants appeared to embrace was an appreciation for self-care practices. Traditional coping mechanisms and strategies such as 'just get my head down, and just not acknowledge it' (Lucas) and 'brushing it under the rug' were challenged and recognised as ineffective at a time of isolation and disruption. These seem to have been replaced with acknowledgement that they need to be 'more kind' (Zoe) and 'more compassionate' (Natalie) with themselves, to have proactive approaches and for some, to take more control in understanding, managing and improving their own mental health.

> One positive thing from the lockdown and COVID is that it's made me a lot more aware of my mental health and how much, not even like just lockdown, but even before lockdown, my mental health wasn't the best but I didn't realise that at the time and then through lockdown I started become more in tune with the fact that I wasn't okay. And I was able to pinpoint why I wasn't okay and try and figure out ways or research ways into basically getting to be okay. And trying to heal my mental health. So I think now in my new normal is just, always being a bit more aware of how am I actually doing and a lot more educated about, you know, the mental health aspect of everything really.
>
> *(Lily, female, 22 years)*

> No, I think it's changed COVID has had an impact, but I think its permanent. It's changed the way that I view myself. It's brought to light the reasons why I was feeling the way that I have and in some ways, it's been a positive thing because now I fully understand, but I don't think I will ever get back to this sense of normalcy.
>
> *(Amelia, female, 18 years)*

> In terms of before the pandemic, I would have said that I never would have once thought about the fact that I feel kind of wrong at all times, but not really sure why. I think before the pandemic, I just kind of always assumed it's just a self-confidence thing, it will come with time or whatever. And now, post pandemic it's actually a case of 'no, I do understand that'. I know 100%, I would not be where I am right now, I probably wouldn't be acknowledging a lot of the things that are potential issues, for example, pre COVID I was never really a confident person but I definitely have more confidence than I do in the current day … And in some ways, it's been healthier to have gone through it in terms of acknowledging things that you do need to work on your own mental health, and you do need to look after yourself and find the methods that work for you in a healthy manner that don't affect other people negatively and things like that. And I don't think I would have developed that if I hadn't gone through COVID.
>
> *(Lucas, male, 23 years)*

The COVID-19 pandemic's impact on young people's mental health appears to be a double-edged sword. While challenges certainly arose, there's also a silver lining. The crisis served as a wake-up call, leading to a heightened awareness of mental health and a willingness to prioritise self-care. This newfound knowledge and proactive approach have the potential to shape a future where mental health is valued and nurtured by young people.

5.3 Living with uncertainty and its impact on mental health

There was a recurrent narrative of uncertainty and loss of control caused by the ever-shifting landscape of the pandemic. To some, it seemed like the restrictions imposed put them in a perpetual state of limbo, without a clear understanding of how long the pandemic or associated restrictions would last, or what the future held. This left them feeling anxious and concerned for their well-being as well as that of their loved ones. For Lily and Alex, this ongoing state of anxiety was so bad that they felt it reversed their progress towards recovery from their pre-existing mental health condition (anorexia). Others spoke about the interference with sleep patterns and increased emotions of vulnerability.

> When lockdown first started I was quite far in my recovery and I was able to maintain that for the first month or two I think, but as restrictions just kept getting extended and the situation was becoming more and more unknown or it was becoming worse, it wasn't becoming better put it that way, I think that affected my progress. So, I started taking steps back instead of steps forward, so, I would say it was fine and then it gradually started to deteriorate.
>
> *(Lily, female, 22 years)*

> I was worrying quite a lot about how my friends were doing. Like, even though I would never see them. And like my parents were both key workers so I was worried about them quite a lot, like my dad's a [key worker] so I was worried about him, like going out into the world and kind of getting hurt and stuff. But yeah, I think it did kind of make a lot of my worries a bit worse, because I didn't really have any way of knowing if things were all right or not. I think it's probably influenced the way that I worry about things even still now. I think, just sort of, like things that I don't really know the outcome to. Like that still kind of messes with my head a bit and I just, I don't know how to put this into words, but I think it affects me more if I kind

> of know that I'm not going to know the outcome of a worry. Like lockdown was so uncertain the whole time and I think it was more of the uncertainty of what was going to kind of happen in the next stage that stressed me out the most.
>
> *(Oliver, male, 16 years)*

> I would say my anxiety sort of around the clinical environment definitely existed before COVID, but I would say COVID exacerbated things because I think there was such a long period where I didn't see other people. When placement did start, it felt very full on. I definitely felt that COVID and the pandemic, and not seeing people for such a long time definitely exacerbated things and made things worse. So yeah, so those first, in fact, I would say for about six months after the first placement, I really, really didn't enjoy. I felt very anxious about going in, I would try to go in as little as I could.
>
> *(Zayan, male, 22 years)*

The loss of established routines and social connections was also problematic for many. Social activities play a crucial role in shaping identity, providing validation and strengthening self-esteem; thus it was unsurprising to hear from the participants how the replacement of these with forced isolation led to their mental health being affected. One example of this was motivation, in the face of such uncertainty, they spoke about how they lacked motivation daily and that they found it hard to put effort into things whose results were unclear or insignificant. This was particularly highlighted in the interviews with three participants (Sophia, Elena and James) who appeared to question their identity and purpose because of their struggles to adjust from an active life to confinement.

> Definitely yeah, like I find it really hard to kind of stay motivated. There's just it's really hard to kind of keep going with things when you don't know whether they're going to count for anything. What you're going to do, when everything is really uncertain.
>
> *(Sophia, female, 24 years)*

> I almost just felt like we were in permanent holiday mode. But I think there were other times when it was like, you couldn't see the end. It kept going and kept going. There was [these] constant daily news briefings that we all sat in front of the telly to watch. It was just like, nothing's changing. what possibly could be the way out of this? Which I think does make you struggle a bit mentally, because it's just like, when you're told those things that I feel make me who I am, when can I start doing those again?
>
> *(James, male, 23 years)*

> Every single day I got increasingly worried like 'what if I can't do this, like what if I just can't stay inside?' Like, I, there's nothing I'm doing, … I'm not doing anything, there's no activity that I'm doing. I was really, like, genuinely worried about the transition from like, a really busy and active life to just being inside.
>
> *(Elena, female, 23 years)*

For one young female, the absence of religious and community support further exacerbated feelings of unease, highlighting the importance of such structures in providing solace and stability.

I don't know in those moments you just kind of like you're like oh my gosh, like I don't know what's happening. It's kind of like unknown and I think for me, like, when I go to the mosque, it makes me feel like at peace in a way. So not having that kind of made me feel like, I don't what's happening, so yes it was quite hard.

(Soraya, female, 19 years)

From the initial lockdown in March 2020, there were announcements, measures and/ or further lockdown restrictions broadcast monthly for nearly two years (Institute for Government., 2022). Alongside the uncertainty, the constant need to adapt to new ways of living due to the evolving pandemic presented further challenges and frustration with the complexities of reintegration into a post-pandemic world particularly highlighted. While societal narratives might suggest a universal desire to return to pre-pandemic normalcy, and that it should be easy, the reality for many young people appears to be far more nuanced. This was highlighted particularly well by Lucas who felt that older people tend to have more established lives than younger people who are still exploring who they are and what they want to do. The shift to online communication and social isolation during lockdowns fundamentally altered the way they interacted with the world. Re-establishing in-person connections and navigating social situations after a period of isolation was a source of unexpected anxiety for numerous individuals, which continues for some still today.

My social anxiety got much worse. [continues to say] Actually, I don't think I had social anxiety before but after the pandemic, I'm so like, my social anxiety is really strange. I had never experienced this before. But it's still happening. Like literally, like, in regular situations, like the workplace or with friends and stuff. And I'm pretty sure it developed like, right after the pandemic so it was kind of like, the heightened awareness to social situations, like, 'am I behaving properly here?' Or 'am I interpreting signals correctly?' and stuff like that.

(Elena, female, 23 years)

I think, overall, it's definitely got a lot better, especially as just other things have changed in my life. Like, I'm not in lower school anymore, which I found very difficult. But I'd say the one thing that is definitely stayed since locked down is just, I am much more anxious than I was before about being with a lot of people. And that's just, especially in school. I'd say that's the thing that sort of I didn't have before. And then since lockdown that stayed.

(Emily, female, 17 years)

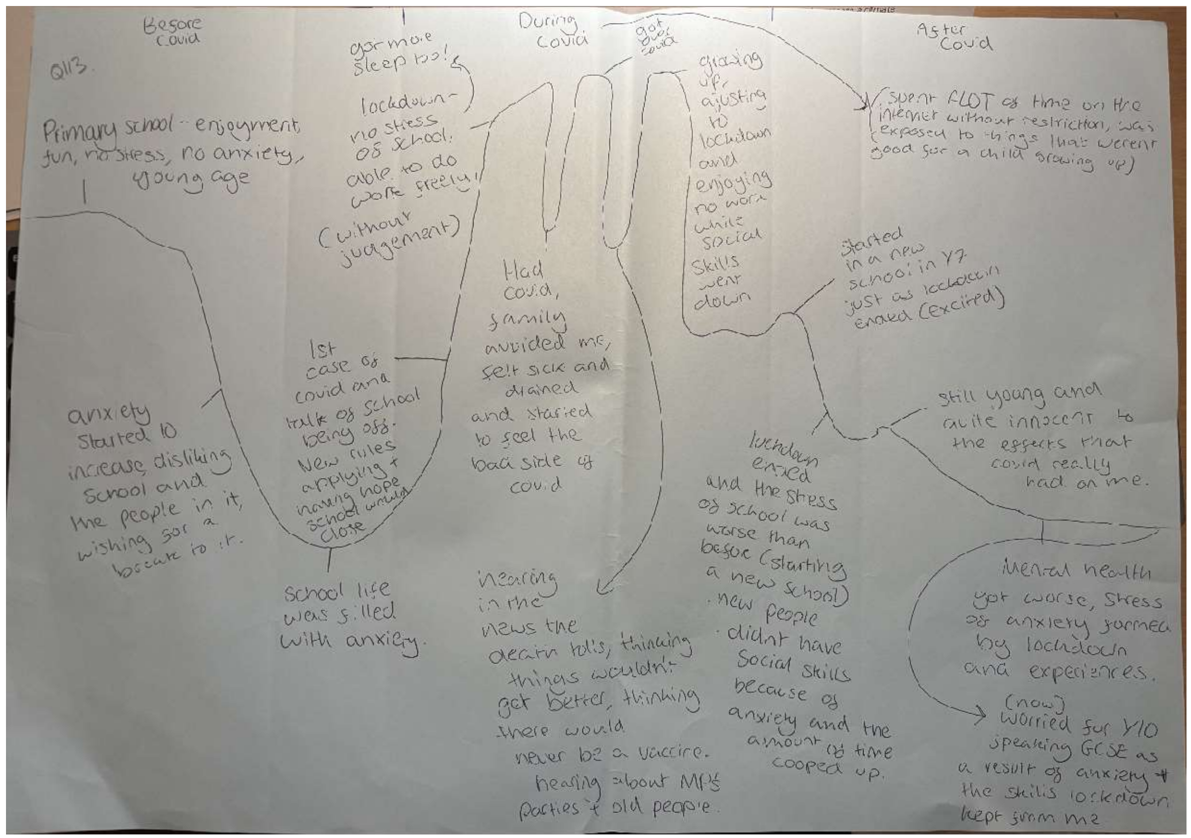
I feel like some people have an understanding that 'ah well after so many years in isolation, wouldn't you want to get back out there and go and, you know, go and socialise, date more and do XYZ'. But for some people, their entire way of socialising had to change pretty much overnight. And that's not something that you can just fix after a year, like having a sudden shift to a whole other lifestyle, and having to then adapt back. There are people who are of a different age range, who are older, that might criticise and might say, you know, well, I've been able to get back into it fine, like I've done this and that and it's like, it makes sense. But at the same point in time, if you've lived a certain amount of your life, you've already gotten used to certain things and created your own systems and your own routines and stuff. And when it gets switched up, it definitely affects you. But because you've been so used to these routines and situations for so long already, then being asked to go back into that, you're probably a bit more used to it. Whereas people who are my age during the pandemic, you know, they might start going to university or they might start looking for full time

> employment and they might start moving out of the parents' house or go into a whole other city. And, you know, that's a whole new thing, going from school to, you know, full time employment or higher education. That's a switch up of your life. That's a very big change to make. And then to suddenly make this change and then overnight be told, Oh, doesn't matter what you picked, you're now doing this. And not having that routine in place for years already, that would 100% mess with anyone, that makes sense why people my age were very affected by it.
>
> *(Lucas, male, 23 years)*

The toll of constant change was highlighted by Emily and Grace, who described their struggles at having to return to school after adapting to staying at home.

> I think generally, when at first, when we went into lockdown, I'd find that difficult. But then the more I was staying at home, I'd sort of relaxed, and then when I came out of lockdown again, it would sort of go back up and get worse. So it tends to be whenever it's changed, it got not as easy for me. [she continues] I had many a breakdown with my mum at home. And for sometimes at school as well, I just get myself really worked up and upset about it. I think that's probably what I found the hardest was having to come back out of the lockdowns and go back to school, after I'd sort of just got used to staying at home all the time.
>
> *(Emily, female, 17 years)*

Grace's timeline begins with a positive portrayal of her early years, describing primary school as "fun," with "no stress" and "no anxiety." However, even before the first COVID-19 lockdown, Grace began experiencing increasing anxiety and a growing dislike for school, culminating in what she identifies as the lowest point in her mental health. Unlike many other participants, Grace initially welcomed the lockdowns, as they meant she no longer had to attend school, something she found deeply stressful. Instead, her anxiety during this period stemmed from watching the news and worrying about others, particularly the health of family members. In the post-COVID period, Grace reports a further decline in her mental health, especially after transitioning to secondary school. Although initially excited, she describes the stress as worse than before. Towards the end of her timeline, Grace reflects that her ongoing struggles with anxiety, stress, and reduced social confidence stem largely from the experience of lockdown and feeling "cooped up."



(Grace, female, 16 years)

The constant change, fear of the unknown, and disrupted routines all conspired to create a climate of anxiety and erode mental health in young people. The fact that the participants spoke about experiencing anxiety today, post-COVID-19 that previously was not an issue, highlights uncertainty wasn't just a temporary stressor and has had some lasting impact on mental health.

5.4 Experiencing disruption to life transitions and a sense of lost time

The concept of 'lost years' is not merely about time passing without incident; it is about crucial developmental milestones being deferred or skipped entirely. For young people, this period was supposed to be a time for exploring independence, building careers, and forming lasting relationships. However, several participants spoke about how their lives, and this exploration was 'completely stopped', leaving them in a unique position where they were ready to 'build their own lives', only to find everything brought to an abrupt halt.

> I feel like mine was bad, like in that specific age because it was at the end of high school and at the beginning of uni, like those two years. So at the end of high school, it was kind of bad because it was the last year, I was gonna see my friends and we were really close and like one day they just told us tomorrow, we close everything. And we thought it would be just for a week, but it was for the whole year. So that was kind of bad and also for university, I feel like if it wasn't for COVID, I would have been a little better at studying and things like that.
>
> *(Imogen, female, 21 years)*

> I don't think it was as difficult as it is for people in my age group, because I think we're in a position where we're starting to explore our independence. And that was just sort of completely stopped. I think we're in a unique position where we're starting to build our own lives, and build friendships. And obviously, everything came to a stop very quickly. And I think that was quite difficult to deal with.
>
> *(Zayan, male, 22 years)*

The psychological toll of this interruption cannot be overstated; it represents a significant disruption in the natural progression from adolescence to adulthood. Moving away from family and friends for employment or further education is a huge independent step, and forming your own relationships and networks is crucial to integrating in the new setting. However, this was difficult due to the restrictions. Two individuals discussed this in detail; Imogen spoke about how her mum, based in another country, tried to help link her with another student, and Florence explained how the restrictions and associated anxiety about being 'caught' affected her ability to make new friends, having lasting consequences.

> For me, it's hard to make friends, to meet people. So the people I met, like my mom sent me a phone number of someone else's daughter that was here, but I was like, I'm not gonna text her. There's no way I'm doing that, but, I was like so bored at home, I didn't want to stay home, so I texted her and I went out.
>
> *(Imogen, female, 21 years)*

> We're having a Mexican night like, really pumped people I would get on with like outside, if I'd had met them, and I was really excited but like the whole time I was so stressed that like, someone was going to have caught me on CCTV [she continues] So I stopped getting invited to stuff because I would just turn it down because I was too anxious. So I think people started to think maybe I was a bit weird or didn't like going out, which isn't true. Like, in another life, I'd have been at every single one, I didn't like make good friends with them. I almost lost some friends before I could make friends with them. I still see them now, we always say hi, but I wonder if I would have been part of that friendship group now or whether I'd have more friends at uni now if I had just taken the risk.
>
> *(Florence, female, 21 years)*

The feeling of lost time is further amplified by a sense of comparison with other age groups. Whilst the participants recognised that COVID-19 and the associated restrictions were difficult for everyone, there was concordance that those younger and older were not at the same crucial juncture in their personal development. Although most children and young people had their academic learning moved online, the participants aged 15 years upwards had exams and associated preparation which added an additional layer of pressure and stress.

> My year wasn't the ones doing exams during that time, but we were sort of doing all the leading up to and preparing for them. So compared to other people who are actually quite similar in age, I still think it was harder because we were sort of, well, we've got to do all this stuff for exams, but we can't actually be in school. And then I also think with like more older people, I feel like I missed out on sort of the time period where I would've started doing things more, like going to concerts and things like that. Like, it gave me, I think, a lot of anxiety. Like I've only just now been able to go to the cinema with my friends and things cos I think I've missed the time where I would've started doing more big things by myself. And

> then cos I didn't do that, I felt, I was conflicted cos I think, I felt like I was far behind everybody else and I was like, oh, I should have done these things by now. But then I was also really anxious to do them cause I'd spent so much time not doing anything and being at home with my mum all the time.
>
> *(Charlotte, female, 17 years)*

> I mean within me and my family, but I think probably within others, my generation as well, that actually we kept sitting there listening to the news, daily News briefings. We talked about the schools and what they're doing. They talked about all these things that they're putting in for the elderly. What, where was any mention of universities, and higher education. None. [continues] But I think really, for me, it was just at least acknowledge us, now a generation the things that we're missing out on. like yes, the young people, children, young people are losing out on a lot, but actually, so is everybody else.
>
> *(James, male, 23 years)*

Socially, the young people described how they felt they missed out on their 'formative years' or 'best years of their lives'. For the younger aged individuals, this was being able to go to the cinema, concerts and other such places, starting their journey into independence. For the older aged individuals reaching young adulthood, as well as impacting their immediate social lives, it was the wider impact beyond personal development. Work experience, networking, moving away from the family home would all be typical of this age group, but these experiences were out of reach for most. Consequently, the participants felt a lack of instability, contributing to the uncertainty. The precarious nature of youth employment following the closure of their workplace was highlighted by Ben and Will, and Lucas observed that for many of his generation, it was supposed to be the start of their professional life, a launchpad into independence and financial stability.

> Well people who are younger than me, they would have been stuck with the online learning longer than I was personally. Older than me, they probably had more stable jobs before lockdown that weren't just cash in hand and the first come first serve for who gets the shifts and they were at risk of being furloughed and stuff, and you still get paid. I wasn't still getting paid because it said in my contract that I was self-employed because they did that to get away with paying us less.
>
> *(Will, Demiboy, 21 years)*

> There's never a point in time where I think 'God, can we just be over this already!' It's very much a case of 'no', this is something that for people our age, I'm going to be going into my mid-20s and it's very much a case of, you know, this is for some people my age, it's the start of their professional life. And for other people, it's gonna be a case of, they're not going to start their professional life for another few years, because they've just not been able to get into that mind-set. And I think there's a definite danger in some articles and news stories where they'll say millennials aren't doing XYZ, for example, like millennials aren't having enough kids to support the workforce in the future and things like that. And honestly, with how COVID affected people my age it's really not that surprising to me. Like, I feel like some people have an understanding that 'ah well after so many years in isolation, wouldn't you want to get back out there and go and, you know, go and socialise, date more and do XYZ'. But for some people, their entire way of socialising had to change pretty much overnight. And that's not something that you can just fix after a year, like having a sudden shift to a whole other

> lifestyle, and having to then adapt back. There are people who are of a different age range, who are older, that might criticise and might say, you know, well, I've been able to get back into it fine, like I've done this and that and it's like, it makes sense. But at the same point in time, if you've lived a certain amount of your life, you've already gotten used to certain things and created your own systems and your own routines and stuff. And when it gets switched up, it definitely affects you. But because you've been so used to these routines and situations for so long already, then being asked to go back into that, you're probably a bit more used to it. Whereas people who are my age during the pandemic, you know, they might start going to university or they might start looking for full time employment and they might start moving out of the parents' house or go into a whole other city. And, you know, that's a whole new thing, going from school to, you know, full time employment or higher education. That's a switch up of your life. That's a very big change to make. And then to suddenly make this change and then overnight be told, oh, doesn't matter what you picked, you're now doing this. And not having that routine in place for years already, that would 100% mess with anyone, that makes sense why people my age were very affected by it.
>
> *(Lucas, male, 23 years)*

Another dimension of this struggle was the anxiety stemming from all of these missed social experiences and opportunities. For young people, such simple activities like attending concerts (Charlotte) are not trivial, they are rites of passage that signify growing autonomy. The absence of which appeared to have left many feeling 'far behind everybody else', exacerbating feelings of anxiety and inadequacy.

> I feel like I was completely robbed, [continues] because obviously thats a big change in your life, it was supposed to be the best years of my life that I think I've been robbed and I was really sad. Also, I feel like, it is the age if you do start to get mental illness it does start kicking in like, you know. As well before COVID, I was actually questioning, I wonder if I've actually got anxiety. I've never actually seeked a diagnosis But I do, I did always wonder and obviously that actually during COVID, I was like Jesus, I've definitely got it.
>
> *(Florence, female, 21 years)*

Similarly, James lamented over lost formative experiences in societies and committee positions, opportunities that are not just about building a CV but are integral to shaping one's identity and social skills. In one case (Lily), it led to a sense of being stuck in a pre-pandemic state, feeling unprepared for the next life stage, highlighted in her reflection that at 22, she still felt 18 years old.

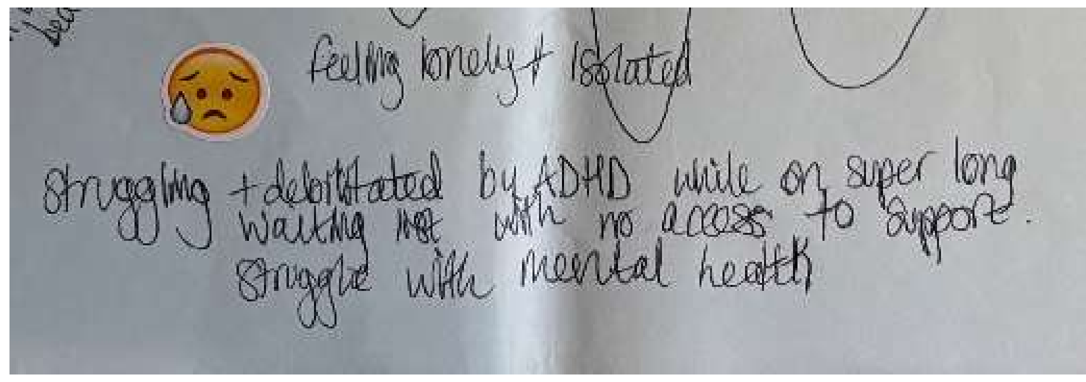
> I think there was a larger extent, to within my generation, there was a lot of things that we all went through together, we lost all those formative years in societies and committee positions and everything else that is so important in that life stage.
>
> *(James, male, 23 years)*

> I think it was different in the fact, in the sense of, so many people would always tell me their university years or the years that you are at university at that age, is where you start figuring yourself out. And it just felt like all of that was halted. So, even though I'm 22 Now, I still feel like I'm 18 because those years that I had were lost during lockdown. so I'm not sure whether people who are of an older age or a younger age really felt that.
>
> *(Lily, female, 22 years)*

Participants’ descriptions of lost milestones and disrupted transitions echo what has been described as a “pandemic skip”, where expected stages of adolescence appeared to be bypassed due to pandemic restrictions (Schneider, 2023). From a SIT perspective, these missed experiences may also represent interruptions to the shared social environments through which young people typically develop and affirm social identities, including peer groups, educational cohorts and key transitional events. When these collective experiences were removed or delayed, opportunities for young people to negotiate their developing identities within these social contexts were also disrupted (Jenkins, 2014; Tajfel & Turner, 1979). For many participants, this disruption appeared to extend beyond the immediate circumstances of the pandemic, contributing to feelings of lost time, social isolation, and anxieties about falling behind during a critical period of transition.

5.5 Experiences of accessing and engaging with mental health support

The experiences of participants that accessed, or attempted to access, some form of mental health support during COVID-19 painted a vivid picture of the complexities and inadequacies of the mental health support system. Already struggling prior to the COVID-19 pandemic, it was unsurprising to hear about long waiting lists and the continued impact on individuals’ mental health, highlighted by Natalie.



(Natalie, female, 24 years)

However, it was an unanticipated finding that when support had been accessed, it had not necessarily been that helpful. The lack of a ‘one size fits all’ approach and the struggle to find genuine connection with mental health professionals were highlighted resulting in an exacerbation of feelings of isolation and disconnection.

Six individuals aged across the full spectrum of the age range in this research discussed this. Emily described her concerns that she would be viewed as ‘being silly’ for seeking support have already been referred to previously (section: Experiences of dismissal and the need for validation). The basis for this is likely to be linked to the lack of support from Emily’s head of school year where she felt her feelings were dismissed as jealously, invalidating her emotional state.

> Not really, because he [head of school year], he was a bit unsympathetic. And he, he like, used to sort of say to me, I was kind of making it up how I was feeling so because I was jealous that my like, sister was getting a lot of attention and support, which, obviously I wasn't, and wasn't very nice to hear. So I wouldn't say they were very helpful really.
>
> *(Emily, female, 17 years)*

In fact, Emily was so affected by the lack of support she felt she received at school, a place she considered students should 'get looked after', that she returned to the subject at the end of her interview when asked if she had any further comments.

> I think we've probably mostly covered it all. But I'd say the main thing, I don't know if this has anything to do with your research, but the main thing that probably affected me the most, was sort of, I did feel like there was a real lack of support, especially for sort of people who are my age who were in school, and you would expect that that would be a place where you could more easily, you know, get looked after, I think I definitely felt let down by my school. And it really influenced my decision about where I was going to go after I finished school and things like that.
>
> *(Emily, female, 17 years)*

Similarly, Martha lived alone in student accommodation during all the COVID-19 pandemic, and told of her struggles to get out of bed most days and inability to undertake her university work, a result of her emotional state at the time. Going through the appropriate channels, Martha struggled to get her depression officially diagnosed and consequently, when she informed her department they were not very helpful. The lack of official diagnosis and necessary documentation to evidence this to her department highlighted the bureaucratic obstacles Martha experienced, undermining both her feelings and delaying much-needed support.

> Yeah, essentially. And they wouldn't really give me any help, this is my department in particular, they wouldn't really give me any help with anything until I'd got that document. So until I had that, they just thought that it was all fake, essentially. And, obviously, it wasn't easy to get to get that. And I think anyone who knew me personally, could easily say, yeah, she she's depressed. Yeah, it's quite frustrating, [continues] I don't know why it would take that long. But just the first time I asked them, it was so difficult to get it. So I gave up after a while. And then this year, I didn't actually need it that much. I just wanted to speak to someone. Just like talking therapy, not medication or anything. So they gave me a diagnosis to send to DDSS for seasonal affective disorder. All that time ago, I needed that. And I get it when I didn't want it. So yeah. Great.
>
> *(Martha, female, 23 years)*

Following a severe mental crisis, Charlotte was within the support system and so did not experience bureaucratic obstacles in accessing support. However, she did appear to experience pitfalls of misaligned support on her journey through various mental health services. Being referred to family work when it was not the root issue resulted in Charlotte having additional stress rather than relief.

> And so I was working with them and then they, during COVID they offered to go online, but I was like, I don't, because I never really got on with him anyway, it was a bit awkward, so I didn't want to do it. So I stopped doing that. And then when I went to the hospital, I saw, um,

> a doctor and then the STAR team [Supportive Treatment and Recovery service], and then. After that they ref, they couldn't refer me to CAMHS because of the, uh, waiting list. So they referred me to MAST [Multi Agency Support Team] instead, which is more like, I think family work cos I had mentioned, uh, like my dad. And then that was, it wasn't right for me. So I ended up having like more problems because all anyone wanted to talk about was my family, and I was like, that's not the problem that I'm having. So it was quite. I did get to speak to people, but it wasn't really the right people.
>
> *(Charlotte, female, 17 years)*

Charlotte continued to describe her frustration at the perceived gap in mental health services particularly for young people aged between 16 and 18 years old, something that has been widely acknowledged and referred to as the 'transition gap' (Hendrickx et al., 2020).

> I don't know how to explain it other than like the support should just be there and it isn't, like when I needed it. I would literally be, I remember like, I would be crying at my phone, just scrolling through aimlessly all this stuff and there was just nothing. And I think especially in the 16 to 18 like gap, like lots of children's services won't have me because I'm over 16 and this is what's happened with my ADHD diagnosis. We might have to go private because of this. If I go on the children's waiting list. I'll be 18 by the time they get round to me. But I can't go on the adults waiting list until I'm 18. And I have the same experience with mental health things as that. They won't have you cos you're not under 16, but then the adult services won't have you because you're not over 18, so I think it's just, there's just a big gap.
>
> *(Charlotte, female, 17 years)*

The COVID-19 pandemic's shift to online therapy presented its own set of challenges. Several individuals talked about their experience of remote mental health support; the start of online Zoom meetings for his mental health support group (STAMP) was a positive turning point for Ben as indicated in his timeline (5.1.1.1 Amplified challenges), however others cited awkwardness, a lack of privacy, and difficulty gauging emotional cues with this method (Oliver and Lily).

The importance of connection with those offering mental health support was highlighted by numerous participants. If it was felt there was a connection, the support was viewed as beneficial, but a lack of connection and young people appeared to withdraw, irrespective of how the support was delivered.

> I was very anxious and I was still feeling quite low mood and things, but now I feel like I did the last few months cause I did have counselling that where … I had it a few times, but I actually felt like I made a good connection with the person and I was like actually getting something out of it.
>
> *(Charlotte, female, 17 years)*

However, remote methods such as those delivered over the phone made establishing a connection even more difficult and had additional inadequacies. Based in an office at school, Oliver described his discomfort with phone support due to privacy concerns and technical issues.

> Yeah, I think because it was over the phone. I think that was probably one of the biggest reasons that I just didn't click with it. Because yeah, I felt quite awkward, kind of, like sitting in a, like they got me like a little room with their phone in. And, like staff would keep walking past and stuff. And it just felt a bit like, too forced, I think. Yeah. And like, it wasn't

> the best, it didn't have the best microphone on the phone as well. So the lady would keep like, say ‘I'm sorry, I didn't quite catch that one’.
>
> *(Oliver, male, 16 years)*

The combination of inappropriate environment, impersonal nature of over-the-phone counselling and technical difficulties did not provide a supportive setting that encouraged open communication, in fact it led to Oliver disengaging from mental health support altogether. This was Oliver’s first contact with mental health support and so he had no previous experience or knowledge of what to expect. This was the opposite for Lily, who had received regular face to face mental health support related to her eating disorder prior to the pandemic, which then moved to taking place by phone. Lily’s account further supported the inadequacy of remote support methods where she felt the inability for non-verbal cues to be read made it too easy to conceal one’s true feelings, contributing to a lack of connection and understanding of the underlying issues.

> I think it was definitely that that type of support and treatment I was receiving, I think as soon as it goes to none face to face it's kind of useless, for example, it's so easy to lie about your well-being over the phone as they can't read your face, they can't read your expression or your body language So I found on so many occasions I was being asked how things were and I was just answering like 'Yes, everything's fine', whereas I knew deep down that everything wasn't fine.
>
> *(Lily, female, 22 years)*

The existing mental health support system does not appear to meet the diverse needs for young people, who have or want their own agency, recognising what they need and when they need it. The lack of a ‘one size fits all’ approach, coupled with the limitations of remote support and bureaucratic hurdles, created a significant barrier to accessing effective support and care during the COVID-19 pandemic. Most of the participants in this research who had accessed support expressed a desire for genuine human connection and support tailored to their individual situations that is empathetic, accessible, and flexible.

5.6 Intersectionality and mental health

At the outset of the interviews and focus group, the participants were introduced to the concept of intersectionality in the context of the research. A brief explanation was provided, highlighting that the research aimed to explore their mental well-being experiences during the COVID-19 pandemic while also considering how aspects of their identity may have influenced these experiences. To clarify this multifaceted concept, I described the notion that individuals belong to multiple social categories or groups (Abrams et al., 2020), offering my own identities as an example: "female, white, British, mother, wife, academic, student, netballer." I further explained that these intersecting identities can confer both privilege and disadvantage, and the purpose of the research was to understand how young people perceived their own identities as shaping their mental well-being.

As the initial interviews progressed, it became apparent that the participants found the concept challenging to grasp. To help understanding, additional examples were introduced through narratives about 'friends' (personas) (Thomas et al., 2021), each experiencing the pandemic under different circumstances that potentially impacted their mental well-being. For instance, one example described a female friend with a higher socio-economic status who was employed and able to work from home, living in a house with a garden and private bedrooms, resulting in a relatively positive mental well-being experience. Conversely, another example illustrated a male friend working in a supermarket, requiring regular travel and contact with others outside the home while living with his family, which contributed to poorer mental health outcomes.

When asked to reflect on their individual identities and the extent to which these identities shaped their mental health experiences, most participants did not perceive a direct connection. Rather, their reflections were often expressed indirectly, becoming apparent when they compared their circumstances to those of others. For example, Martha recounted the experiences of a close friend who faced unique challenges at the intersection of ethnicity, sexuality, and cultural expectations.

> One of my best friends, he's Zambian. He emigrated to the UK quite a while ago. But his parents don't believe in, like, mental health issues. And he said that a lot of people in his community also feel the same. So it's difficult to talk about those things. He's also gay. So that's another thing he can't talk about.
>
> *(Martha, female, 23 years)*

Similarly, Florence and Amelia reflected on how the intersection of ethnicity, socio-economic status, and employment conditions shaped people’s experiences during the pandemic, recognising that individuals from minority ethnic backgrounds likely faced greater difficulties. Florence acknowledged her relative privilege as a middle-class white individual, identifying socio-economic differences as a key factor.

> Yeah, I feel like people who weren't or who are not white, who are minority ethnic, had a worse experience. Because I feel like there are socio-economic disparities associated with Black and minority ethnic groups, and I think those disparities were highlighted during COVID. They're the ones that work zero-hour contracts, people-facing jobs, shop workers, things like that. And obviously that's not necessarily all Asian minority ethnic and Black people. But I'd say the economic disparity there is a factor, and I think that's why maybe I was obviously lucky as, like, a middle-class white person that I didn't have that experience.
>
> *(Florence, female, 21 years)*

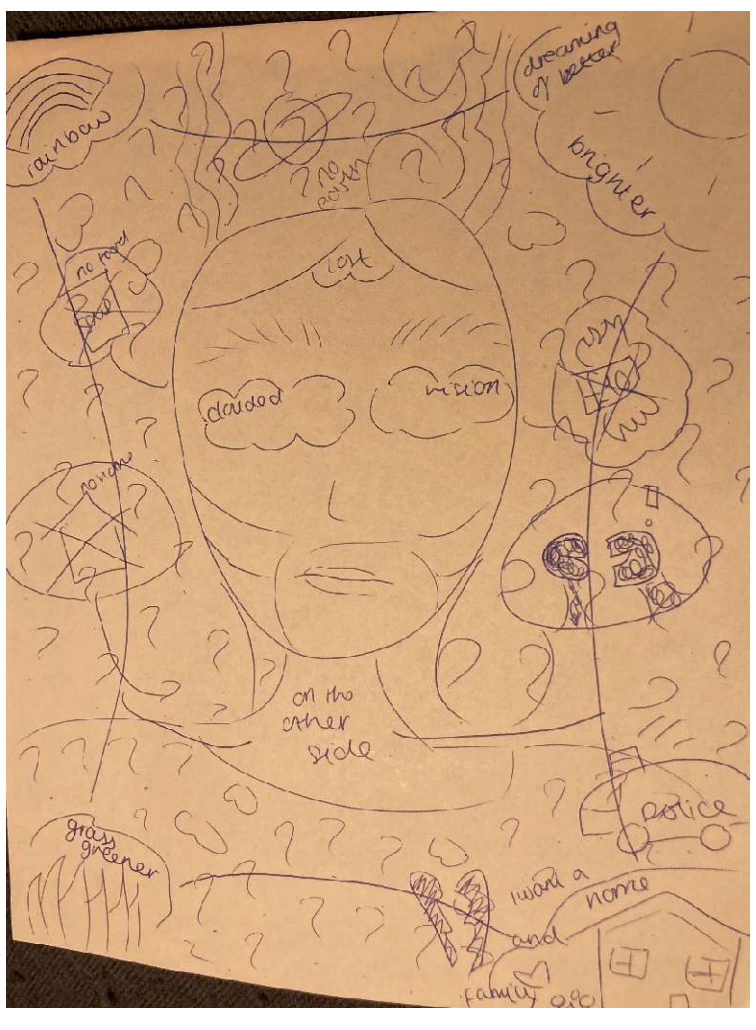
Amelia further elaborated on these systemic inequalities, emphasising the structural factors that contributed to heightened stress and adversity among marginalised groups.

> I think in most situations, it's always people who are white who have a better experience than people who are not white, and I don't think there was any exception for COVID. Because if you think about it, some different cultures have a lot bigger families, so they're used to seeing all their family members. And then suddenly they're just four people in a house, and it's just that extreme difference. A lot of people of colour who have been failed by the education

> system are going to be in jobs that require them to be there. So they're not going to have the liberty to work from home, which would cause a lot more stress for them.
>
> *(Amelia, female, 18 years)*

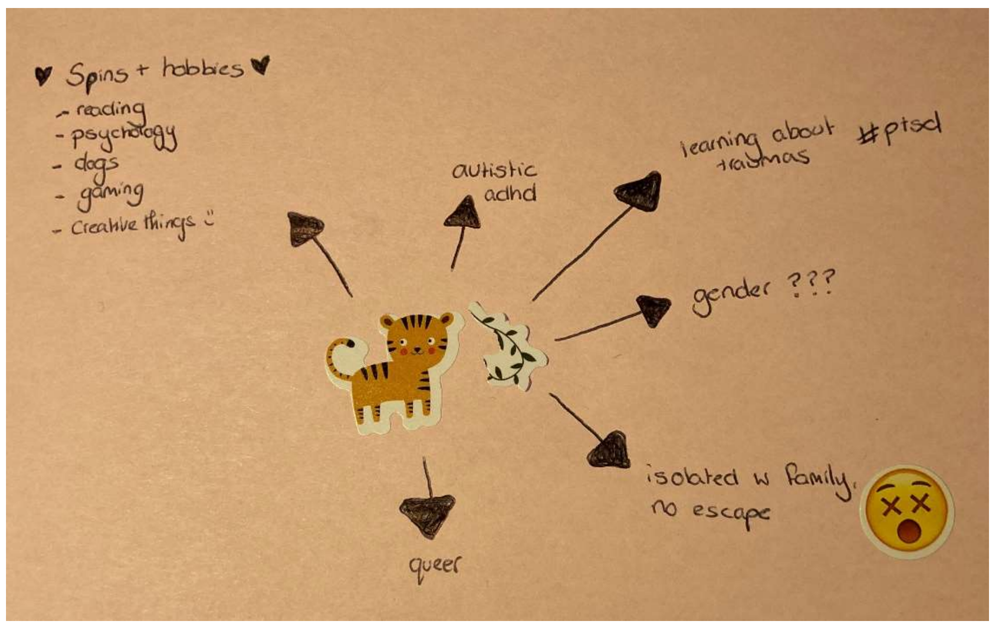
Despite these insights, the participants in the focus group similarly struggled to apply the concept of intersectionality to their own mental health experiences. Their multiple identities were evident in the drawings they produced, particularly those created by Mia, Zoe, Taylor, and Ben. However, when these drawings were used as prompts for discussion, they did not make explicit connections between their identities and their mental health. They seemed to view their identities and mental health as separate parts of their lives, rather than seeing how these aspects could influence each other.

Of the four drawings, Mia's most closely resembled a formal portrait. Central to the image is a large face surrounded by question marks and circles, with annotations including "lost", "vision," and "clouded". The drawing includes references to housing instability ("I want a home and family"), social neglect ("no home", "no food"), and drawings indicating money and two figures in confrontation. In contrast to the darker themes, there is hopeful imagery ("rainbow," "dreaming of better," and "brighter") reflecting a tension between aspiration and adversity. The drawing suggests fractured identity, emotional vulnerability, and longing for safety and belonging, which is tied with the many question marks all around the portrait indicating confusion about herself and her place in the world. Interpreting the drawing alongside Mia's timeline (4.2.5.2. The lifeline of connection) which details an abusive relationship, assault, isolation and homelessness, it becomes evident that her social identities are fragmented and shaped by fear, marginalisation, and unmet needs. It is clear how the trauma Mia has experienced has affected her mental health.



(Mia, female, 18 years)

The drawings by Taylor, Zoe, and Ben are much more abstract, using symbols, metaphors, and fragmented text to express complex and often conflicting aspects of their social identities. Taylor's drawing features arrows pointing from a central animal figure to terms like "gender???", "queer", "autistic ADHD" and "isolated w family, no escape," suggesting they felt/ feel entrapment within both familial and gendered roles. They list "Spins and hobbies" - positive elements including "gaming" and "creative things" but these seem marginal and almost separated from the other elements, hinting at the limited space for affirming identity within constrained environments.

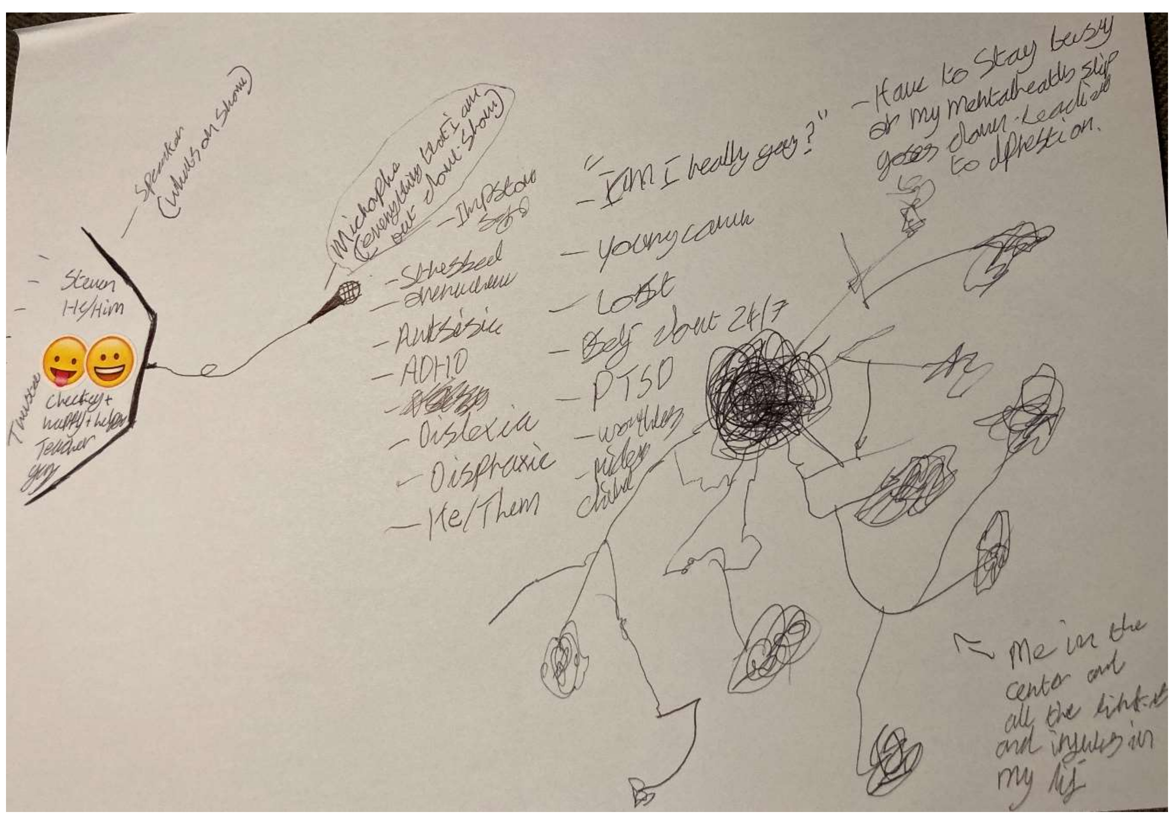


(Taylor, non-binary, 20 years)

Zoe's piece is a circular shape, like a protective shell or boundary with a further boundary inside that is densely scribbled. This inner boundary creates a sense of containment or maybe internal chaos, which contrasts with the words and symbols in the center including "warm," "artistic," "neurospicy," "kind," "musical," "listener," and "chaotic". These indicate her multifaceted identity and express both strengths and struggles. Being warm and kind may speak to emotional intelligence and empathy, being "neurospicy" (a playful term often embraced within neurodivergent communities, (Owsley, 2024)) and "chaotic" may reflect lived experience with conditions like ADHD or autism, where internal or social disorder can coexist with creativity and depth. The drawing hints at how social identities such as neurodivergence, creativity, sensitivity may influence mental health through both empowerment and challenge.

(Zoe, female, 22 years)

Ben's drawing is deeply expressive and raw, using chaotic lines radiating from a dark, central scribble (indicated as Ben) representing the many identities he holds. The surrounding words reflect both external traits and internal states such as "cheeky", "lost" and "worthless" highlighting the contrast between how he presents to the world and how he may feel inside. The presence of a speaker and microphone emphasises this, indicating "what's on show" and "everything that I am", possibly pointing to the effort involved in performing certain aspects of identity and a yearning to be heard and understood. The drawing gives a clear sense of emotional overload, with numerous labels and feelings listed. Expressions of uncertainty such as "am I really gay?" and the note that staying busy is necessary to avoid declining mental health and depression, suggest that identity confusion and pressure may be tightly linked to his emotional wellbeing. The drawing vividly communicates the weight of multiple identities, the expectations they carry, and how these intersect in ways that deeply affect Ben's mental health.



(Ben, male, 21 years)

Collectively, these visual representations deepen the intersectional analysis by illustrating how identities are experienced not as discrete categories but as layered, overlapping, and sometimes conflicting dimensions of self. The drawings communicate the emotional labour involved in navigating gender, sexuality, neurodivergence, creativity, and social expectation. Although participants did not always explicitly frame their experiences through the language of intersectionality, their narratives and visual expressions reveal an acute awareness of how multiple identities interact to shape vulnerability and resilience. Mental health, in this context, is understood as relational and structurally situated rather than solely individual.

5.7 Conclusion

Building on the social and relational disruptions outlined in Chapter 4, this chapter has focused on the emotional and psychological consequences of those changes. While Chapter 4 considered how young people's external worlds were altered, this chapter has explored how those altered conditions were experienced internally, particularly in relation to coping, vulnerability and support.

The findings suggest that the pandemic interacted with existing mental health challenges rather than creating difficulties in isolation. Many participants described prior experiences of anxiety or low mood that had been manageable within structured environments. When routine and social contact were reduced, these coping mechanisms were strained. Feelings of comparison, self-doubt and reluctance to seek support further shaped how distress was experienced and expressed. Experiences of

formal mental health support were mixed. Some young people found services helpful, while others perceived them as impersonal or insufficiently tailored to their needs. In contrast, peer relationships were frequently described as sources of validation and understanding. These accounts reinforce the relational nature of mental health during adolescence and early adulthood, where feeling heard and recognised is central to wellbeing.

The exploration of identity, including through visual representations, added depth to the analysis by illustrating how different aspects of self, including gender, ethnicity, sexuality and neurodivergence, formed part of young people's experiences, even when not explicitly framed in structural terms. Together, Chapters 4 and 5 provide a detailed account of how social disruption and emotional response were closely connected. The following chapter extends this analysis by examining population-level patterns in mental health using data from the UKHLS, to explore how certain variables (sex, ethnic group, household income and urbanicity) may shape these experiences across groups.

CHAPTER 6 QUANTITATIVE ANALYSIS

6.1 Outline of chapter

This chapter displays the results of the quantitative analyses. These increase in complexity starting with a descriptive overview of the cleaned data cohorts, moving onto bi-variate and then multilevel modelling analyses with the aim of providing an understanding of the relationships between the mental health outcomes, SDQ and GHQ-12 scores, and the strata variables. The chapter then concludes with the findings from the MAIHDA analyses.

6.2 Descriptive sample statistics

Demographic and descriptive information of the three cohorts are presented in this section. An overview of the key characteristics is displayed in Table 6.1, followed by descriptive information of each of the strata variables by the outcome measures, SDQ and GHQ-12, highlighting any group differences.

Table 6.1. Descriptive statistics for the sample.

Wave	7	7	13
Age group	Youth (10-15 years)	Adult (16-30 years)	
Total, n	3434	4789	4496
Age, Mean (SD)	12.6 (1.65)	19.9 (2.63)	23.1 (4.22)
Sex, n (%)			
Male	1701 (49.5)	2253 (47.0)	1994 (44.4)
Female	1733 (50.5)	2536 (53.0)	2502 (55.6)
Ethnic group, n (%)			
Asian	298 (8.68)	463 (9.67)	424 (9.43)
Black	210 (6.12)	335 (7.0)	158 (3.51)
Pakistani	283 (8.24)	319 (6.66)	304 (6.76)
White	2415 (70.3)	3419 (71.4)	3366 (74.9)
Mixed	201 (5.85)	185 (3.86)	202 (4.49)
Other	27 (0.79)	68 (1.42)	42 (0.93)
Household income quintile £, Mean (SD)*	3576.0 (2371.2)	3653.0 (2589.3)	4335.8 (3152.5)
1	1563.0 (404.5)	1282.5 (498.2)	1326.2 (591.5)
2	2410.9 (196.8)	2332.5 (226.9)	2691.0 (322.6)
3	3147.1 (218.7)	3158.2 (256.6)	3801.7 (337.9)
4	4012.3 (313.3)	4224.0 (383.8)	5145.1 (486.1)
5	6751.0 (3452.2)	7269.2 (3464.6)	8719.8 (4123.0)
Urbanicity, n (%)			
Urban	2687 (78.2)	3921 (81.9)	3582 (79.7)
Rural	747 (21.8)	868 (18.1)	914 (20.3)
SDQ, Mean (SD)	10.7 (5.84)		
Normal	2984 (86.9)		
Abnormal	450 (13.1)		
GHQ-12, Mean (SD)		10.8 (5.71)	12.3 (6.14)
Normal		3395 (70.9)	2884 (64.1)
Psychological distress indicated		1394 (29.1)	1612 (35.6)

*not equivalised, outliers removed.

The composition of the three cohorts is generally similar across all strata variables with some proportional differences. The youngest cohort in Wave 7 (Wave 7 Youth) was evenly split between males and females, changing in the older cohorts to include more females (53% and 56%). Young White people were the largest ethnic group represented, followed by young people of Asian and Pakistani ethnic backgrounds. The biggest changes between the cohorts in ethnic group is seen in those of Black and Mixed ethnicity, with proportional differences of 3.5% and 2% respectively. The smallest ethnic group represented was young people in the Other ethnic group category where the highest proportion was in the W7 Adult cohort (1.42%). Four fifths of young people lived in an urban area with little change over time or with age. As would be expected, household income is highest for young people in Wave 13 (due to inflation, cost of living, etc) and across all Wave 13 quintiles, with the exception of quintile 1 of the Wave 7 Youth cohort. A similar pattern in household income is

observed in all three cohorts where between quintiles 1 and 4 gradual increases are observed, and then from quintile 4 to 5, household income on average trebles.

The SDQ total scores in the youth cohort in Wave 7 revealed that the majority of young people were within the normal range (86.9%), with a notable minority (13.1%) classified as abnormal. Much larger proportions of older individuals in both Waves 7 and 13 (Adult cohorts), reported generally higher GHQ-12 scores indicating psychological distress, which also increased over time (29.1% and 35.6% respectively).

6.3 Bivariate analysis

The following section explores potential differences in mental health across the strata variables, providing some understanding of how the cohorts in this study align with previous evidence that different dimensions of inequality impact mental health (See Intersectional Strata section). For each cohort, the proportion of young people with a high SDQ or GHQ-12 score indicating abnormal or psychological distress is displayed in Table 6.2, along with the mean and spread of the outcome score for each strata variable.

Table 6.2. SDQ and GHQ-12 scores by strata variables: proportion with higher scores, mean and standard deviation.

	W7 Youth			W7 Adult			W13 Adult		
	SDQ Abnormal, n (%)	**Mean (SD)**	**p-value***	**GHQ-12 distress, n (%)**	**Mean (SD)**	**p-value***	**GHQ-12 distress, n (%)**	**Mean (SD)**	**p-value***
All cohort	450 (13.1)	10.7 (5.8)		1394 (29.1)	10.8 (5.7)		1612 (35.9)	12.3 (6.1)	
Sex			0.122			<0.001			<0.001
Male	211 (12.4)	10.6 (5.8)		488 (28.7)	9.9 (5.2)		570 (35.4)	11.3 (5.8)	
Female	239 (13.8)	10.8 (5.9)		906 (52.3)	11.7 (6)		1042 (64.6)	13.2 (6.3)	
Ethnic group			<0.001			0.005			<0.001
Asian	18 (6)	9.1 (5)		125 (41.9)	10.3 (5.6)		140 (33)	12.1 (6.3)	
Black	15 (7.1)	8.7 (5.5)		94 (44.8)	10.3 (5.6)		52 (32.9)	11.3 (6.2)	
Pakistani	20 (7.1)	9.6 (5.5)		83 (29.3)	10.4 (5.9)		83 (27.3)	11.5 (6)	
White	368 (15.2)	11.2 (6)		1009 (41.8)	11 (5.7)		1224 (36.4)	12.4 (6.1)	
Mixed	24 (11.9)	10.6 (5.4)		63 (31.3)	11.5 (6.2)		89 (44.1)	13.4 (6.9)	
Other	5 (18.5)	10.9 (6.7)		20 (74.1)	11.3 (6.2)		24 (57.1)	14.9 (8.3)	
Household income quintile			0.001			0.515			0.140
1	103 (15.1)	10.8 (6.1)		325 (47.5)	10.9 (6.1)		330 (38.4)	12.8 (6.7)	
2	120 (17.4)	11.4 (6.4)		297 (43.1)	10.8 (5.7)		317 (35.3)	12.3 (6.4)	
3	85 (12.4)	10.7 (5.6)		285 (41.7)	11.1 (5.9)		333 (36.3)	12.3 (6)	
4	78 (11.3)	10.6 (5.6)		265 (38.5)	10.6 (5.4)		326 (35.9)	12.2 (6)	
5	64 (9.3)	9.9 (5.5)		222 (32.3)	10.6 (5.3)		306 (33.5)	12 (5.7)	
Urbanicity			0.014			0.030			
Urban	338 (12.6)	10.5 (5.8)		1184 (44.1)	10.9 (5.8)		1300 (36.3)	12.4 (6.2)	0.070
Rural	112 (15)	11.2 (6)		210 (28.1)	10.4 (5.3)		312 (34.1)	12 (5.9)	

* Sex and Urbanicity=Mann-Whitney U Test; Ethnic group and Household income quintile= Kruskal-Wallis H test.

Among the young people in Wave 7 (Wave 7 Youth), females, Other and White ethnicity, rural living and those in the lowest two household income quintiles had higher mean SDQ scores than the overall cohort. Young people of Other ethnicity appear to be disproportionally affected with the highest proportion with an SDQ score in the abnormal range, however this is based on very small numbers (total=27). To explore if differences in SDQ score were statistically different in each of the strata, Mann-Whitney U (sex and urbanicity), and Kruskal-Wallis H tests (ethnic group and household income quintile) were performed. A non-parametric test, the Mann Whitney U test investigates if there are differences between two groups; the Kruskal-Wallis H test is an expansion of the Mann-Whitney U test, enabling comparison across three or more groups (Riffenburgh, 2012). The results of these tests in the Wave 7 Youth cohort indicated that in most cases, differences in SDQ scores were statistically different except for sex ($p<0.05$).

GHQ-12 scores in older individuals in Wave 7 (Wave 7 Adult) were found to be above the cohort average in those who were female, of White, Mixed or Other ethnicity, living in an urban area and in

the mid household income quintile (3). There was big disparity in the proportion of individuals reporting GHQ-12 score indicating psychological distress, particularly sex and ethnicity. Over half (52%) of females had GHQ-12 scores past this threshold compared to 29% of males, and nearly three quarters (74%) of those of Other ethnicity, nearly double that of the next largest group (Black, 45%).

Post-COVID-19 in Wave 13, the average GHQ-12 score across the cohort increased by 1.5 points to 12.3 since Wave 7, and all mean GHQ-12 scores were higher across individual strata variables. Similarly, the overall proportion of individuals with a GHQ-12 score above the threshold indicating psychological distress had increased (36%), however this appears to be a consequence of increases in a few particular groups of individuals rather than across the whole cohort. The group with the largest proportion in Wave 13 indicating psychological distress was females (65%) followed by those of Other ethnicity (57%). There is similarity in the Wave 13 Adult cohort to Wave 7 Adult in those with higher than average GHQ-12 scores in terms of sex (females), ethnicity (White, Mixed or Other) and living area (urban). The only difference was in household income, where individuals in the lowest household income had increased GHQ-12 scores.

The results of the non-parametric statistical tests suggested that household income quintile in adults in Waves 7 and 13, and urbanicity in Wave 13 Adult were not statistically different but there were differences in GHQ-12 scores in sex and ethnic group, and in Wave 7 Adult, urbanicity.

6.4 Multilevel modelling analyses

Examining group-specific effects and interactions within each strata variable on mental health is necessary to understand any potential trends and provide indications of how the quantitative data may align with the qualitative exploration. This section outlines the analysis using multilevel models, exploring differences within and across sex, ethnic group, household income and urbanicity.

The modelling strategy including the rationale for using multilevel linear models and the stepwise approach to including strata variables is detailed in Chapter 3 (see Section 3.7.3.3). The analyses applied both random intercept and random slope models, and model fit was evaluated using Likelihood Ratio Tests (LRTs). In most cases, random intercept models provided the best fit to the data. Specifically, in all but three instances, the simpler intercept-only models outperformed more complex slope models, as indicated by p-values greater than 0.05. In the few cases where the LRT suggested that random slopes would improve model fit ($p < 0.05$), the models failed to converge due to estimation issues encountered in R. This suggests that although random slopes may have theoretical value in capturing group-level trends, practical limitations in data structure or model complexity resulted in instability (Browne & Draper, 2006). As such, the results presented below are based on random intercept models. Full model outputs for SDQ and GHQ-12 scores are displayed in Tables 6.3-6.5.

Overall, the multilevel model results appear to be fairly similar; there are consistent patterns across the Waves with limited variation in the model performance metrics.

In the Wave 7 Youth results, the average predicted SDQ scores fall within a narrow and statistically significant range, while unexplained variance (SD) remains stable despite increasing model complexity. Among the strata variables, ethnic group plays the most significant role in explaining differences in SDQ scores, whereas sex has the least impact. The model including ethnic group and household income (y7_E+H) provides the best overall fit according to both the AIC and BIC, and explains a modest proportion of the variability in SDQ scores (Table 6.3).

For the older individuals, the Wave 7 and Wave 13 Adult models produce similar ranges of average predicted GHQ-12 scores, though scores are higher post-COVID-19 (Wave 13 Adult). Again, unexplained variance is not affected by model complexity. Unlike the Youth models, sex is the most influential factor in explaining GHQ-12 score variability, with household income having minimal impact in Wave 7 Adult (Table 6.4) but becoming more relevant in Wave 13 Adult (Table 6.5) when combined with ethnic group. Across both waves for the Adult data, more complex models, such as Model_All, are preferred as they better capture the interplay between factors like sex, ethnic group, and household income, even when simpler models perform similarly on standard metrics.

While the multilevel models provide a useful overview of how single and combined strata variables relate to mental health outcomes, their capacity to capture non-additive effects of social stratification is limited. These multilevel analyses therefore serve two complementary purposes: first, to identify how individual social variables and their additive combinations contribute to differences in mental health scores; and second, to provide an empirical and conceptual foundation for the subsequent MAIHDA analysis. In particular, the findings suggest that the influence of individual strata varies depending on the mental health outcome (SDQ vs GHQ-12), age group, and time point. This underscores the importance of moving beyond additive modelling and toward a more nuanced intersectional approach, where interactions among social positions can be systematically assessed and interpreted.

Table 6.3. Summary of random intercept models including key parameter estimates and model fit statistics: Wave 7 Youth.

Term	y7_S	y7_E	y7_H	y7_U	y7_S+E	y7_S+H	y7_S+U	y7_E+H	y7_E+U	y7_H+U	y7_S+E+H	y7_S+E+U	y7_S+H+U	y7_E+H+U	Model_All
Intercept	10.666***	9.944***	10.667***	10.823***	9.944***	10.666***	10.823***	9.831***	9.944***	10.858***	9.831***	9.944***	10.858***	9.831***	9.831***
Intercept SD	0.119	0.434	0.236	0.322	0.436	0.251	0.329	0.585	0.434	0.442	0.59	0.436	0.451	0.585	0.59
SD (Observations)	5.844	5.786	5.829	5.839	5.786	5.828	5.839	5.752	5.786	5.821	5.752	5.786	5.82	5.752	5.752
SD (Intercept urbanf)				0.423			0.423		0	0.506		0	0.507	0	0
SD (Intercept hhincquinf)			0.479			0.481		0.706		0.515	0.707		0.517	0.706	0.707
SD (Intercept ethnf)		0.958			0.958			1.109	0.958		1.109	0.958		1.109	1.109
SD (Intercept sexf)	0.091				0.065	0.118	0.094				0.105	0.065	0.123		0.105
Num.Obs.	3434	3434	3434	3434	3434	3434	3434	3434	3434	3434	3434	3434	3434	3434	3434
AIC	21878.2	21819.4	21866.6	21874.1	21821.4	21868.5	21876	21792.3	21821.4	21862.3	21794.2	21823.4	21864.1	21794.3	21796.2
BIC	21896.6	21837.8	21885.1	21892.5	21846	21893	21900.6	21816.9	21846	21886.8	21824.9	21854.1	21894.8	21825	21833.1
ICC	0	0	0	0	0	0	0	0		0	0		0		

Note: S = Sex, E = Ethnic group, H = Household income, U = Urbanicity. Model_All= S+E+H+U.

+ $p < 0.1$, * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 6.4. Summary of random intercept models including key parameter estimates and model fit statistics: Wave 7 Adult.

Term	A7_S	a7_E	a7_H	a7_U	a7_S+E	a7_S+H	a7_S+U	a7_E+H	a7_E+U	a7_H+U	a7_S+E+H	a7_S+E+U	a7_S+H+U	a7_E+H+U	Model_All
Intercept	10.772***	10.696***	10.825***	10.668***	10.662***	10.771***	10.626***	10.686***	10.402***	10.668***	10.650***	10.392***	10.626***	10.399***	10.388***
Intercept SD	0.916	0.194	0.087	0.287	0.929	0.916	0.948	0.205	0.435	0.287	0.932	0.994	0.948	0.435	0.994
SD (Observations)	5.641	5.709	5.714	5.71	5.636	5.641	5.638	5.708	5.702	5.71	5.635	5.63	5.638	5.701	5.629
SD (Intercept urbanf)				0.378			0.352		0.515	0.378		0.479	0.352	0.512	0.474
SD (Intercept hhincquinf)			0.063			0.065		0.122		0	0.127		0	0.083	0.091
SD (Intercept ethnf)		0.351			0.348			0.362	0.425		0.362	0.417		0.429	0.422
SD (Intercept sexf)	1.29				1.286	1.29	1.286				1.286	1.279	1.286		1.279
Num.Obs.	4789	4789	4789	4789	4789	4789	4789	4789	4789	4789	4789	4789	4789	4789	4789
AIC	30173.8	30287.8	30292.1	30287.9	30172.1	30175.8	30172.2	30289.6	30281.6	30289.9	30173.8	30167	30174.2	30283.5	30168.9
BIC	30193.2	30307.3	30311.5	30307.3	30198	30201.7	30198.1	30315.5	30307.5	30315.8	30206.2	30199.4	30206.5	30315.9	30207.8
ICC	0	0	0	0	0.1	0	0.1	0	0		0.1	0.1		0	0.1

Note: S = Sex, E = Ethnic group, H = Household income, U = Urbanicity. Model_All= S+E+H+U.

+ $p < 0.1$, * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 6.5. Summary of random intercept models including key parameter estimates and model fit statistics: Wave 13 Adult.

Term	a13_S	a13_E	a13_H	a13_U	a13_S+E	a13_S+H	a13_S+U	a13_E+H	a13_E+U	a13_H+U	a13_S+E+H	a13_S+E+U	a13_S+H+U	a13_E+H+U	Model_All
Intercept	12.217***	12.423***	12.327***	12.233***	12.321***	12.220***	12.118***	12.376***	12.231***	12.246***	12.275***	12.129***	12.132***	12.196***	12.096***
Intercept SD	0.955	0.447	0.133	0.211	1.029	0.962	0.978	0.473	0.533	0.217	1.042	1.068	0.98	0.548	1.077
SD (Observations)	6.091	6.15	6.161	6.162	6.079	6.087	6.089	6.145	6.147	6.159	6.074	6.076	6.086	6.142	6.071
SD (Intercept urbanf)				0.257			0.274		0.363	0.234		0.362	0.249	0.347	0.346
SD (Intercept hhincquinf)			0.216			0.231		0.292		0.2	0.298		0.216	0.282	0.288
SD (Intercept ethnf)		0.997			0.908			1.016	1.026		0.933	0.936		1.043	0.96
SD (Intercept sexf)	1.345				1.333	1.347	1.346				1.334	1.332	1.348		1.333
N Obs.	4496	4496	4496	4496	4496	4496	4496	4496	4496	4496	4496	4496	4496	4496	4496
AIC	29018.3	29111.4	29119.1	29119.2	29012.9	29018.5	29018.7	29110.1	29110.4	29120.2	29011.3	29011.9	29019.3	29109.5	29010.6
BIC	29037.5	29130.7	29138.3	29138.5	29038.6	29044.1	29044.3	29135.8	29136.1	29145.8	29043.3	29043.9	29051.3	29141.5	29049
ICC	0	0	0	0	0.1	0	0	0	0	0	0.1	0.1	0	0	0.1

Note: S = Sex, E = Ethnic group, H = Household income, U = Urbanicity. Model_All= S+E+H+U.

+ $p < 0.1$, * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

6.5 MAIHDA analyses

This section presents the MAIHDA results, a more detailed and flexible analysis (Merlo, 2018) of the differences in the mental health outcomes (SDQ and GHQ-12) and the variations within and between the strata variables (sex, ethnic group, household income and urbanicity) to provide understanding of how these influence mental health. To begin with, summary statistics of the strata in the three Wave datasets are tabulated, and then the MAIHDA results are presented separately for each Wave.

6.5.1 Overview of strata

Ensuring a sufficient number of respondents in each social stratum is crucial for reliable analysis in intersectional MAIHDA (Evans, Leckie, et al., 2024). Summary statistics are presented in Table 6.6 and indicate that across the three Waves, between 79 and 85 strata were considered, with all of these strata containing at least one observation. Over 64% of the strata have 10 or more respondents, and over 50% have 20 or more. The number of observations on average per stratum ranged between 20-26, thus most strata appear to have sufficient sample size to obtain reliable estimates and is comparable to other studies that have used MAIHDA (Evans et al., 2018; Evans, 2019; Mahendran et al., 2022a, 2022b; Ben Van Dusen et al., 2024).

Table 6.6. Sample size of social strata, defined by sex, ethnic group, household income quintile and urbanicity.

Strata	Wave		
	7 Youth	7 Adult	13 Adult
Total, n	84	79	85
Median (range)	20 (1-195)	26 (1-299)	22 (1-314)
Sample size, n (%)			
100 or More	11 (13.1)	12 (15.2)	13 (15.3)
50 or More	23 (27.4)	25 (31.6)	24 (28.2)
30 or More	29 (34.5)	35 (44.3)	33 (38.8)
20 or More	44 (52.4)	46 (58.2)	44 (51.8)
10 or More	54 (64.3)	61 (77.2)	57 (67.1)
Less than 10	30 (35.7)		

The intersectional analyses revealed some important insights into intersectional differences in the two different outcome scores, SDQ and GHQ-12, influenced by sex, ethnic group, household income, and urbanicity. Within each of the Wave analyses, a two-level intersectional MAIHDA model where individuals (Level 1) are nested hierarchically in 84, 79 and 85 intersectional social strata-context combinations (Level 2) for Wave 7 Youth, Wave 7 Adult and Wave 13 Adult cohorts respectively. Two versions of this model were tested: Model A (the null model) and Model B, main effects including sex, ethnic group, household income and urbanicity. A third model was built and tested based on Model B including age as an additional main effect (Model C) yielding similar results to

Model B. This is likely to be a reflection of the data already being stratified into age groups. For this reason, Model C results are not discussed further here. In each case, the intercept represents the expected outcome, SDQ score for Wave 7 Youth and GHQ-12 score for Waves 7 and 13 Adults, for the reference group: Male, White, in the lowest household income quintile, living in an urban area, and at the mean age. The results are presented in Table 6.7, and Appendix 19 presents additional results from Model C (including age). The results include regression coefficients and the within- and between-stratum variances, as well as the Variance Partition Coefficient (VPC) and Proportional Change in Variance (PCV).

Table 6.7. Parameter estimates for linear MAIHDA models of outcome, SDQ score: Wave 7 Youth.

Predictors	Model A y7		Model B y7	
	Estimates	*(95% CI)*	*Estimates*	*(95% CI)*
Fixed Effects: Regression Coefficients				
(Intercept)	10.31 ***	(9.91, 10.71)	11.79 ***	(11.06, 12.52)
Sex				
Male (Ref)			-	
Female			0.28	(-0.18, 0.74)
Ethnic group				
White (Ref)			-	
Asian			-2.33 ***	(-3.12, -1.53)
Black			-2.71 ***	(-3.60, -1.81)
Pakistani			-1.99 ***	(-2.83, -1.16)
Mixed			-0.61	(-1.51, 0.28)
Other			-0.4	(-2.62, 1.81)
Household income				
Q1 (Ref)			-	
Q2			0.15	(-0.56, 0.87)
Q3			-0.61	(-1.33, 0.11)
Q4			-0.77 *	(-1.51, -0.02)
Q5			-1.61 ***	(-2.36, -0.86)
Urbanicity				
Urban (Ref)			-	
Rural			-0.14	(-0.73, 0.45)
Random Effects: Variances				
Stratum-Level (τ_{00})	1.56	(1.52, 1.60)	0.15	(0.13, 0.16)
Individual-Level (σ^2)	32.88	(32.69, 33.07)	32.99	(32.80, 33.18)
Summary statistics				
Strata	84		84	
Observations	3434		3434	
Variance Partition Coefficient (VPC)	4.53		0.45	
Proportional Change in Variance (PCV)			90.6	
ICC	0.05		0	

*p<0.05, ** p<0.01, *** p<0.001

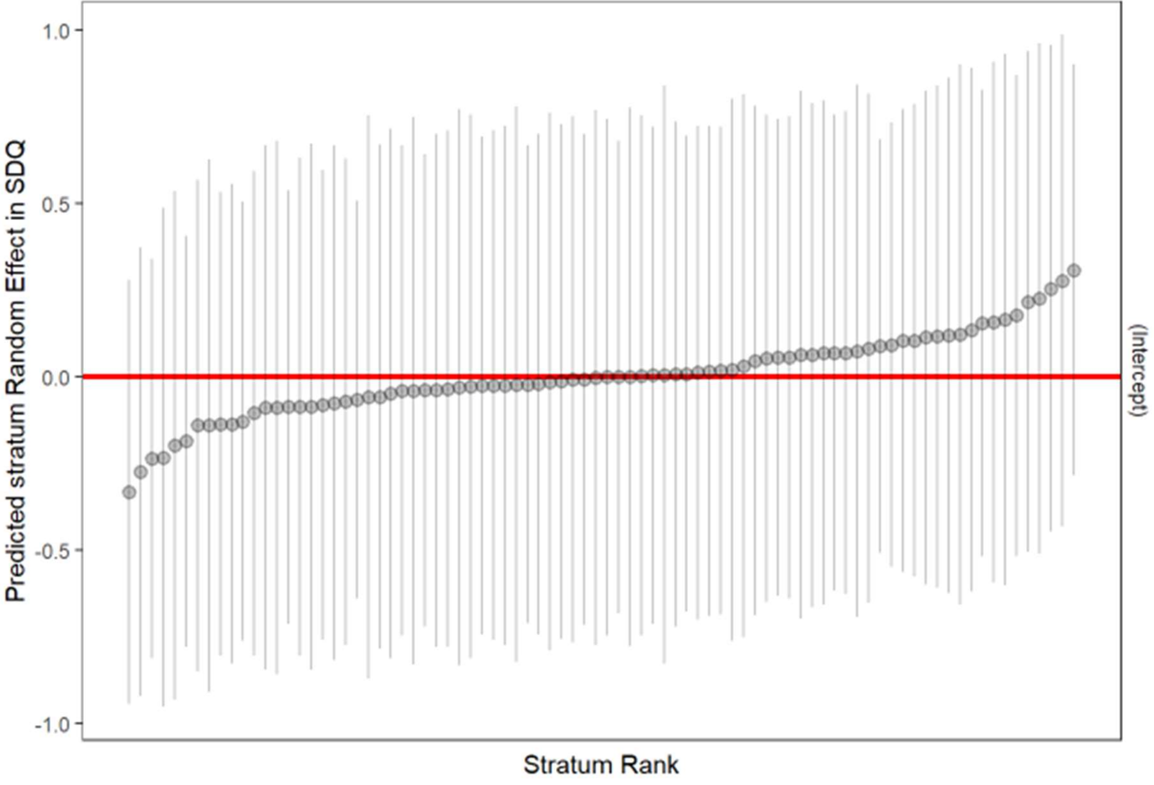
6.5.2 Wave 7 Youth

To comprehend to what extent intersectionality can aid the understanding of mental health, in this case utilising SDQ scores, in young people aged 10-15 years, the VPC was determined of the null model (Model A). The total variance in SDQ scores that presents at the intersectional strata (between-stratum) level was found to be 4.53% (Table 6.7) thus the majority of the variance is at the individual

level. This aligns with research examining health-related outcomes where Keller et al. (2023) reported finding VPCs typically ranging between 0.5 and 41.9%, and a median VPC of 5.5%. As a relatively modest VPC (Kern et al., 2020), it indicates that there is some influence on the SDQ score by the variables - sex, ethnic group, household income and urbanicity, individually and in combinations, as well as other unknown factors.

Model B allows for examination of the relationships between sex, ethnic group, household income and urbanicity, with the results suggesting there is evidence of multiplicative effects. Firstly, the VPC reduced to 0.45%, not zero, thus the inclusion of the additive main effects explained some, but not all of the between-stratum variation. The PCV was 90.6% indicating the majority of the stratum-level variation, the differences in SDQ scores, was attributable to the additive effects of the strata variables, consequently the remainder resulted from intersectional interactions. This is shown graphically in Figure 6.1 which displays the strata-level residuals. All of the intersectional effects have large 95% confidence intervals that cross zero indicating they are not statistically significant, therefore the additive main effects rather than the interactive effects, better explain the SDQ scores in young people aged 10-15 years.

Figure 6.1. Predicted stratum interaction effects, ranked low to high with approximate 95% CI. SDQ score: Wave 7 Youth.



The fixed effect results displayed in Table 6.7 represent the additive patterns of the strata variables. Sex and urbanicity appear to have a negligible effect on SDQ scores in young people as both are not

statistically significant. Controlling for all other variables, the SDQ scores for young females were 0.28 points higher than for males, and young people living rurally had lower SDQ scores by 0.14 points compared to those in urban areas.

A clear dose-response relationship was observed between household income and SDQ scores, with higher income generally associated with lower SDQ scores. Young people in the highest household income quintile (Q5) exhibited SDQ scores 1.6 points lower than those in the lowest household income quintile (Q1), a highly significant difference.

As indicated in the multilevel analyses, ethnic group appeared to be a strong predictor of SDQ scores. After holding all other variables constant, all ethnic groups had SDQ scores lower than White individuals. Black, Asian and Pakistani young people had significantly lower SDQ scores by 2.71, 2.33 and 1.99 points, respectively.

Similar to the VPC which can be affected by individual-level variability within strata potentially obscuring or reducing the apparent differences between strata (Evans, Leckie, et al., 2024), additive patterns (as discussed above) can obscure key results. Examining the range of predicted SDQ scores and the intersections across strata can help with this. The highest and lowest predicted SDQ scores are presented in Table 6.8 along with the interaction effects and their approximate 95% confidence intervals. Predicted SDQ scores and interaction effects for all strata are detailed in Appendix 20.

Table 6.8. Five highest and lowest strata for predicted mean SDQ scores and interaction effects (Model B): Wave 7 Youth.

							Predicted SDQ (I+M effects)		Predicted SDQ (I effects)		
Rank	**Stratum**	**Sex**	**Ethnic group**	**Household income quintile**	**Urbanicity**	**Stratum size**	**Mean**	**95% CI**	**Mean**	**95% CI**	**Rank (I effects)**
Five lowest											
1	1252	Male	Black	5	Urban	7	7.38	(6.1, 8.6)	-2.66*	(-3.5, -1.8)	2
2	2252	Female	Black	5	Urban	10	7.79	(6.6, 9.1)	-3.23*	(-4.1, -2.5)	1
3	1152	Male	Asian	5	Urban	14	7.91	(6.8, 9.0)	-2.60*	(-3.4, -1.9)	3
4	2152	Female	Asian	5	Urban	18	8.01	(6.9, 9.0)	-1.30*	(-2.1, -0.6)	12
5	1552	Male	Pakistani	5	Urban	6	8.11	(6.8, 9.4)	-2.04*	(-2.9, -1.2)	5
Five highest											
80	2612	Female	White	1	Urban	130	12.04	(11.2, 13.0)	0.08*	(0.0, 0.2)	49
81	1622	Male	White	2	Urban	178	12.09	(11.2, 12.9)	-0.13*	(-0.2, -0.1)	40
82	2611	Female	White	1	Rural	37	12.10	(11.1, 13.2)	0.38	(-0.1, 0.9)	68
83	1621	Male	White	2	Rural	58	12.11	(11.1, 13.1)	0.11	(-0.2, 0.4)	54
84	2621	Female	White	2	Rural	67	12.11	(11.1, 13.1)	0.55*	(0.4, 0.8)	71

* Indicates significant, 95% CI does not include zero

The individual strata results suggest that generally Black, Asian and Pakistani young people in high income households living in urban areas have lower predicted SDQ scores, and those with the highest predicted SDQ scores are generally White, living in the lowest income households in rural areas. Interestingly, there is no dominant sex trend in the top or lowest five strata. Figures 6.2 and 6.3 display these final predicted SDQ scores graphically; firstly, ranked from lowest to highest predicted SDQ score (Figure 6.2) and grouped by the strata variables - sex, ethnic group, household income and urbanicity (Figure 6.3). The association between household income and SDQ score is apparent, as well as higher SDQ scores in White young people particularly in the lowest household income quintiles.

Figure 6.2. Predicted mean SDQ scores with approximate 95% CI (Model B): Wave 7 Youth.

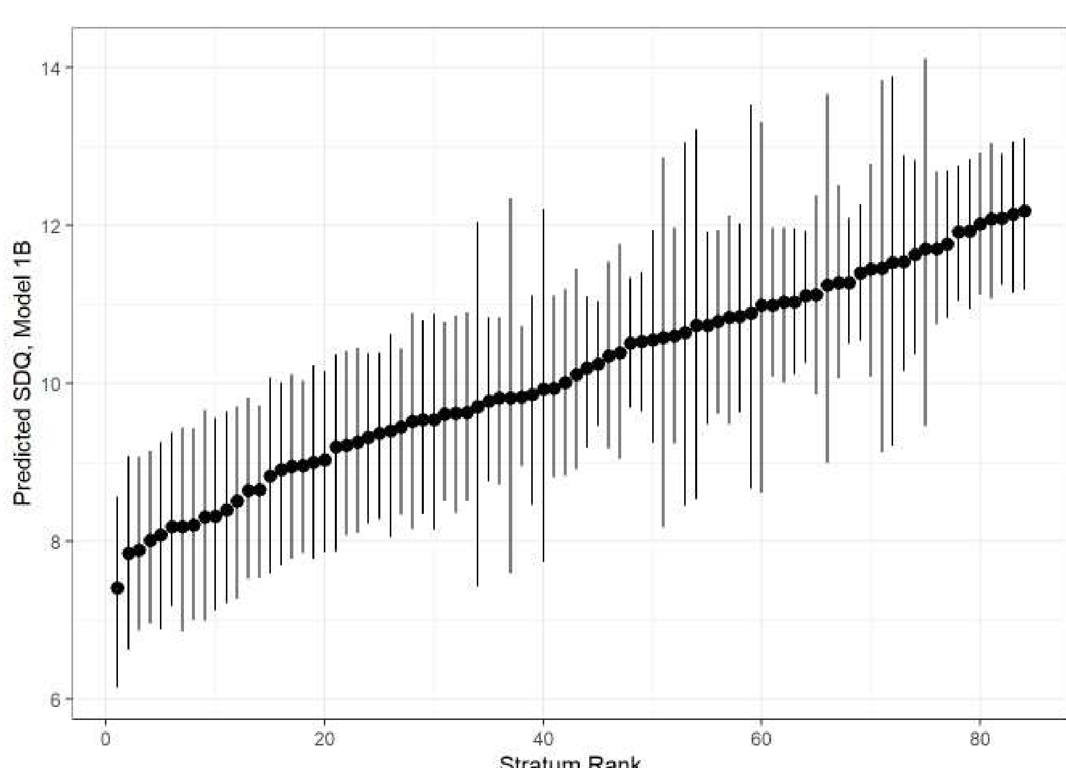
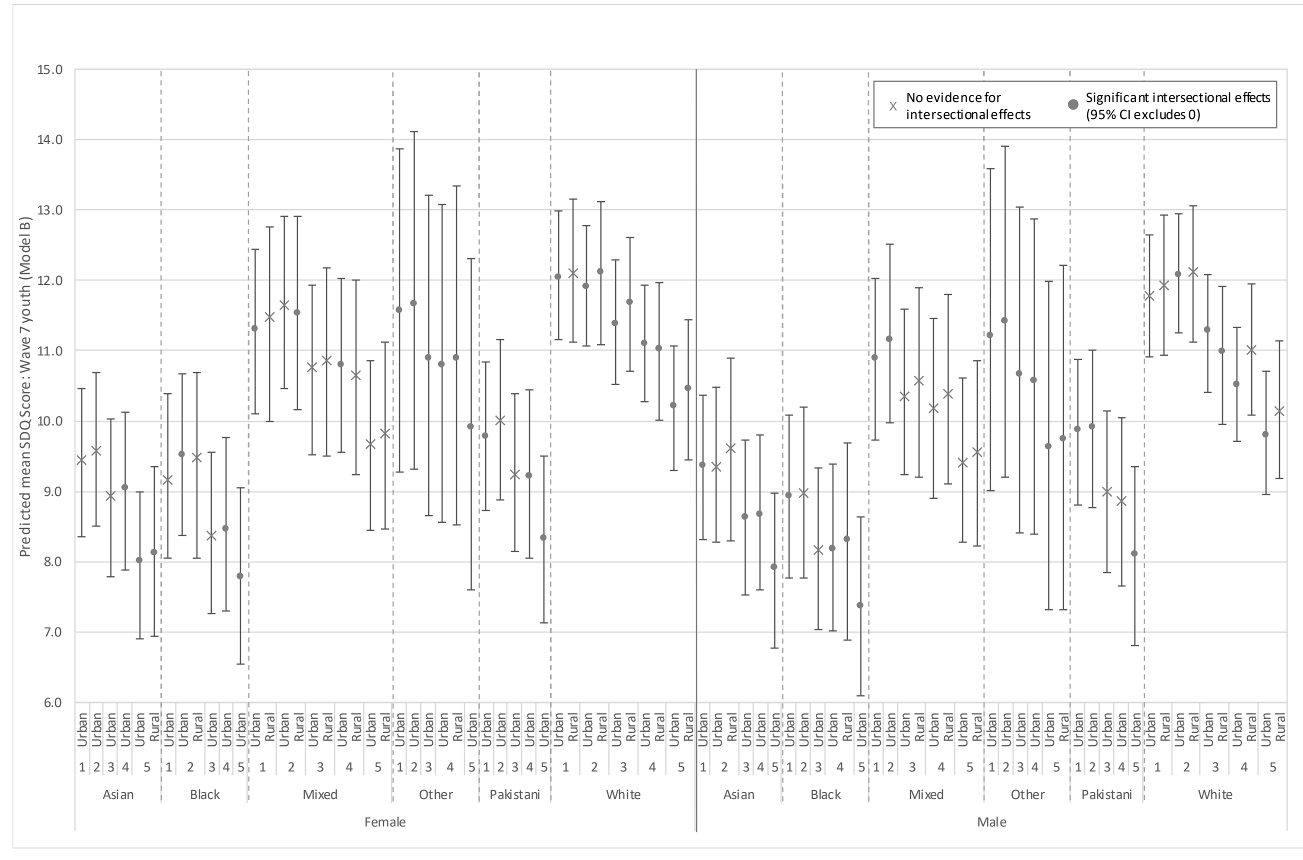


Figure 6.3. Predicted mean SDQ scores with approximate 95% CI by strata - sex, ethnic group, household income quintile and urbanicity (Model B): Wave 7 Youth.



6.5.3 Waves 7 and 13 Adult

As with the multilevel analyses, the MAIHDA results for individuals aged 16-30 years in Waves 7 (Wave 7 Adult) and 13 (Wave 13 Adult) are similar, and differ particularly from the younger aged individuals in Wave 7 Youth (Table 6.9 and Table 6.10).

Table 6.9. Parameter estimates for linear MAIHDA models of outcome, GHQ-12 score: Wave 7 Adult.

Predictors	Model A ad7		Model B ad7	
	Estimates	*(95% CI)*	*Estimates*	*(95% CI)*
Fixed Effects: Regression Coefficients				
(Intercept)	10.68 ***	(10.36 – 11.00)	9.63 ***	(9.05 – 10.20)
Sex				
Male (Ref)			-	
Female			1.79 ***	(1.44 – 2.14)
Ethnic group				
White (Ref)			-	
Asian			-0.84	(-1.43 – -0.25)
Black			-0.79	(-1.46 – -0.12)
Pakistani			-0.82 *	(-1.52 – -0.12)
Mixed			0.42	(-0.43 – 1.28)
Other			0.13	(-1.24 – 1.50)
Household income				
Q1 (Ref)			-	
Q2			-0.13	(-0.66 – 0.41)
Q3			0.08	(-0.47 – 0.63)
Q4			-0.39	(-0.95 – 0.16)
Q5			-0.35	(-0.92 – 0.23)
Urbanicity				
Urban (Ref)			-	
Rural			0.70 **	(0.23 – 1.17)
Random Effects: Variances				
Stratum-Level (τ_{00})	0.96	(0.94, 0.99)	0.05	(0.04, 0.05)
Individual-Level (σ^2)	31.61	(31.45, 31.77)	31.65	(31.49, 31.81)
Summary statistics				
Strata	79		79	
Observations	4789		4789	
Variance Partition Coefficient (VPC)	2.95		0.16	
Proportional Change in Variance (PCV)			95.2	
ICC	0.03		0	

*p<0.05, ** p<0.01, *** p<0.001

Table 6.10. Parameter estimates for linear MAIHDA models of outcome, GHQ-12 score: Wave 13 Adult.

Predictors	Model A ad13		Model B ad13	
	Estimates	*(95% CI)*	*Estimates*	*(95% CI)*
Fixed Effects: Regression Coefficients				
(Intercept)	12.25 ***	(9.91, 10.71)	11.43 ***	(10.77 – 12.09)
Sex				
Male (Ref)			-	
Female			1.93 ***	(1.52 – 2.34)
Ethnic group				
White (Ref)			-	
Asian			-0.41	(-1.09 – 0.26)
Black			-1.28 *	(-2.29 – -0.27)
Pakistani			-1.18 **	(-1.96 – -0.40)
Mixed			0.93 *	(0.04 – 1.82)
Other			2.02 *	(0.14 – 3.89)
Household income				
Q1 (Ref)			-	
Q2			-0.56	(-1.21 – 0.08)
Q3			-0.47	(-1.11 – 0.17)
Q4			-0.62	(-1.27 – 0.03)
Q5			-0.89 **	(-1.55 – -0.24)
Urbanicity				
Urban (Ref)			-	
Rural			0.55 *	(0.04 – 1.06)
Random Effects: Variances				
Stratum-Level (τ_{00})	1.3	(1.27, 1.34)	0.07	(0.07, 0.08)
Individual-Level (σ^2)	36.86	(36.69, 37.04)	36.79	(36.61, 37.0)
Summary statistics				
Strata	85		85	
Observations	4496		4496	
Variance Partition Coefficient (VPC)	3.41		0.19	
Proportional Change in Variance (PCV)			94.3	
ICC	0.03		0	

*p<0.05, ** p<0.01, *** p<0.001

The null models for the older aged cohorts in Waves 7 and 13 had VPCs of 2.95% and 3.14% respectively. This suggests that the total variance in GHQ-12 scores at the intersectional strata level was relatively small, and the majority of the variance is at the individual level. Even more than the Wave 7 Youth cohort. The inclusion of the main effects in Model B sees the VPC reduce, as expected (Evans, Leckie, et al., 2024) but not to zero, indicating that some differences in GHQ-12 scores

between stratum are unexplained in both Wave 7 (0.16%) and Wave 13 (0.19%) Adult cohorts. Examining the additive and interactive effects using PCV, again Model B for both Waves 7 and 13 Adult cohorts have a PCV around 95%. This signifies that ~5% or less of the total variance between strata is attributable to interaction effects. As with Wave 7 Youth, the additive main effects better explain GHQ-12 score in individuals aged 16-30 years in Waves 7 and 13 (Figures 6.4 and 6.5).

Figure 6.4. Predicted stratum interaction effects, ranked low to high with approximate 95% CI. GHQ-12 score: Wave 7 Adult.

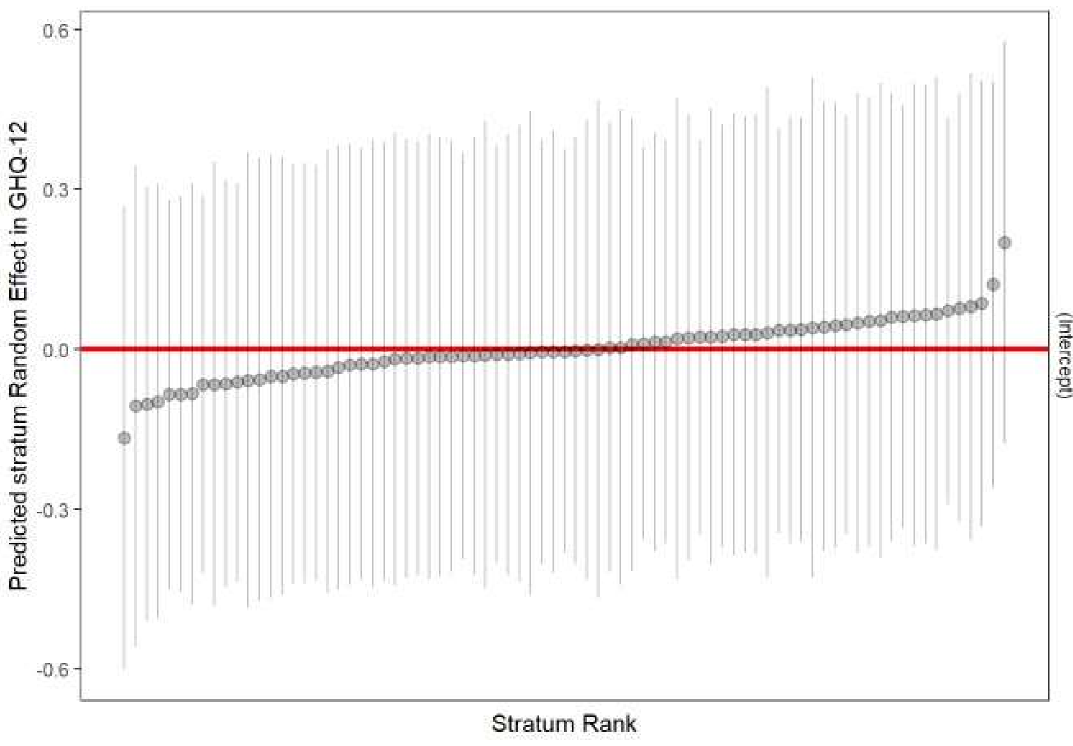
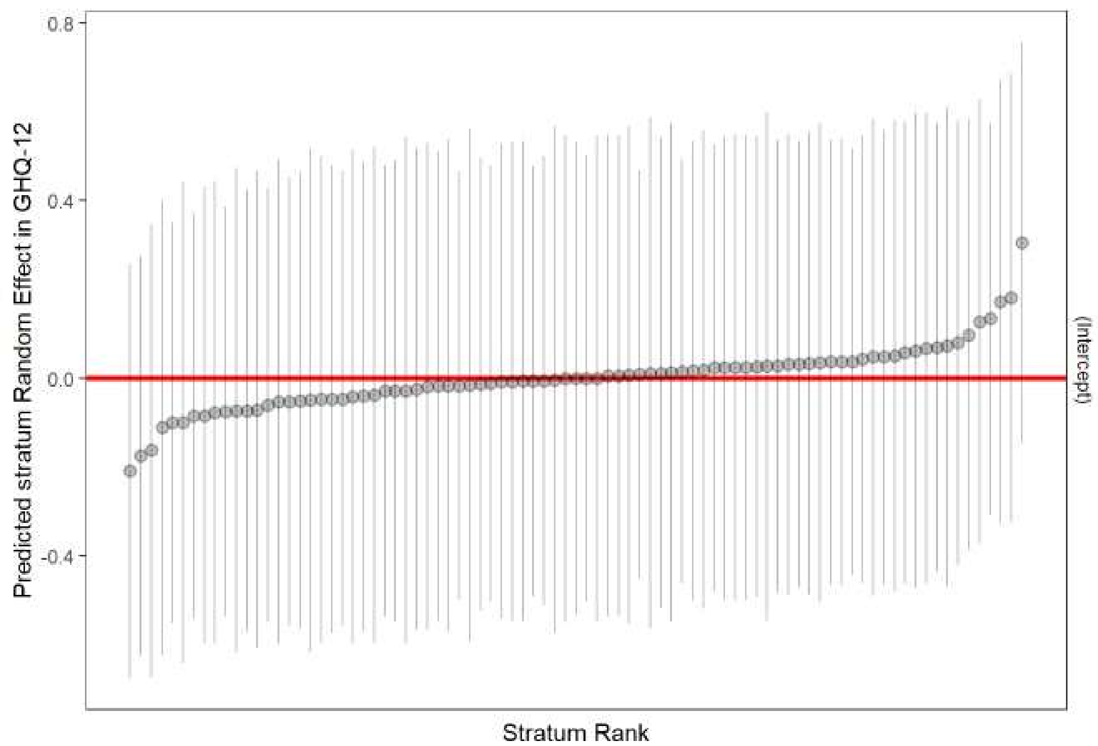


Figure 6.5. Predicted stratum interaction effects, ranked low to high with approximate 95% CI. GHQ-12 score: Wave 13 Adult.



Unlike the Wave 7 Youth models, the fixed effect results indicated that sex and urbanicity are significant predictors of GHQ-12 scores in the Wave 7 Adult and Wave 13 Adult cohorts. Ethnic group, particularly in the Wave 7 Adult cohort, appeared to play a less important role on GHQ-12 scores and there was no 'dose-response' relationship observed with household income quintile.

In Wave 7 Adult (Table 6.9), females, and those living in rural areas had higher GHQ-12 scores than males and those living in urban areas by 1.79 and 0.70 points respectively, when holding all other variables constant. Asian, Black and Pakistani individuals all had GHQ-12 scores approximately 0.80 points lower than their White counterparts, with those of Mixed and Other ethnicity having higher GHQ-12 scores. However only Pakistani individuals in Wave 7 Adult were significant ($p<0.05$). Although not significant, individuals in all household income quintiles except Q3, had lower GHQ-12 scores ranging from 0.13 to 0.39 points lower.

Examining the fixed effects of Wave 13 Adult, again females had significantly higher GHQ-12 scores than males by 0.93 points (Table 6.10). Similarly, those living in rural areas on average had GHQ-12 scores 0.55 higher than those living in urban areas ($p<0.05$). A similar pattern emerged in ethnic group and GHQ-12 scores with Wave 7 Adults where those of Asian, Black and Pakistani ethnic group had lower GHQ-12 scores by up to 1.28 points than White individuals. Individuals of Mixed or Other ethnicities had higher GHQ-12 scores by 0.93 and 2.02 points respectively. All of these results were significant except for the Asian ethnic group. Finally, individuals in Wave 13 that lived in the

highest income households (Q5) had significantly lower GHQ-12 scores than those living in the lowest income households.

Table 6.11 and 6.12 allow more detailed exploration of the patterns of predicted GHQ-12 scores including interaction effects across the strata. Predicted SDQ scores and interaction effects for all strata are detailed in Appendix 20. In Wave 7 Adults (Table 6.11), it appears that generally Asian men living in high income households in urban areas have the lowest predicted GHQ-12 scores, and those with the lowest GHQ-12 scores are females of Mixed ethic group living in urban areas. For this latter group, household income appears to not be important.

Table 6.11. Five highest and lowest strata for predicted mean GHQ-12 scores and interaction effects (Model B): Wave 7 Adult.

Rank	Stratum	Sex	Ethnic group	Household income quintile	Urbanicity	Stratum size	Predicted GHQ-12 (I+M effects) Mean	Predicted GHQ-12 (I+M effects) 95% CI	Predicted GHQ-12 (I effects) Mean	Predicted GHQ-12 (I effects) 95% CI	Rank (I effects)
Five lowest											
1	2151	Male	Asian	5	Rural	2	8.44	(7.5, 9.4)	-2.01	(-3.0, -1.0)	1
2	2142	Male	Asian	4	Urban	37	9.06	(8.4, 9.9)	-0.68	(-1.2, 0.1)	15
3	2242	Male	Black	4	Urban	27	9.15	(8.3, 10.0)	-1.23	(-1.8, -0.6)	7
4	2152	Male	Asian	5	Urban	26	9.15	(8.3, 9.9)	-1.05	(-1.7, -0.5)	8
5	2552	Male	Pakistani	5	Urban	6	9.15	(8.2, 10.0)	-1.31	(-2.2, -0.5)	4
Five highest											
75	1432	Female	Other	3	Urban	5	12.22	(10.7, 13.8)	1.88	(1.7, 2.1)	79
76	1352	Female	Mixed	5	Urban	16	12.22	(11.2, 13.2)	0.52	(-0.1, 1.2)	61
77	1322	Female	Mixed	2	Urban	14	12.42	(11.4, 13.4)	1.19	(0.6, 2.0)	73
78	1312	Female	Mixed	1	Urban	23	12.52	(11.5, 13.5)	1.46	(1.0, 2.1)	77
79	1332	Female	Mixed	3	Urban	19	12.63	(11.6, 13.6)	1.06	(0.4, 1.6)	71

Table 6.12. Five highest and lowest strata for predicted mean GHQ-12 scores and interaction effects (Model B): Wave 13 Adult.

Rank	Stratum	Sex	Ethnic group	Household income quintile	Urbanicity	Stratum size	Predicted GHQ-12 (I+M effects) Mean	Predicted GHQ-12 (I+M effects) 95% CI	Predicted GHQ-12 (I effects) Mean	Predicted GHQ-12 (I effects) 95% CI	Rank (I effects)
Five lowest											
1	2631	Male	White	3	Rural	81	10.39	(9.2, 11.7)	-0.42	(-0.9, 0.1)	28
2	2152	Male	Asian	5	Urban	28	10.71	(9.1, 12.5)	0.13	(-0.6, 1.0)	51
3	2651	Male	White	5	Rural	91	10.82	(9.7, 12.0)	0.33	(0.0, 0.8)	61
4	2242	Male	Black	4	Urban	13	10.85	(9.1, 12.7)	0.85	(0.2, 1.6)	74
5	2641	Male	White	4	Rural	87	10.88	(9.7, 12.1)	0.15	(-0.3, 0.6)	53
Five highest											
81	1651	Female	White	5	Rural	119	13.21	(12.1, 14.2)	0.56	(0.2, 0.8)	68
82	1622	Female	White	2	Urban	295	13.53	(12.7, 14.2)	0.08	(0.0, 0.1)	48
83	1342	Female	Mixed	4	Urban	22	13.84	(12.2, 15.5)	-0.49	(-1.0, 0.2)	25
84	1612	Female	White	1	Urban	230	13.92	(13.2, 14.7)	-0.07	(-0.1, 0.0)	40
85	1332	Female	Mixed	3	Urban	24	13.96	(12.3, 15.7)	-0.51	(-1.1, 0.2)	23

The patterns are not as clear for individuals in Wave 13 (Table 6.12), particularly in the lower end of GHQ-12 scores. This group tends to be males in higher income households but there are no dominant ethnic or urbanicity groups. There is more similarity amongst the strata with the higher GHQ-12 scores which generally is White or Mixed ethnic group females, living in urban areas across the spectrum of household income

The patterns across the strata can be better observed in Figures 6.6 and 6.7 which display the predicted GHQ-12 scores, grouped by the strata variables (sex, ethnic group, household income quintile and urbanicity). It is clear in Wave 7 Adults that the predicted GHQ-12 scores are generally higher in females compared to males, and in the Mixed and Other ethnic groups. The GHQ-12 scores overall are higher in Wave 13 Adult compared to the other Wave cohorts but any differences are much less striking.

Figure 6.6. Predicted mean GHQ-12 scores with approximate 95% CI by strata – sex, ethnic group, household income quintile and urbanicity (Model B): Wave 7 Adult.

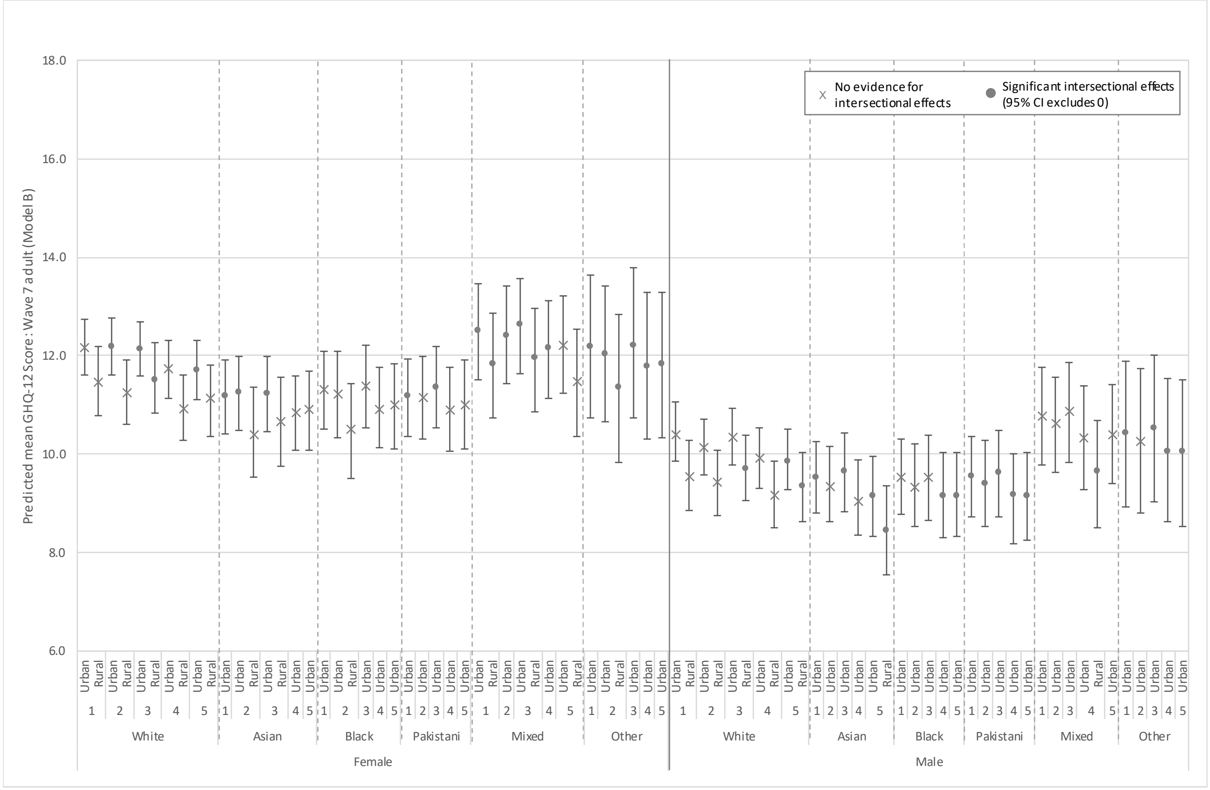
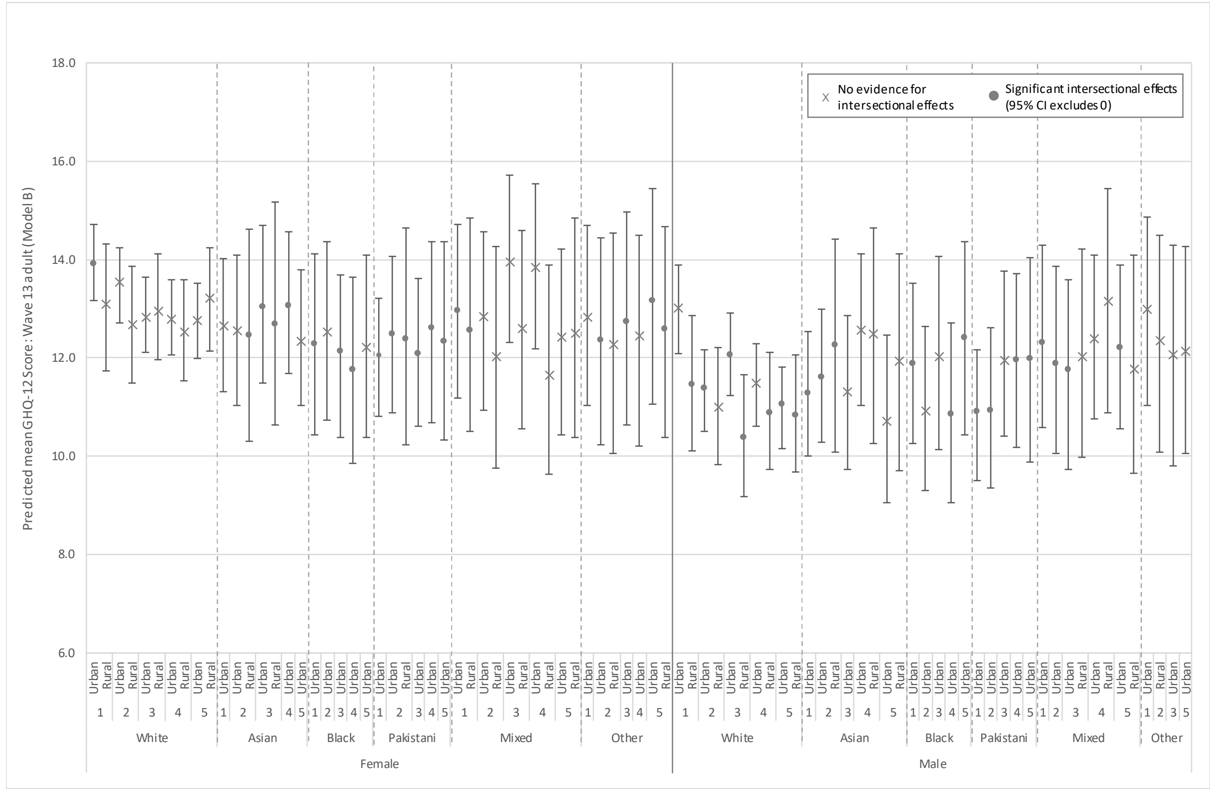


Figure 6.7. Predicted mean GHQ-12 scores with approximate 95% CI by strata – sex, ethnic group, household income quintile and urbanicity (Model B): Wave 13 Adult.



6.6 Conclusion

Drawing on the longitudinal data from UKHLS, the analyses highlight patterns across age, sex, ethnic group, household income, and urbanicity, and reveal both consistency and variation in how these factors influenced psychological distress over time. The demographic overview indicated broad representativeness across strata, with most young people living in urban areas and the majority identifying as White, mirroring the broader UK population's ethnic composition (ONS, 2021). Analysis by age group showed that while younger adolescents (10–15 years) mostly reported normal mental health according to SDQ scores (87%), older individuals (16–30 years) exhibited a growing prevalence of psychological distress, with GHQ-12 scores rising across waves (Wave 7: 29% - Wave 13: 36%) reflecting increased mental health challenges as young people transitioned into adulthood.

Sex and ethnic group emerged as the most salient predictors of poorer mental health, with females, particularly those from White, Mixed, or Other ethnic backgrounds reporting higher levels of distress. Household income was a more prominent factor for the younger cohort (SDQ score), especially among those identifying as White, Mixed, or Other ethnic group and combined with rural living. In the older cohort, psychological distress (as measured by GHQ-12 scores) exhibited similar patterns; however, sex emerged as a more predominant factor, and household income appeared to play a less significant role. Individuals with higher GHQ-12 scores were generally White, Mixed, or Other females living in urban areas.

Multilevel and MAIHDA analyses reinforced the significance of these findings. Among younger individuals, ethnic background had a stronger impact on SDQ scores, whereas for older cohorts, sex was the predominant factor influencing GHQ-12 scores across Waves 7 and 13. While most variance was attributable to individual-level main effects rather than intersectional interactions, the modelling demonstrated how structural factors shape mental health differently across social groups. Importantly, the use of MAIHDA enabled the identification of both additive and interactional effects, revealing how combinations of identity factors compound or alleviate risk in specific contexts. While the majority of explained variance stemmed from individual-level factors, intersectional analysis captured additional nuances that would have been obscured in conventional models. For example, the compounded disadvantage experienced by White or Mixed ethnicity females from lower-income households in urban settings emerged as a pattern of heightened risk especially in the older age group, while some minority ethnic groups appeared comparatively protected, even in the face of socioeconomic adversity. These findings suggest that mental health inequalities are not merely additive but are shaped through the interlocking effects of structural positioning.

Moreover, the relative differences in intersectional effects across cohorts - stronger for sex in older groups, and for ethnicity in younger ones, underscore the need for age- and context-sensitive approaches to mental health policy and intervention. The results suggest that universal mental health

strategies may miss key subgroups experiencing heightened or compounding vulnerabilities. Intersectional methods thus not only reinforce what is known from main-effect analyses but crucially enhance our understanding of who is most affected, when, and under what conditions. These insights can support more targeted resource allocation and more equitable mental health service planning. Further interpretation and policy implications are explored in the Discussion chapter (Chapter 7).

CHAPTER 7 SYNTHESISING INSIGHTS: INTERPRETING FINDINGS THROUGH THE LITERATURE

7.1 Outline of chapter

This thesis combines the findings of the quantitative exploration of a nationwide dataset and qualitative interviews with young people, with the aim of understanding how their mental health has changed during the COVID-19 pandemic, and how intersectionality can aid the understanding of mental health in young people. This chapter summarises, as a result of this thesis, the contribution to knowledge, and brings together the mixed methods findings with the wider literature to discuss mental health in young people.

7.2 Qualitative findings

The qualitative findings shed light on the multifaceted experiences of young people navigating mental health challenges during the COVID-19 pandemic. They appear to underscore the profound impact of social isolation, the complexities of identity, and the varying degrees of access to support, all of which shaped their mental health outcomes in distinct ways.

Social isolation was developed as a central theme through the analytic process, reflecting a consistent pattern of meaning across participants' accounts. As routines ground to a halt and physical interactions ceased, many young people experienced heightened loneliness and a sense of disconnection. Virtual communication provided some relief, but the lack of in-person contacts left gaps that were difficult to bridge. For those with strong social networks, friendships became lifelines, with some even breaking lockdown rules to seek comfort in human connection. Conversely, those without these networks found themselves struggling, their sense of isolation deepening over time. The pandemic not only disrupted social lives but also intensified existing mental health conditions. Many young people reported pre-existing struggles with anxiety, depression, eating disorders, and neurodevelopmental conditions such as ADHD or dyslexia, all of which were magnified by the prolonged uncertainty and sudden shift to remote learning. The self-directed learning was challenging for all of the young people at that stage in their life, with the neurodiverse individuals particularly affected. Irrespective of whether the young people were studying or in employment, motivation gradually waned and was hugely impacted. For many, the home environment, once a place of rest. became a site of stress, blurring the lines between personal and academic life.

One of the most striking findings was the tendency of the young people to downplay their own struggles. Many felt that others had it 'worse', leading to a reluctance to seek formal mental health support. When support was pursued, the experiences were mixed; some found it beneficial, while others encountered impersonal, one-size-fits-all approaches that failed to resonate with their unique

situations. Remote mental health services, though convenient, often lacked the emotional connection necessary to foster genuine healing, further alienating some young people from the support they sought. Validation was developed as a critical factor in young people's mental health journeys. There appeared to be a desire to be heard and understood, with young people lamenting the dismissal of their struggles by adults and institutions. Friends often filled this void, providing emotional validation and solidarity in ways that formal systems could not. These informal networks proved invaluable, serving as protective factors against mental health deterioration.

Yet, amidst the struggles, there were glimmers of resilience and self-discovery. For some, the pandemic served as a period of reflection, prompting reassessments of personal values, career aspirations, and life goals. Isolation offered a unique space for introspection, enabling young people to identify coping strategies, develop emotional awareness, and, in some cases, emerge with a stronger sense of self.

Intersectionality played a nuanced role in shaping these experiences, though its impact was not always overtly acknowledged by the young people. While most young people did not explicitly link their intersecting identities to their mental health, their reflections on peers' experiences indicated an underlying awareness of structural inequalities. Socio economic disparities and racial inequalities subtly influenced the pandemic's impact, with some participants recognising their relative privilege compared to peers facing greater adversity. These reflections, though indirect, hinted at a broader understanding of how identity can shape mental health outcomes.

The qualitative findings illustrate the intricate web of factors influencing young people's mental health during the pandemic. Social isolation, pre-existing vulnerabilities, and limited access to appropriate support created a challenging landscape, while intersectionality subtly shaped these experiences. The pandemic highlighted the importance of nurturing social support networks and ensuring mental health services are accessible, validating, and attuned to the diverse identities and experiences of young people.

7.3 Quantitative findings

Demographic statistics for the three Wave cohorts show a consistent composition across the strata variables. There was generally an even split between males and females, and those in the White ethnic group were the most represented (~72%) corresponding with the ethnic group breakdown of the UK population (ONS, 2021d). Most of the young people lived in urban areas. The SDQ scores indicated that the mental health of young people aged 10-15 years in Wave 7 (Wave 7 Youth) was largely classed as normal with 13% falling within the abnormal range. Among individuals aged 16–30 years, 29% in Wave 7 (Wave 7 Adult) exhibited psychological distress based on GHQ-12 scores, increasing to 36% in Wave 13 (Wave 13 Adult).

Results from bivariate analyses demonstrated significant differences in mental health outcomes in the different cohorts based on sex and ethnicity, particularly highlighting heightened psychological distress in females and various ethnic minority groups. Among younger individuals (10–15 years) in Wave 7, those identifying as White, Mixed, or Other ethnicities, living in rural areas and lower income households, had higher SDQ scores, indicating poorer mental health. Similar trends were observed in the older cohort (16–30 years) for GHQ-12 scores in Waves 7 and 13, although household income was less influential.

Multilevel models were employed to further investigate these associations, revealing that ethnic background had a more substantial impact on SDQ scores among younger individuals (aged 10-15 years) in Wave 7, whereas sex emerged as the predominant factor influencing GHQ-12 scores in the older age cohorts in both Waves 7 and 13. The MAIHDA analysis attempted to provide further clarity on how these factors interplay and influence mental health. Although intersectional interactions were present, the majority of variance in SDQ and GHQ-12 scores occurred at the individual level, with additive main effects providing better explanatory power.

Examining the individual strata in each of the cohorts highlighted the importance of sex, ethnic group, household income and urban in the predicted outcome scores. Irrespective of the outcome score (SDQ or GHQ-12) used, the MAIHDA analyses indicated that Black, Asian and Pakistani individuals in Wave 7 living in urban high income households had a predicted lower outcome score and thus better mental health. Unlike for the young people aged 10-15 years, for the older cohorts (16-30 years) sex appeared to be play an important role in mental health, particularly for males. The lowest GHQ-12 scores in Wave 13 were amongst White, Asian and Black males, living in higher income households. Conversely, those with the predicted highest outcome scores and consequently increased risk of poorer mental health or psychological distress were White or Mixed ethnicity individuals. In the younger age group (10-15 years), it particularly was those living in households with the lowest incomes and the older age group (16-30 years), it was females living in urban areas.

Overall, these findings highlight significant additive effects in explaining mental health outcomes, while intersectional interactions play a secondary role. The results support the utility of nuanced analytical approaches such as MAIHDA in understanding the complex interplay of individual and structural factors influencing mental health in young people.

7.4 Integration of qualitative and quantitative findings: a narrative weaving and joint display approach

Drawing on Fetters et al. (2013), the integrated analysis of qualitative and quantitative data demonstrated a strong alignment. Integration in this research was undertaken through two complementary strategies: narrative weaving and joint display. Narrative weaving involves organising

qualitative and quantitative findings around shared themes, allowing points of convergence, divergence and expansion to be discussed within a single interpretive account rather than presenting each strand separately (Fetters et al., 2013). This approach was particularly appropriate for this research because it enabled population-level patterns in mental health to be considered alongside young people's lived experiences of disruption, uncertainty and support. A joint display was then used to present these integrated findings visually, supporting comparison across the two datasets and aiding the development of meta-inferences (Fetters et al., 2013; Guetterman et al., 2015). While these approaches strengthen integration by making connections between datasets more explicit, they also require careful interpretation to avoid privileging one strand over the other or overstating coherence where findings are only partially aligned. In this thesis, the purpose of integration was therefore not to force agreement between qualitative and quantitative findings, but to examine how each strand illuminated different dimensions of young people's mental health during and after the COVID-19 pandemic. This integration highlighted both confirmation, with supportive findings across both strands of the data, and expansion, where qualitative data provided additional insights into the complex lived mental health experiences of young people during the pandemic. The following discussion is organised around five key themes, summarised in the joint display in Table 7.1.

Psychological Distress and Social Isolation Quantitative findings showed that psychological distress among young people aged 16 years and older increased from 29.1% in Wave 7 (2015–2017) to 35.6% in Wave 13 (2021–2023), as measured by GHQ-12 scores. These increases were accompanied by a rise in the average GHQ-12 score from 10.8 to 12.3. The qualitative narratives reinforced these patterns: social isolation, disrupted routines, and loneliness were central themes. Oliver (male, 16 years) and Zayan (male, 22 years) offered detailed accounts of isolation and digital disconnect, with Zayan reflecting 'even though I was with other people, I still felt alone', aligning with the increase in distress observed in the quantitative data. These accounts highlight the extent to which young people's experiences were shaped by the loss of shared social environments. Educational settings, peer groups, and everyday interactions typically provide important contexts through which identity and belonging are negotiated (Jenkins, 2014). Their disruption during the pandemic not only altered routines but also reduced opportunities for young people to situate themselves within these social contexts, contributing to feelings of disconnection and distress.

Intersectional complexity in mental health challenges Quantitative analysis indicated disparities across sex and ethnic groups. For instance, in Wave 13, 65% of females reported psychological distress compared to 35.4% of males; although small numbers, distress was also disproportionately higher among those of Other (57.1%) and Mixed (44.1%) ethnic backgrounds. The qualitative findings shed light on the lived complexity of these disparities. Martha (female, 23 years) recounted the struggles of a close friend who was male, gay and from Zambia, and Florence (female, 21 years) reflected that she may have had a better experience during the pandemic due to her relative privilege

‘I think that’s why maybe I was obviously lucky as, like, a middle-class White person that I didn’t have that experience’. This reflects the value of qualitative data in illustrating the mechanisms underlying statistical trends.

Access to mental health support Although this was not measured in the quantitative data, the increase in distress (GHQ-12 scores) did not appear to correspond with improved support. Qualitative accounts highlighted dissatisfaction with mental health services, particularly remote formats. Emily and Lily, for example, described how support was lacking ‘I did feel there was a real lack of support, especially for sort of people who are my age in school’ (Emily, female, 17 years), and remote support felt impersonal and difficult to engage with, ‘I think as soon as it goes to none face to face it’s kind of useless, for example, it’s so easy to lie about your well-being over the phone as they can’t read your face, they can’t read your expression or your body language’ (lily, female, 22 years). This expands upon the quantitative findings by offering critical perspectives on the perceived usefulness and accessibility of mental health care.

Resilience and reflection While the outcome scores, SDQ and GHQ-12, capture distress prevalence and severity, they do not reflect adaptive coping or how young people bounced back following difficult experiences. Qualitative data added this layer, with participants such as Zayan, Charlotte and Martha shared stories of how the pandemic led them to think deeply about their lives, explore their identities, and set new goals for the future. These reflections often led to increased self-understanding and resilience as Zayan (male, 22 years) described ‘It was it was a huge learning experience… I think going through those sort of emotions and experiences, has made me a better person at the risk of sounding cliché, but I think I learned a lot from it’. Such experiences illustrate aspects of mental health that quantitative data may not be able to capture, offering a broader understanding of how young people coped with the challenges of the pandemic.

Temporal trajectories of mental health Although GHQ-12 scores are measured cross-sectionally within each wave, their comparison over time allows inference of worsening trends. Qualitative data, however, provided real-time, retrospective accounts of changing emotions, feelings and experiences. Initially, some felt hopeful or enjoyed the break from usual routines but as time progressed, many became anxious, tired, and frustrated. These personal stories help explain how the challenges of the pandemic developed and deepened, offering a clearer picture than survey data alone.

Table 7.1. Joint display of qualitative and quantitative findings.

Key Theme	Qualitative Evidence	Quantitative Evidence	Integration Outcome
Psychological distress	Social isolation, disrupted routines, loneliness (e.g., Oliver, Zayan)	GHQ-12: 29.1% (W7) → 35.6% (W13); Mean score: 10.8 → 12.3	Confirmation
Intersectional inequalities	Marginalisation and identity struggles (e.g., Soraya, Will)	Higher distress in females (65%) and Other/Mixed ethnic groups (57.1%, 44.1%)	Expansion
Mental health support	Frustration with remote/ standardised support (e.g., Martha, Lily, Emily)	Distress prevalence remained high despite service availability	Expansion
Resilience and growth	Coping, identity redefinition, reflection (e.g., Soraya, Martha)	Not captured in GHQ-12	Expansion
Temporal trajectories	Retrospective accounts of shifting experiences across pandemic phases	Longitudinal comparison shows mental health outcome scores increase from W7 to W13	Expansion

7.5 Discussion of the key findings in relation to the wider literature

The COVID-19 pandemic and associated lockdowns disrupted societal norms for individuals of all ages, with widespread closures of workplaces, educational institutions, and public spaces, alongside severe restrictions on movement (BBC News, 2020; British Academy, 2021). Research indicates that these disruptions to daily life and reduced social interaction had varying impacts across populations on health and well-being (Tayib, 2024), with young people in particular affected (Montero-Marin et al., 2023). Adolescence is a critical developmental period marked by increasing autonomy, identity formation, and reliance on peer relationships (Blakemore & Mills, 2014; Tanner et al., 2008), and the pandemic interrupted these normative experiences in unprecedented ways.

Numerous studies have examined both the immediate and lasting effects of the pandemic on young people with common themes identified, including heightened anxiety, stress, and pervasive feelings of uncertainty and loss (Cross et al., 2024; McKinlay et al., 2022; O'Sullivan et al., 2021; Pearcey et al., 2024; Peterle et al., 2022; Scott et al., 2021). These outcomes were shaped not only by individual psychological responses but also by broader systemic and contextual factors, including school closures, digital exclusion, disrupted access to mental health services, and increased familial stress. Longitudinal studies and national surveys have confirmed that these effects have endured, with recent data showing that psychological distress among young people remains elevated well beyond the acute

phase of the pandemic (Allen et al., 2023; Corrigan et al., 2024; Devlin, 2024; McCurdy & Murphy, 2024).

The impact of the pandemic was not homogenous. As identified in this research and supported by wider literature, pre-existing health conditions and neurodevelopmental disorders further intensified young people's experiences of distress (Ching, Hahn, et al., 2025; Pearcey et al., 2024). The qualitative data illustrate how disruption to daily routines, educational engagement, and healthcare access created particular challenges for young people managing existing mental health or neurodevelopmental conditions, highlighting how these intersecting vulnerabilities compounded pandemic-related stressors (Creswell et al., 2021; Scott et al., 2021). Social connection was identified as a critical factor throughout the pandemic. A well-established protective factor for adolescent mental health (Blum et al., 2022; Brown & Klute, 2006), the sudden loss or reduction of in-person social interaction profoundly affected young people's ability to cope. Research has consistently shown that loneliness and isolation during adolescence are strongly associated with poorer mental health outcomes (Holt-Lunstad, 2024; Li et al., 2021). This was particularly evident among participants who had limited access to social or digital networks, reinforcing existing inequalities in access to emotional support and digital infrastructure (Judd, 2018; Worsley et al., 2023).

While the dominant narrative has been one of loss and psychological strain, this research, like others by Demkowicz et al. (2024) and Cross et al. (2024), also found that some young people experienced moments of introspection, personal growth, and greater openness around mental health. For a subset of young people, the disruption to routine offered a unique opportunity for self-reflection and re-evaluation of priorities, suggesting that even in the context of crisis, young people displayed adaptive resilience and engaged in positive coping strategies (McKinlay et al., 2022; Stapley et al., 2020). Central to this research was the application of an intersectional lens, recognising that mental health experiences cannot be understood in isolation from the social structures that shape them. As the literature on intersectionality has shown (Bowleg, 2012; Collins & Bilge, 2020), identities such as ethnic group, sex, class, disability, and sexuality do not operate independently but interact to produce complex and often compounding experiences of marginalisation. Although the qualitative data highlighted the difficulty participants had in articulating the influence of intersecting identities, patterns of inequality were apparent in both the narrative and quantitative data. This reflects broader challenges in operationalising intersectionality, particularly in quantitative research, where additive effects often dominate and subtle interaction effects are more difficult to detect (Evans & Erickson, 2019; Evans, Leckie, et al., 2024; Moreno-Agostino et al., 2023). The findings from this research align with and extend the existing body of evidence, demonstrating that the pandemic not only exacerbated pre-existing vulnerabilities among young people but also highlighted critical gaps in mental health support systems. The intersectional approach employed in this research helps to situate young people's experiences within broader structural contexts including health inequalities, systemic

discrimination, and social determinants of health, thereby offering a more comprehensive understanding of how COVID-19 shaped adolescent mental health. The following sections examine these themes in greater detail, focusing on five key domains identified through this research: mental health impact, pre-existing conditions, social connection and support, positive reflections and coping, and intersectionality.

7.5.1 Mental health impact

For many of the young people in this research, the first lockdown was initially perceived in a largely positive light, often described as resembling an extended holiday as reflected in Florence's comment 'I was thinking this is great, this is an extended summer' (Florence, female, 21 years). Life continued but online, homework was undertaken virtually with friends and social gatherings took the form of online quizzes and kitchen discos. Contact with friends and family outside of the household was maintained, albeit reduced, providing the critical support network required during adolescence (Brown & Klute, 2006) and helping young people to know they were 'not alone'. However, as the novelty wore off and restrictions continued, the young people described how they felt it began to take a toll on their mental health. Feelings of anxiety, loneliness, disconnection, and a loss of routine were commonly described, exacerbated by the absence of in-person social interactions. These qualitative findings are consistent with broader research on the psychosocial impact of pandemics. In their rapid review of COVID-19 and previous pandemics such as Ebola and influenza, Meherali et al. (2021) found that young people frequently reported experiencing stress, worry, helplessness, as well as social and risky behavioural problems. These patterns were echoed in several global studies examining the psychological effects of COVID-19 (Hawes et al., 2022; Loades et al., 2020; Racine et al., 2021), as well as in UK based quantitative and qualitative research (Cross et al., 2024; McKinlay et al., 2022; O'Sullivan et al., 2021; Pearcey et al., 2024; Peterle et al., 2022; Scott et al., 2021).

Beyond the immediate emotional impacts, many of the young people also spoke of a more enduring sense of loss associated with 'missed time' and disrupted developmental milestones. Adolescence is typically a period of exploration, growing independence, and relationship building (Blakemore & Mills, 2014; Tanner et al., 2008). Even before the pandemic, today's youth were already navigating a prolonged transition to adulthood (Twenge, 2017); the pandemic appears to have further intensified this by creating what has been described as a 'disconnect between the stage of our lives we feel we are at and the reality of the age and stage we are in' (Hampson, 2023), a phenomenon referred to as the 'pandemic skip' (Schneider, 2023).From the perspective of Social Identity Theory, these missed experiences can be understood as disruptions to the shared contexts in which identity is typically formed and negotiated, including peer groups, educational cohorts, and collective developmental milestones (Jenkins, 2014). The absence of these experiences may therefore have limited opportunities for young people to consolidate a sense of belonging and continuity during a key developmental period. Although such sentiments have been observed across age groups (Coleman &

Lyon, 2023), young people appear particularly affected, with many reporting a sense of loss tied to missed rites of passage and major life events (Macdonald et al., 2024; Scott et al., 2021). This was exemplified by Lily (female, 22 years) who explained ‘So, even though I’m 22 now, I still feel like I’m 18 because those years that I had were lost during lockdown’. The frustration associated with this loss and the lack of acknowledgement by the wider society was evident in the interviews particularly with Lucas and James, who expressed a shared sentiment ‘we lost all those formative years in societies and committee positions and everything else that is so important in that stage of life’ (James, male, 23 years). In the study by Demkowicz et al. (2024), nearly all of the young people (>80) described feelings of loss often associated with normative teenage events such as the last day of school, learning to drive and starting university. Similarly, one parent in the study by O’Sullivan et al. (2021) noted that their daughter felt upset and disappointed at having been ‘robbed of a rite of passage’. Florence (female, 21 years) echoed this view in her interview, stating ‘I feel like I was completely robbed’, believing the COVID-19 pandemic and associated lockdowns had meant she missed out on the best years of her life.

Longitudinal evidence from the COVID-19 lockdown period further reinforces the sustained impact of the pandemic on youth mental health. For example, a year long study exploring psychological wellbeing among university students found persistently high levels of psychological distress, fluctuating over the 12-month period but remaining elevated compared to pre-pandemic baselines (Allen et al., 2023). Although there were signs of recovery in the later stages of the research, coinciding with the gradual easing of restrictions in the UK, distress and anxiety levels had not fully returned to pre-COVID-19 norms. Similar trends were observed in other quantitative analyses, both in general youth populations (Bennett et al., 2022; Newlove-Delgado et al., 2021), and with younger age groups (Shen et al., 2024). Supporting these findings, quantitative data from this research shows an increased proportion of young people reporting GHQ-12 scores above the clinical threshold for psychological distress in Wave 13 (2021/22), compared to pre-pandemic levels in Wave 7 (2015/16). Notably, most young people (24/26) who participated in interviews and focus group also recorded GHQ-12 scores exceeding the clinical threshold. Taken together, these findings indicate a widespread and enduring psychological impact of the pandemic on young people.

7.5.2 Pre-existing conditions

For some, these challenges were further compounded by existing health conditions. Consistent with findings by Ching, Downs, et al. (2025), Scott et al. (2021) and Creswell et al. (2021), young people in this research with pre-existing mental or physical health conditions, as well as those with neurodevelopmental disorders, appeared to encounter heightened difficulties during the pandemic period. Several participants described a loss of control over the management of their conditions, resulting in elevated experiences of anxiety and depression, and in some cases, acute mental health crises. Lily (female, 22 years) reflected on the impact of the lockdowns on her eating disorder

‘lockdown definitely did affect my whole progress and on multiple occasions caused me to relapse’, and for Martha and Will, it was a worsening of their depression as Martha described ‘it got worse, it was already bad, and then it was even worse after [the lockdowns]’ (Martha, female, 23 years) and Will ‘I had to go back on anti-depressants’ (Will, Demiboy, 21 years). The abrupt transition to online learning, coupled with the persistent uncertainty surrounding the pandemic, posed specific challenges for neurodiverse individuals. These participants described difficulties with concentration, feeling overwhelmed, and emotional dysregulation, which in turn adversely affected their motivation, sense of academic progress, and daily routines, including sleep and eating patterns, further compounding the deterioration of their mental health. Moreover, the ongoing changes in lockdown measures, particularly the intermittent closure and reopening of educational and workplace settings, appeared to exacerbate stress and anxiety among this group. These experiences closely reflect those reported in Pearcey et al. (2024) qualitative study of 11–16 year-olds, in which young people with pre-existing conditions similarly identified the unpredictability of restrictions as a significant source of psychological distress.

7.5.3 Social connection and support

In addition to personal and structural vulnerabilities, social factors played a critical role. A key factor underlying these mental health outcomes was the disruption of social connection, a concept broadly encompassing social support, social networks, and the reduction of social isolation and loneliness (Lund et al., 2018). The importance of social connection to both mental and physical health is well established (Holt-Lunstad, 2024), and its absence during lockdowns likely compromised key sources of emotional and developmental support for young people. Given that social connections are fundamental to young people’s well-being and development (Blum et al., 2022), the sudden restriction of face to face contact with peers, family members, and the wider community created significant barriers to maintaining psychological resilience. Notably, the young people in this research (Oliver, Soraya, and Zayan) that struggled to maintain some form of social interaction (digital or otherwise), reported heightened loneliness and emotional distress compared to their peers, as Soraya (female, 19 years) explained ‘it felt even more like lonely in a way because I didn't have like, because obviously you have family support but that's a bit different to having friends who are your age’. This reflects findings by Li et al. (2021), who identified social support as a critical buffer against the negative psychological effects of the pandemic.

Among those participants who experienced difficulties and considered seeking formal support beyond their family and friends, a recurrent theme was the tendency to delegitimise their own struggles. Many young people in this research normalised their distress by framing it within the broader context of shared adversity, reasoning that ‘everyone is facing similar issues’, or by comparing themselves unfavourably to others in more severe circumstances, as Emily (female, 17 years) described ‘I just kind of felt like there were people who were having a lot more difficult time than I was, and said, I

should let them sort of get more support'. This minimisation of personal difficulties is consistent with existing literature on youth mental health. In a systematic review examining barriers to professional help-seeking among young people, over one third of the included studies indicated that young people often preferred to manage their problems independently and expressed uncertainty regarding whether their difficulties were sufficiently serious to warrant professional intervention (Radez et al., 2021). Furthermore, Radez et al. (2021) reported that young people were more likely to seek help when they felt respected, listened to, and not judged. This finding resonates with insights from (Wasson Simpson et al., 2022) as well as the current research, where the young people identified both a fear of being dismissed and actual experiences of not being taken seriously when accessing support services. In particular, school-based support generated mixed responses. While some young people acknowledged efforts made by schools, a common sentiment was that schools fell short in providing adequate mental health support. This perception aligns with the findings of McKinlay et al. (2022) and Pearcey et al. (2024), where in the latter study students also reported feeling abandoned by their schools regarding wellbeing provision.

For those young people who engaged with professional mental health services, support was delivered remotely via telephone or online platforms. However, this mode of delivery appeared to pose significant limitations. The lack of in-person interaction was cited as a barrier to forming meaningful connections, and in some cases, it impeded the effectiveness of the support altogether. Although young people have been characterised as 'digital natives' (Judd, 2018), this does not necessarily translate into a preference for digital modes of mental health support. A number of studies have reported ambivalent attitudes toward remote support from both service providers and recipients. Worsley et al. (2023) found that while both staff and young people recognised advantages to digital delivery, it was 'not for everyone'. Consistent with findings from the present research, remote formats were frequently associated with a loss of rapport and the absence of important non-verbal cues.

7.5.4 Positives

While the dominant narrative surrounding the COVID-19 pandemic and associated lockdowns emphasises the negative effects on young people's mental health, the disruption to daily life also created an unexpected opportunity for introspection and personal growth. As highlighted by Demkowicz et al. (2024), participants in this research reported that the enforced pause in routine activities allowed them time and space to reflect on their lives and re-evaluate. This period of self-discovery led to shifts in both academic and social trajectories, trying out new activities, alongside heightened self-awareness, for example recognising emotional cues. This was highlighted by Lily and Zayan, who reflected 'I think it's helped me identify the threshold for reaching out' (Zayan, male, 22 years). Comparable themes were identified in the qualitative studies conducted by Cross et al. (2024) and McKinlay et al. (2022), where participants described the experience as a process of 're-centring' and gaining a renewed appreciation for their own mental health. This reflective process appeared to

foster greater openness among young people in discussing their mental health with others, an outcome that was also identified in the present research. These behaviours may also be understood as part of how young people coped with the challenges of the pandemic. As discussed by Stapley et al. (2020), young people often use strategies such as finding new activities, learning to accept difficult situations, seeking support (mainly family and friends) and positive thinking. In this context, taking time to reflect and being more open about mental health may have helped them manage stress and adapt to the uncertainty they were facing.

7.5.5 Intersectionality

The concept of intersectionality was central to this research, and the findings underscore the complex interrelations among various social identities in shaping young people's mental health experiences. Many participants in the qualitative component found it difficult to articulate how their intersecting identities (e.g., sex, ethnic group, socioeconomic status) influenced their mental health, a finding that reflects the inherent complexity of applying intersectionality in practice, as noted by other researchers (Rice et al., 2019; Rodó-De-Zárate, 2017; Salami, Bharwani, et al., 2024). In contrast, the quantitative analysis, using MAIHDA, revealed clearer disparities in mental health outcomes. By examining the interplay of sex, ethnic group, household income, and urbanicity, the analysis identified an overall increase in GHQ-12 scores, indicating a deterioration in mental health post-pandemic. This may reflect a combination of factors such as age related increases in psychological distress (Bell et al., 2024; Thorisdottir et al., 2021) and the broader impact of the COVID-19 pandemic. While intersectional factors did contribute to mental health outcomes, the findings suggested that additive effects were more pronounced than interaction effects. This aligns with previous research employing both conventional statistical approaches (Thierry Gagné et al., 2021; Prichett et al., 2024; Terhaag et al., 2021) and MAIHDA, which have similarly found that additive influences, particularly sex, ethnic group, and socioeconomic status, are the dominant contributors to disparities in mental health outcomes (Balloo et al., 2022; Bell et al., 2024; Evans & Erickson, 2019; Kern et al., 2020; Lorthe et al., 2023; McIsaac et al., 2021; Moreno-Agostino et al., 2023; Pilz González et al., 2025). The lack of a substantial presence of interaction effects in all three cohorts should be interpreted cautiously according to Evans, Leckie, et al. (2024). They suggest that the summary statistics (VPC and PCV) may be masking notable interaction effects in some individual strata that could have potential policy or practice relevance. Additionally, the MAIHDA method tends to produce more conservative estimates due to its shrinkage properties, which may explain the absence of interaction effects in the analysis. This shrinkage effect is beneficial in reducing the risk of Type I errors, but it also means that meaningful interactions may not be detectable if the sample size is insufficient to identify small effects (Bell et al., 2019; Ben Van Dusen et al., 2024). It is important to recognise that while only small interaction effects were found in this analysis, this does not necessarily mean they do not have an impact. It may simply be that the research did not have the power to detect these effects in the

population. Finally, the absence of significant interaction effects does not diminish the value of an intersectional framework (Evans, Leckie, et al., 2024). Interlocking systems of oppression still shape distinct lived experiences, and intersectionality remains critical for understanding and addressing inequities, especially in ensuring support for those most affected, regardless of statistical significance.

In this research, females identifying as White, Mixed, or Other ethnic groups generally reported higher mental health scores (GHQ-12 and SDQ), indicative of poorer mental health. Differences were observed across age groups and cohorts (pre- and post-COVID-19), particularly in relation to living in an urban or rural area and household income. In the pre-COVID-19 cohort (Wave 7), those living in rural areas exhibited higher scores, whereas in 2022, those living in urban areas reported worse outcomes. Household income emerged as a significant factor, with young people from lower income households consistently reporting poorer mental health, although the influence of income appeared to diminish with age. This finding aligns with a broad literature base linking socioeconomic disadvantage to adverse mental health outcomes, primarily due to factors such as chronic stress, limited access to support and services, and a greater risk of emotional and social challenges (Marmot et al., 2020).

Studies employing MAIHDA in youth populations have reported similar associations between sex, household income (used here as an indicator for SES), and mental health outcomes. For instance, using data from the National Longitudinal Study of Adolescent to Adult Health, Evans and Erickson (2019) found that females, immigrants, and those from low income households exhibited the highest depression scores. Among the limited studies using MAIHDA during the pandemic, both Moreno-Agostino et al. (2023) and Lorthe et al. (2023) identified poorer mental health outcomes, including increased anxiety and depression, among females and socioeconomically disadvantaged groups (e.g., those experiencing financial hardship or substandard housing). Evidence regarding the relationship between ethnicity and mental health outcomes remains less consistent. Although Black, Asian, and other minority ethnic groups were disproportionately affected by the pandemic (Alcendor, 2020; Kirby, 2020), this was not reflected in the mental health outcomes of the present research, a finding also reported elsewhere (Balloo et al., 2022; Moreno-Agostino et al., 2023). Instead, the results suggested that individuals identifying as White, Mixed, or Other ethnic groups experienced poorer mental health. This apparent discrepancy may reflect lower help-seeking behaviour among Black and Asian communities, which has been widely attributed to cultural stigma, language barriers, mistrust of healthcare systems, and a lack of culturally competent services (Coelho et al., 2022; Mantovani et al., 2017).

This research supports broader evidence that young people’s mental health has deteriorated, before, during, and after the COVID-19 pandemic. Through qualitative methods, it also highlights that the causes of this decline are multiple and complex. However, recent discourse has raised questions about whether this decline reflects a genuine crisis or instead a perceived lack of resilience among younger

generations (Pickles, 2024; Triggle, 2025). In addition to reduced resilience, other proposed explanations include increased mental health awareness and literacy among young people, as well as over diagnosis of mental health conditions (Elgot, 2025; The Economist, 2023). Foulkes and Andrews (2023) have labelled this the 'prevalence inflation hypothesis', arguing that while awareness campaigns improve recognition of serious symptoms, they may also lead individuals to misinterpret everyday distress as clinical mental health problems. This, in turn, can worsen symptoms and fuel further awareness efforts, creating a self-reinforcing cycle. The global nature of this decline has led some to describe it as a 'generational mental health crisis' (Bosurgi & Bhargawa, 2025), a consequence of a multitude of global and local factors that are interconnected. The combination of the COVID-19 pandemic, social media, deepening inequalities in society and crisis in support systems have contributed to worsening mental health in young people creating a 'Perfect Storm' (Duggan, 2021; Lester & Michelson, 2024; Mental Health First Aid England, 2023; Nicholls, 2023). Regardless of ongoing clinical or academic debates, the lived experiences of young people, supported by both quantitative and qualitative findings in this research, show that the pandemic and its associated lockdowns have had a profound and lasting impact on their mental health. Nearly three years since the lifting of major restrictions in the UK (Institute for Government., 2022), these effects remain visible.

CHAPTER 8 CONCLUSION

8.1 Outline of chapter

This final chapter draws together the key findings of this thesis and situates them within the broader academic, methodological, and applied contexts. It articulates the contribution of the research across methodological and theoretical domains, continuing to the implications for policy and practice, recommendations for future research, and reflections on limitations and reflexivity.

8.2 Methodological contribution

This thesis makes a methodological contribution through the application and integration of mixed methods within an intersectional framework to examine young people's mental health during the COVID-19 pandemic. The combination of quantitative analysis using the UKHLS and qualitative data generated through interviews and a focus group enabled both the identification of population-level patterns and the exploration of the lived experiences underpinning these patterns. The use of MAIHDA provided a nuanced way of examining intersecting social identities, allowing for the identification of additive effects across sex, ethnicity, household income and urbanicity. However, as demonstrated in this research, quantitative approaches alone were limited in their ability to explain how these patterns were experienced and interpreted by young people. The qualitative component addressed this by providing depth and context, enabling a more comprehensive understanding of mental health experiences during the pandemic.

A further methodological contribution lies in the integration of qualitative and quantitative data. As discussed in Chapter 7, this was achieved through narrative weaving and the use of a joint display. This approach enabled findings from both strands to be brought together in a coherent and transparent way, supporting the development of meta-inferences while maintaining the integrity of each dataset. In doing so, the thesis demonstrates the value of mixed methods approaches in capturing the complexity of young people's mental health, particularly when examined through an intersectional lens. Beyond these methodological contributions, this research also makes a contribution to theoretical understandings of young people's mental health.

8.3 Theoretical contribution

This thesis contributes to theoretical understandings of young people's mental health by applying and critically engaging with intersectionality and the social determinants of health. Together, these frameworks enabled an examination of how structural inequalities shape mental health outcomes, while also recognising the broader social, economic, and environmental contexts in which young people's lives are situated.

The findings support existing literature which highlights that mental health is not solely an individual experience but is shaped by intersecting social positions and structural conditions. The quantitative analysis demonstrated that additive effects of sex, ethnicity, household income and urbanicity were significant in predicting mental health outcomes, reinforcing the importance of structural inequalities. At the same time, the qualitative findings provided insight into how these inequalities were experienced in everyday life, including through access to support, social relationships, and perceptions of self-worth.

However, the analysis also highlighted some limitations in the application of intersectionality at the level of individual experience. While structural inequalities were evident, young people did not always explicitly articulate their experiences in intersectional terms. In these instances, Social Identity Theory was useful in helping to interpret how young people understood themselves in relation to others, particularly through processes of comparison, belonging, and perceived norms. This was evident, for example, in how participants minimised their own distress by comparing themselves to others who they perceived to be worse off.

In addition, the findings relating to disruption during the pandemic, described in this thesis as a form of ‘pandemic skip’, highlight how the interruption of normative life experiences shaped young people’s sense of identity and future orientation. While this concept is grounded in the empirical data, it also speaks to broader theoretical discussions about identity development during adolescence and the role of social context in shaping this process.

8.4 Implications for policy and practice

The methodological strengths and limitations of this research have been discussed in Chapter 3 and should be considered when interpreting the implications of the findings. This research has several important implications for policy, practice, and research. One of the most significant findings is the inadequacy of current mental health services to meet the diverse and intersecting needs of young people. The research demonstrated that many young people experienced mental health support as impersonal, poorly tailored, or inaccessible, particularly during the COVID-19 pandemic. These findings underline the necessity for mental health services that are ‘youth-friendly’, meaning they are inclusive, responsive, and attentive to the individual experiences and social identities of young people (National Children's Bureau, 2021; Office for Health Improvement & Disparities, 2023). Approaches, such as the THRIVE Framework (Wolpert et al., 2019) in the UK, that move beyond one-size-fits-all service delivery models and incorporate greater flexibility, cultural competence, and validation of lived experience are essential.

The research also highlights the need for structural and systemic interventions that address the upstream determinants of mental health. Through the lens of intersectionality, it became apparent that

social inequalities, such as poverty, discrimination, and limited educational opportunities, exert a significant influence on mental health outcomes, even if these effects were not always consciously acknowledged by the participants. Policy interventions, therefore, must go beyond clinical support to also address these broader determinants through measures such as income support, educational equity, and anti-discrimination legislation (Hagell et al., 2018; Marmot et al., 2020).

Emotional validation was identified as a particularly important factor for young people seeking support. Many participants described feeling unheard or dismissed, particularly when engaging with formal mental health services. As such, professionals working with young people should prioritise relational approaches that foster trust, empathy, and authenticity. This is consistent with literature demonstrating that help-seeking among youth is hindered by fears of judgment and invalidation, and that supportive, validating relationships significantly improve outcomes (Radez et al., 2021; Wasson Simpson et al., 2022). Given the critical role that informal networks, especially friendships, play in protecting mental health, mental health strategies should consider how to support and legitimise these forms of peer support. Schools have an important role to play in this regard, yet participants in this research expressed ambivalence about school based mental health provision. This suggests a need for significant investment in schools' capacity to provide mental health support that is youth centred, adequately resourced, and informed by the voices of young people themselves (Richter et al., 2022).

The sustained psychological distress evident in the quantitative data indicates that the impact of the pandemic is enduring, necessitating long term mental health support strategies for young people. Importantly, the findings suggest that young people’s mental health needs to be understood within the broader social ecology, not simply as isolated individual pathology. Moreover, while the research found that additive effects (e.g., sex, ethnic group and household income) were more predictive of mental health outcomes than interaction effects, the intersectional framework nonetheless proved valuable. Even where statistical interactions were not pronounced, the qualitative data captured the nuanced ways that overlapping identities and systemic forces shaped mental health experiences. This supports arguments made by intersectionality theorists that the absence of statistical interaction effects does not negate the significance of structural inequality in shaping outcomes (Evans, Leckie, et al., 2024). The mixed methods approach adopted in this research, combining MAIHDA with qualitative interviews, represents a valuable contribution to intersectional mental health research and demonstrates the utility of integrated methodological designs in enabling a more nuanced understanding of complexity (Bell et al., 2024).

8.5 Recommendations for future research

Building on the findings of this research, several avenues for future research are recommended. There is a clear need for longitudinal research that examines the longer-term impact of the COVID-19 pandemic on young people’s mental health, particularly as they transition into adulthood. While this

research provides insight into experiences during and shortly after the pandemic, the enduring effects remain unclear.

Further research is needed to explore intersectionality using both qualitative and quantitative approaches. While this research demonstrated the value of combining MAIHDA with qualitative methods, there remains scope to develop approaches that better capture interactional effects and lived experiences of intersecting identities. Although this research included sex, ethnic group, household income, and urbanicity, other important identities such as sexual orientation, gender identity, disability, and migration status were excluded due to data limitations. Inclusion of these dimensions would allow for a more comprehensive analysis of the social determinants of mental health. Additionally, more nuanced and multidimensional indicators of socioeconomic status, such as parental education, occupational class, or material deprivation, would better capture the complexities of young people's economic environments.

Future research should also strive to address the limitations related to representation and generalisability. The qualitative component of this research was conducted in a single city and comprised a largely White, middle-class sample. This limits the applicability of the findings to other racialised groups or regional contexts. Recruiting more diverse and nationally representative samples will be essential for building a more complete picture of how mental health is shaped across different identities and environments. There is also scope to more fully involve young people throughout the research process. Although participants contributed to the design of the research, a more robust co-participatory or co-production approach could enhance both the relevance and impact of future research. Engaging young people as collaborators rather than subjects would better reflect the principles of intersectionality and empower marginalised voices in shaping mental health research and policy. As others have argued, involving young people in designing mental health services and social support is critical to ensuring those services are responsive and effective (Bell & Pollard, 2022; Wright et al., 2024). This is particularly important for those at the intersections of multiple forms of disadvantage, who may otherwise continue to be underserved.

Finally, there are opportunities for further methodological innovation. While MAIHDA provided a powerful tool for examining additive and interaction effects, its effectiveness is dependent on sample size and the richness of available data. Future studies could explore the use of larger datasets and finer grained identity categories to enhance the detection of subtle interaction effects. Integrating quantitative approaches such as MAIHDA with more in-depth qualitative methods could further strengthen understanding of how social identities and structures influence mental health. Such methodological pluralism would not only strengthen the evidence base but also help bridge the gap between individual lived experience and structural determinants of mental health.

8.6 Limitations

While methodological considerations have been addressed in Chapter 3, it is important to critically reflect on a number of broader conceptual and contextual limitations that shape the interpretation of the findings presented in this research.

The research draws on measures of mental health that are primarily based on self-reported psychological distress. While this allows for the identification of patterns at scale and captures subjective experiences, it does not provide clinical diagnoses and may not fully reflect the complexity or variability of mental health conditions. As such, the findings are better understood as capturing experiences of distress and wellbeing rather than clinically defined disorders. This distinction is particularly important when considering the diversity of ways in which young people understand and articulate their mental health.

The focus on young people at a particular stage of the life course also shapes the scope of the findings. Adolescence and early adulthood are periods characterised by rapid social, emotional, and developmental change, and while this makes them critical for the study of mental health, it also introduces variability that is difficult to fully account for. The experiences presented in this thesis may therefore not be directly transferable to younger children or older adult populations, and even within the sample there are differences in life stage and circumstance that influence how the pandemic was experienced.

The use of an intersectional framework provided a valuable lens through which to examine structural inequalities; however, the research also highlights some of the challenges associated with its application. While the quantitative analysis identified clear additive effects across social categories, interactional effects were less evident, reflecting wider methodological challenges in operationalising intersectionality. In the qualitative data, although structural inequalities were present, participants did not consistently articulate their experiences in explicitly intersectional terms. This required interpretive work on the part of the researcher and points to a broader limitation in applying structural frameworks to individual narratives. In this context, SIT offered a useful complementary perspective, particularly in understanding how young people positioned themselves in relation to others through processes of comparison and belonging. However, the use of multiple theoretical lenses also introduces complexity, and there remains a degree of tension in reconciling structural and social-psychological explanations.

The research is also situated within the specific context of the COVID-19 pandemic, a period of unprecedented disruption. While this provides important insight into young people's experiences during a unique historical moment, it also limits the extent to which the findings can be generalised beyond this context. The disruption to education, social relationships, and everyday life was

exceptional, and the ways in which young people responded may not fully reflect experiences in more typical circumstances.

Finally, while the mixed methods design enabled a more comprehensive understanding of young people's mental health, integrating qualitative and quantitative data presents inherent challenges. Although narrative weaving and joint display approaches were used to support integration, there remains the possibility that differences between datasets were not fully explored or that one strand was foregrounded over the other in the interpretation of findings.

8.7 Reflexivity

8.7.1 Understanding adolescence and mental health

At the outset of this research, my understanding of young people's mental health was shaped primarily by personal experience, both from my own adolescence and through observations of my daughter, who was 14 years old at the time. In retrospect, I recognise that these perspectives were limited, and that the memories I drew upon from my youth were likely to be both selective and, in some cases, distorted (Lacy & Stark, 2013). As I engaged more deeply with the literature, my awareness of the complexities of adolescence grew. I began to appreciate adolescence not simply as a transitional phase, but as a critical period within the life course marked by profound biological, psychological, and social changes. These transformations, coupled with ever-shifting societal expectations, were understood as key factors influencing young people's behaviours, attitudes, and mental health. While I had some awareness that such factors could impact mental health, I had not fully grasped the extent or intricacy of these influences. Subconsciously, I had developed a binary view: I perceived young people with severe mental health conditions as having experienced significant adversity, whether through traumatic events, socioeconomic disadvantage, or genetic predisposition. Conversely, I viewed those experiencing less severe symptoms, such as anxiety, as dealing with issues that were more manageable and comparatively minor. These assumptions were largely informed by anecdotal accounts and representations in the media, rather than empirical evidence.

As my knowledge base expanded over the course of the research, my perceptions began to shift. I moved away from compartmentalising mental health conditions and instead began to understand them as embedded within the broader, dynamic context of adolescence. This re-conceptualisation became particularly salient during a conversation with my daughter. In a situation that might previously have escalated into a heated argument, I responded with greater patience and empathy, recognising the multiple pressures she was experiencing. The outcome was notably different: rather than ending in conflict, the discussion concluded with mutual understanding. On reflection, this moment made clear how my evolving perceptions, shaped by both academic insight and ongoing reflexive practice, were

not only influencing my research approach but also transforming my personal relationships and everyday interactions.

8.7.2 Understanding intersectionality

In a similar way, my understanding of intersectionality at the outset of this research was also limited. Although I was broadly aware that factors such as ethnicity, socioeconomic status, and sex could influence mental health outcomes, I had not yet encountered these ideas through the lens of intersectionality, nor had I consciously reflected on how different aspects of identity interact to shape lived experiences. My thinking at the time was fragmented, I could recognise individual dimensions of inequality, such as the impact of poverty or racism, but I had not yet developed a framework for understanding how these forces compound and intersect. I had encountered intersectionality as a term, but only superficially, and certainly not in a way that enabled me to apply it meaningfully in a research context. Engaging with the theoretical literature on intersectionality presented a steep learning curve. It challenged me not only to grasp complex and often contested conceptual debates, but also to consider how intersectionality might be operationalised within both quantitative and qualitative research designs. This process was as intellectually demanding as it was transformative. As I began designing the qualitative component of the research, particularly the interview questions, I found myself increasingly aware of how the multiplicity of identities including sex, ethnicity, class, sexuality, and ability, shape mental health in ways that are not easily reducible to single categories. This growing awareness influenced how I framed the research questions, the interviews and focus group with young people, and how I reflected on my own positionality throughout the research process. Crucially, this learning was not confined to academic spaces. During informal conversations about the research with peers, I found myself better able to articulate the concept of intersectionality in accessible terms and to acknowledge my own position within these intersecting structures. Recognising this helped me to remain attuned to the asymmetries of power and privilege embedded in both the research process and the everyday lives of the young people I was trying to understand.

8.7.3 Steep quantitative learning curve

While I initially viewed the quantitative phase of the research as the most manageable, it ultimately proved to be one of the most challenging. Entering the research, I felt more confident in my quantitative skills than in any other aspect of the research. I perceived quantitative analysis as relatively straightforward producing answers that are either right or wrong, with little ambiguity. This stood in contrast to the qualitative phase, which with prior experience, felt as more interpretive, less certain, and requiring a different kind of intellectual agility. However, the reality was far more complex. Although I had some experience with statistical analysis, I had not engaged with it for some time. Building the analysis in stages was conceptually and technically demanding. MAIHDA, in

particular, was unfamiliar and introduced a steep learning curve. While generating the outputs was manageable, interpreting them was far more difficult than I had anticipated.

This process challenged my assumptions about quantitative research being ‘black and white.’ I found myself revisiting techniques, repeating steps, and seeking additional support especially from my supervisor. In hindsight, I recognise that I delayed asking for help at times, influenced by a desire to prove competence. This slowed my progress and added unnecessary pressure. This experience deepened my appreciation of quantitative research as interpretive in its own right.

8.7.4 Emotional qualitative rollercoaster

I approached the interviews and particularly the focus group with a sense of trepidation. Despite having prior experience in qualitative research, I had never engaged directly with young people in this context, and I found myself grappling with multiple layers of uncertainty. I worried about whether young people would want to take part, whether I was casting the recruitment net wide enough to engage a diverse and representative cohort, and whether participants would feel able to speak openly about deeply personal experiences, especially those relating to mental health. I was also concerned about my ability to capture the intersectional dimensions of their identities, how different aspects of who they are might shape or compound their experiences of mental health. These apprehensions were accompanied by a growing awareness of the power dynamics and privilege embedded in the researcher-participant relationship. By that stage of the research, my understanding of structural inequalities had deepened significantly. I became increasingly mindful of my own position as a white, middle-class, university-educated, heterosexual woman in her late 40s, with the relative privilege of a stable home life and the ability to work from home during the pandemic. While these factors had presented challenges, they also afforded me a degree of safety and support not necessarily available to the young people in the research. As discussed in Chapter 3, I adopted a reflexive approach to participant engagement, recognising the importance of positionality in shaping the research encounter. What followed was a humbling experience. The young people who took part in the interviews and especially the focus group, were far more open and confident than I had anticipated. In comparison to adults I had interviewed in the past, they were less guarded, more articulate, and incredibly generous with their insights. The focus group, in particular, was an experience I will never forget. It left the deepest impression on me as a researcher and as a person. The group was composed of young people from a specialist mental health support programme, many of whom had experienced significant distress, including acute mental health crises. Observing an earlier session led by another researcher prompted me to think more creatively about how to make the focus group both inclusive and engaging.

Yet the emotional intensity of the group was profound. Some participants arrived with visible signs of self-harm, and two had to leave midway through due to distress (not due to the focus group). I left the

session feeling helpless and overwhelmed. For the first time in my career, I wanted desperately to help but yet felt entirely unable to do so.

That feeling has stayed with me. It made me reflect not only on the weight of young people's experiences, but on the ethical and emotional responsibilities of conducting research in this space. While I am deeply committed to working with young people in the future, I often return to that focus group and wonder whether I have the emotional resilience to carry such stories. It is both a burden and a privilege, and one that I am still learning how to hold.

8.8 Dissemination plans

This research has clear potential for dissemination across academic, policy, and practice audiences. The findings contribute to ongoing discussions around young people's mental health and the impact of the COVID-19 pandemic and will form the basis of at least one manuscript for submission to a peer-reviewed journal such as the Journal of Adolescent Health, BMC Public Health, or Social Science & Medicine. In addition, findings will be presented at relevant academic and practitioner-focused conferences to support wider dissemination and engagement.

From the outset of the research, dissemination was considered as an integral part of the study design. During the recruitment phase, discussions with CHILYPEP emphasised the importance of ensuring that findings are shared in ways that are meaningful and accessible to young people. In line with this, there is a clear intention to return to the STAMP group to share the findings of the PhD and to work collaboratively with young people to co-develop age-appropriate outputs. These may include visual summaries, digital content, or other formats that reflect the preferences and priorities of the group. This co-produced approach to dissemination is intended to ensure that the findings are not only accessible but also relevant to the communities from which the data were generated. Outputs developed with the STAMP group will be shared with Sheffield City Council and local youth organisations to support ongoing work in young people's mental health. There is also potential for wider dissemination through regional networks, such as the South Yorkshire Children and Young People's Health Research (SCYPHeR) group, providing an opportunity to extend the reach of the research and contribute to broader conversations about youth mental health across South Yorkshire.

8.9 Conclusion

This PhD thesis has examined young people's mental health before, during and after the COVID-19 pandemic through a mixed methods, intersectional lens. The findings provide compelling evidence that the pandemic exacerbated pre-existing vulnerabilities, with heightened psychological distress observed in both qualitative accounts and population-level data. The research highlights the complex and interconnected influences of sex, ethnic group, household income, and urbanicity on mental

health, indicating that while additive effects dominate statistically, intersectional dynamics shape lived experiences in important ways.

The application of MAIHDA alongside in-depth qualitative approaches represent a novel methodological contribution. While quantitative findings identified key predictors, qualitative insights enhanced this understanding by contextualising how young people experienced, interpreted, and navigated their mental health challenges. These insights underscore the value of integrating statistical models with narrative accounts to better capture the realities of young people. Crucially, this research amplifies the voices of young people, many of whom felt underserved by formal mental health systems and more supported by peers, and highlighted the importance of validation, trust, and appropriate support. These insights call for more inclusive, structurally-informed approaches to mental health for young people in both policy and practice. Intersectionality provides a vital framework for understanding disparities, combining this with different methodological approaches can help ensure the complexity of young people's mental health is recognised and addressed.

CHAPTER 9 APPENDICES

Appendix 1: Research poster

YOUNG PEOPLE NEEDED!

Did you feel that your mental well-being - your **feelings**, **thoughts** and **behaviour**, was affected during COVID-19?

In this research study, we want to help understand how, and how this may have been influenced by your identity.

WHO?

- **Young people aged between16-24 years**
- **Live in Sheffield**
- **Felt your mental well-being was impacted during COVID-19**

WHAT?

- Short online questionnaire
- 60-minute interview (either online or in-person)
- £20 high-street shopping voucher to say thank you

Scan the QR code to register your interest!

MORE INFORMATION

Maxine Kuczawski at **mkuczawski1@sheffield.ac.uk**, or visit **https://tinyurl.com/29s34exs** to register your interest.

This study has been reviewed by the Department of Sociological Studies Research Ethics Committee, University of Sheffield Ref. 049340.

Participant poster v3 (21/02/2023)

Appendix 2: Participant information sheet

MENTAL HEALTH AMONG YOUNG PEOPLE: AN INTERSECTIONAL PERSPECTIVE

INFORMATION SHEET FOR YOUNG PERSON

You are invited to take part in a research study exploring the experiences of mental well-being in young people during the COVID-19 pandemic.

Before you decide whether you would like to take part, it is important for you to understand *why* the study is being done and *what* it will involve.

Please read this leaflet carefully. You can talk about it with your family, friends or us.

Ask if there is anything you don't understand or if you want more information.

Take time to decide whether or not you want to join in.

Thank you for reading this!

WHY IS THIS STUDY HAPPENING?

The COVID-19 pandemic and the many lockdowns meant we all had to change the way we lived our lives. For many people, they could not go to school or work, spend time with friends or undertake their usual activities such as sports. Everyone experienced this time differently but it is likely that everyone, at one time or another, felt some sort of worry, loneliness, fear or stress. This reason for this study is to try and understand how young people such as yourselves experienced the COVID-pandemic and lockdowns. What sorts of feelings did you have and how did you manage these? Did you speak to anyone about how you felt and did that help? And if you didn't, why not?

By gathering this sort of information, a picture can be built of what you experienced, this can help to inform guidance and support for young people in the future.

WHO CAN TAKE PART IN THE STUDY?

Young people **aged between 16 and 24 years**, who live in **Sheffield** and who at one time or another during the COVID-19 pandemic, felt their **mental well-being may have been impacted**. This could range from not being able to sleep properly or concentrate to feelings such as worry, loneliness, fear or stress.

DO I HAVE TO TAKE PART?

No! It's totally up to you.

IF I AGREE TO TAKE PART, CAN I CHANGE MY MIND?

Yes. If you do decide to take part but change your mind later, you can leave the study up to one week after your interview without giving any reason. After this time, it will not be possible to delete the data collected from you as your identifying information (name) will have been removed and combined with other data for analysis.

WHAT WOULD I BE ASKED TO DO IF I TAKE PART?

If you want to take part in the study, you will be asked to fill in a short questionnaire which will indicate if you can take part in the study. Following this, you will then need to complete a consent form to show that you agree to take part. You can do this at home and post it to us, (a stamped addressed envelope can be provided)

or you can email it, or fill in a consent form on-line. If you are aged 16 or 17 years old, your parent or guardian will also have to sign the consent form.

Maxine Kuczawski, the lead researcher, will contact you to arrange a time to talk with you. The interview will take place either face to face in a place familiar to you, online using Google Meet or by telephone. For online interviews, you will need a computer, labtop or mobile phone with internet access. The interview is expected to last no longer than 1 hour.

At the start of the interview, Maxine will introduce herself and make sure you are happy to continue. You will then be asked questions about your thoughts and experiences of the Covid-19 pandemic and the lockdowns, if and how your mental well-being were affected, and if you sought any support to help you. There are no right or wrong answers, and you do not have to answer any questions you do not want to. The interview will be recorded and what you say will be used for the study analysis, but you will never be identified, your name and contact details will always be kept private.

What are the possible benefits, disadvantages, and risks of taking part?

Your views are valued and taking part will give you the opportunity to tell your 'story' and have your voice heard. It is important that the views of young people are listened to so that life experiences can be shared and understood. It is hoped that the findings from this study will provide an increased understanding about the experiences of young people and their mental well-being during the COVID-19 pandemic, and help to inform support services for young people in the future.

Everyone who participates in the study will be offered a £20 high street shopping voucher at the end of the interview to thank them for their time and effort.

It is possible that thinking and writing about any difficulties you have experienced during the COVID-19 pandemic could make you feel uncomfortable or upset. If this is the case, you can stop at any time for a break, or leave the interview altogether. Information of organisations where you can get further help and support will be made available to you.

Will my taking part in this study be kept confidential?

It is very important that all the information you give is **completely private**. However, if you tell us something that makes us worried about your safety, we may have to discuss this with somebody else as we need to be sure you are safe. This means, what you say would not be kept completely private.

The recording of the interview will only be accessible to Maxine Kuczawski, as the lead researcher. All of the study data will be stored securely in an folder on a secure server at the University of Sheffield.

What will happen to the data collected, and the results of the study?

Your identifiable data (name and contact details) will only be used to contact you about the study. The interview will be recorded, and then written out and checked, but your name and any other information that might identify you will be taken out. The recordings will be deleted as soon as possible, and the research data will be deleted 10 years after the project ends.

Who is organising and funding the study?

The study is organised by Maxine Kuczawski, the lead researcher, as part of a PhD undertaken at The University of Sheffield.

Who is the Data Controller?

The University of Sheffield will act as the Data Controller for this study. This means that the University is responsible for looking after your information and using it properly.

Who has ethically reviewed the project?

Ethical approval means that this study is safe to carry out on young people. The study has been approved by the Department of Sociological Studies Research Ethics Committee (REC No. 049340).

What should I do if I have a problem with this study?

If you have any problems with this study, please contact Maxine Kuczawski, the lead researcher. The contact information for Maxine is at the end of this information.

If you feel you have not been listened to, you can contact the research Supervisor, Professor Alan Walker (Email: a.c.walker@sheffield.ac.uk) or Lindsay Unwin, Research Ethics and Integrity Manager (Email: l.v.unwin@sheffield.ac.uk; Telephone: 0114 222 1443) who will then ensure your complaint is heard properly through the appropriate channels.

Contact for further information

Name:	Maxine Kuczawski, Lead Researcher
E-mail:	mkuczawski1@sheffield.ac.uk
Address:	Department of Sociological Studies, The University of Sheffield, Western Bank, Sheffield S10 2TN

Appendix 3: Participant information sheet – short

MENTAL HEALTH AMONG YOUNG PEOPLE: AN INTERSECTIONAL PERSPECTIVE

INFORMATION SHEET

WHAT IS THIS ABOUT?

You are invited to take part in some research. I am a student, and my research is with the University of Sheffield.

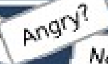
I want to know more about **young people** and how they coped during the COVID-19 lockdowns. I want to know about their mental wellbeing - their **feelings, thoughts** and **what they did** during the COVID-19 lockdowns. I **need your help** to find this out.

WHY IS IT HAPPENING?

The COVID-19 pandemic and the many lockdowns meant we all had to change the way we lived our lives. Everyone experienced this time differently, with many mixed feelings such as loneliness, fear or stress.

Understanding young people's thoughts and feelings during this time, and if they spoke to anyone about them can help to improve support for young people in the future.

WHO?



Nervous?

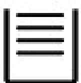
Depressed?

Sad?

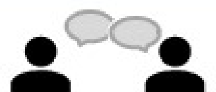
Lonely?

Young people aged between **16 and 24 years**, live in **Sheffield** and who also felt they were **impacted by the COVID-19** lockdowns.

WHAT DO I NEED TO DO?

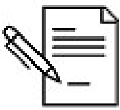


1. Read this sheet



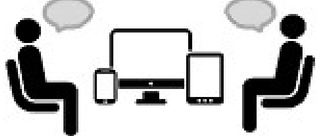
2. Talk to your parent(s)/ guardians about if you are happy to take part.

3. Decide if **you** are happy to take part. If you are, you will...



4. Need to **read and sign** a consent form

5. Be contacted to **arrange a date, time and place** to talk to the researcher



6. Chat face to face or online about your mental wellbeing during the COVID lockdowns

✷Parental consent is also required for young people aged under 18 years ✷

Participant Information Sheet Short v2 (30/09/2022) Page 1 of 2

IMPORTANT INFORMATION

Do I have to take part?

No! It's totally up to you.

If I agree to take part, can I change my mind?

Yes!

Why should I help?

It will give you the opportunity to tell your 'story' and have your voice heard. It is important that the views of young people are listened to so that life experiences can be shared and understood. What you say will help researchers in the future.

Everyone who participates in the study will be offered a £20 high street shopping voucher at the end of the interview to thank them for their time and help.

What are the possible risks of taking part?

It is possible that thinking and writing about any difficulties you have experienced could make you feel uncomfortable or upset. If this is the case, you can stop at any time for a break, or leave the interview altogether.

Will my taking part in this study be kept private?

It is very important that all the information you give is **completely private**.

Your name and contact details will only be used to contact you; they will not be used anywhere else.

The interview will be recorded so that I can write up what we talked about. The recording will then be deleted.

All of the information collected will be stored in a safe place that is password protected, at the University of Sheffield. Only me, the lead researcher, will be able to see it.

The only time what you say might not be kept private is if you say something that makes me worried about your safety, I may have to discuss this with somebody else to make sure you are safe.

Who is doing the study?

Maxine Kuczawski is the lead researcher of the study as part of a PhD. The University of Sheffield has approved the research (REC No. 049340) and will make sure the research is undertaken properly.

Any further questions?

Contact **Maxine Kuczawski** (mkuczawski1@sheffield.ac.uk), Department of Sociological Studies, The University of Sheffield, Western Bank, Sheffield S10 2TN.

Appendix 4: Guardian information sheet

MENTAL HEALTH AMONG YOUNG PEOPLE: AN INTERSECTIONAL PERSPECTIVE

INFORMATION SHEET FOR PARENT/ GUARDIAN

Your child has been invited to take part in a research study. Please take time to read the following information carefully before you decide whether or not your child can take part. Talk to others about the study if you wish or ask Maxine Kuczawski, the lead researcher, if there is anything that is not clear or if you would like more information. Thank you for reading this.

ABOUT THIS STUDY

The COVID-19 pandemic and the many lockdowns meant we all had to change the way we lived our lives. For many people, they could not go to school or work, spend time with friends or undertake their usual activities such as sports. Everyone experienced this time differently but it is likely that everyone, at one time or another, felt some sort of worry, loneliness, fear or stress.

This research study is exploring how young people experienced the COVID-pandemic and lockdowns, their feelings, how they coped and if they sought any support. By gathering this sort of information, a picture can be built of what they experienced so that guidance and support for young people can be informed and improved in the future.

WHO CAN TAKE PART IN THE STUDY?

Young people aged **between 16 and 24 years**, who **live in Sheffield** and who at one time or another during the COVID-19 pandemic, felt their **mental well-being may have been impacted**. This could range from not being able to sleep properly or concentrate, to feelings such as worry, loneliness, fear or stress.

Parental consent is required for young people aged under 18 years to take part in this study.

DO THEY HAVE TO TAKE PART?

No. Taking part is entirely voluntary. It is up to both of you to decide whether or not your child will take part; choosing not to take part will not disadvantage you or your child in anyway.

Should you wish, the researcher is happy to go through this information sheet with you on the phone, and provide further information. Your child will be provided with information about the study too, and the researcher can talk through any questions that they may have before deciding to take part in the study.

If you agree that your child can take part, you will be sent a copy of the consent form which you will both need to complete and sign, to show that you have agreed. Your child will be able to withdraw up to one week after their interview; thereafter their information will have been combined and analysed with that of other participants. Withdrawal from taking part in the study can be done without giving any reason, and without any negative consequences.

WHAT WILL HAPPEN IF MY CHILD TAKES PART?

Your child will then be invited to take part in a one-off interview with the lead researcher.

During the interview, the focus will be on their experiences of the Covid-19 pandemic and the lockdowns, how their mental health well-being was affected, and if any support was sought.

Young people's views are valued and taking part will give your child the opportunity to tell their 'story' and have their voice heard. However, they should not feel any pressure to share anything that they do not want to, or anything that makes them feel distressed or uncomfortable. Before the start of the interview, the

researcher will check again that your child is happy to take part. It will be made clear there are no right or wrong answers, that they do not have to answer any questions they do not want to, and that they can stop the interview at any time. If they agree, the interview will be recorded so that it can be written up afterwards but your child will never be identified. Name and contact details will always be kept private.

The interview will be expected to last no longer than 60 minutes, and will be relaxed so that your child can talk about the topic in their own way. The interview will take place either face to face in a place familiar with your child, online using Google Meet or by telephone. For online interviews, a computer, labtop or mobile phone with internet access will be needed.

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART?

There will be no direct benefit to you or your child other than for your child to be able to share their views and experiences. Taking part will help to increase understanding about the experiences of young people and their mental well-being during the COVID-19 pandemic, and help to inform support services for young people in the future.

WHAT ARE THE POSSIBLE DISADVANTAGES AND RISKS OF TAKING PART?

It is possible that thinking and writing about any difficulties that may have been experienced during the COVID-19 pandemic could make your child feel uncomfortable or upset. If this is the case, your child can stop the interview at any time for a break, or leave the interview altogether. Their wishes will be respected in all circumstances and without question. Information of organisations where further help and support can be found will be made available to your child.

WILL THERE BE PAYMENT?

To recognise the time and efforts, and to say thank you, we will offer your child a £20 high street shopping voucher for their involvement in an interview.

WILL MY CHILD'S TAKING PART IN THIS STUDY BE KEPT CONFIDENTIAL?

Yes. All information about your child collected during the study will be kept **strictly confidential** and stored in accordance with the Data Protection Act, except if they raise a safeguarding issue. If your child raises concerns or any safeguarding issues (for example, if they tell the researcher something that is a child protection concern), this information will have to be passed on. The researcher will inform the designated safeguarding officer (Professor Alan Walker, Main Supervisor) immediately and the local safeguarding authority or police will be informed for further investigation.

The identifiable data (name and contact details of young person) will only be used to contact your child about the study, all other research data will have a code name so your child cannot be identified. Only the researcher will be able to see this information which will be stored securely at The University of Sheffield.

WHAT WILL HAPPEN TO THE DATA COLLECTED, AND THE RESULTS OF THE STUDY?

The recording of the interview with your child will be deleted once it has been written up and checked. The final results of the study will be written in such a way that it is not possible to identify the young people that took part in the interviews.

It is expected that the results of the study will be shared locally, nationally and internationally through journal papers and presentations to other researchers. This is to inform future policies and practices on how mental health support can be improved for young people.

The research data will be deleted 10 years after the project ends, as per the University of Sheffield policy.

WHO IS ORGANISING AND FUNDING THE STUDY?

The study is organised by Maxine Kuczawski, the lead researcher, as part a PhD undertaken at The University of Sheffield.

WHO IS THE DATA CONTROLLER?

The University of Sheffield will act as the Data Controller for this study. This means that the researcher approved by the University of Sheffield is responsible for looking after your child's information and using it properly.

WHO HAS ETHICALLY REVIEWED THE PROJECT?

Ethical approval means that this study is safe to carry out on young people. The study has been approved by the Department of Sociological Studies Research Ethics Committee (REC No. 049340).

WHAT SHOULD I DO IF I HAVE A PROBLEM WITH THIS STUDY?

If you have any problems with this study, please contact Maxine Kuczawski, the lead researcher.

Name:	Maxine Kuczawski, Lead Researcher
E-mail:	mkuczawski1@sheffield.ac.uk
Address:	Department of Sociological Studies, The University of Sheffield, Western Bank, Sheffield S10 2TN

However, if you feel you have not been listened to, you can contact the research Supervisor, Professor Alan Walker (Email: a.c.walker@sheffield.ac.uk; Address: Department of Sociological Studies, The University of Sheffield, Western Bank, Sheffield S10 2T) or Lindsay Unwin, Research Ethics and Integrity Manager (Email: l.v.unwin@sheffield.ac.uk; Telephone: 0114 222 1443) who will then ensure your complaint is heard properly through the appropriate channels.

Thank you for your interest in this study!

Appendix 5: Participant consent form

Child/ Young person identification number: _____________

MENTAL HEALTH AMONG YOUNG PEOPLE: AN INTERSECTIONAL PERSPECTIVE

CONSENT FORM

TO BE COMPLETED BY YOUNG PERSON

Thank you for reading the information about the above named Study. If you would like to take part, please read and complete this form.

	Please initial each box to confirm
1. I confirm that I have read and understand the information sheet dated 30/09/2022 (Version 2) for the above named study. I have had the opportunity to consider the information, ask questions and have them answered satisfactorily.	
2. I understand that my taking part is voluntary and that I am free to withdraw within a week after completing the interview, without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.	
3. I understand that the information I provide will be kept confidential, except if any safeguarding issues are raised. In which case, the researcher can inform a designated safeguarding lead, or the local safeguarding authority.	
4. I understand that, as part of the study, digital recordings of the interview will be taken and analysed by the researcher.	
5. I give permission for the researcher to have access to my responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.	
6. I agree for the data collected from me to be used in future research.	
7. I agree to take part in the above research study.	

Name of Participant	Date	Signature
Lead researcher	Date	Signature

NAME: Maxine Kuczawski, Lead researcher — Professor Alan Walker, Supervisor
E-MAIL: mkuczawski1@sheffield.ac.uk — a.c.walker@sheffield.ac.uk

Participant Consent Form v2 (30/09/2022)

Appendix 6: Guardian consent form

Child/ Young person identification number: ______________

MENTAL HEALTH AMONG YOUNG PEOPLE: AN INTERSECTIONAL PERSPECTIVE

CONSENT FORM

TO BE COMPLETED BY PARENT/ GUARDIAN

This study is exploring the experiences of mental well-being in young people during the COVID-19 pandemic. To do this, I will be undertaking interviews with young people.
For young people aged under the age of 18 years, I wish to seek the consent of parents or a legal guardian before they can take part in an interview.
If you agree for your child to take part in an interview for this study, please complete the sections below.

	Please initial each box to confirm
8. I confirm that I have read and understand the information sheet dated 30/09/2022 (Version 2) for the above named study. I have had the opportunity to consider the information, ask questions and have them answered satisfactorily.	
9. I agree for my child to take part in an interview for the study, and for the interview to be digitally recorded.	
10. I understand that taking part is voluntary and that my child is free to withdraw within a week after completing the interview. I understand that my child does not have to give any reason to withdraw and there will not be any negative consequences.	
11. I understand that the information provided by my child will be kept confidential, except if my child raises any safeguarding issues. In which case, the researcher can inform a designated safeguarding lead, or the local safeguarding authority.	
12. I understand my child's personal details such as name, phone number, and email address is required but will not be revealed to people outside the study.	
13. I understand and agree that my child's words may be quoted in publications, reports, web pages, and other research outputs. I understand that they will not be named or be able to identify in these outputs.	
14. I understand and agree for the anonymised (not identifiable) data collected from my child to be used in future research.	

Name of young person	Date	
Name of Parent or Guardian	Relationship to child	Signature
Lead researcher	Date	Signature

NAME: Maxine Kuczawski, Lead researcher — Professor Alan Walker, Supervisor
E-MAIL: mkuczawski1@sheffield.ac.uk — a.c.walker@sheffield.ac.uk

Appendix 7: Participant eligibility criteria (Qualtrics)

Mental Health Among Young People: An Intersectional Perspective

QUALTRICS ON-LINE QUESTIONNAIRE

ELIGIBILITY					**Criteria**
How old are you:-					>15
Did you live in Sheffield during the COVID-19 lockdowns:-	Yes ☐		No ☐		YES
Please provide the first part of your postcode:-					
Do you live in Sheffield now?	Yes ☐		No ☐		ANY
The following questions During the COVID-19 lockdowns, please indicate if you experienced any of the following:-					
	Always	Often	Sometimes	Never	
Were you able to concentrate on what you were doing?	☐	☐	☐	☐	ANY <> NEVER
Did you feel you were playing a useful part in things?	☐	☐	☐	☐	
Did you feel capable of making decisions about things?	☐	☐	☐	☐	
Were you able to enjoy your normal day-to-day activities?	☐	☐	☐	☐	
Were you able to face up to your problems?	☐	☐	☐	☐	
Did you feel reasonably happy, all things considered?	☐	☐	☐	☐	
Did you lose much sleep over worry?	☐	☐	☐	☐	
Did you feel constantly under strain?	☐	☐	☐	☐	
Did you feel you couldn't overcome your difficulties?	☐	☐	☐	☐	
Did you feel unhappy and depressed?	☐	☐	☐	☐	
Did you feel you were losing confidence in yourself?	☐	☐	☐	☐	
Did you think of yourself as a worthless person?	☐	☐	☐	☐	

Participants that meet the criteria will proceed to the next page

INTERVIEW CONTACT DETAILS

First name:		Surname:	
Telephone number:		Email address:	

How did you hear about this study (For example: Twitter, Facebook, Referral from friend, etc)?

FURTHER QUESTIONS

How would you describe your sex? Female ☐ Male ☐

Is your gender the same as the sex you were registered at birth? If not, please could you describe your gender

Yes ☐ No, please describe your gender ☐

How would you describe your ethnic origin?

WHITE		**ASIAN OR ASIAN BRITISH**	
British	☒	Indian	☐
English	☐	Pakistani	☐
Scottish	☐	Bangladeshi	☐
Welsh	☐	Chinese	☐
Northern Irish	☐	Any other Asian background	☐
Irish	☐		
Gypsy or Irish Traveller	☐	**BLACK/ AFRICAN/ CARIBBEAN/ BLACK BRITISH**	
Any other White background	☐	Caribbean	☐
		African	☐
MIXED		Any other Black background	☐
White and Black Caribbean	☐		
White and Black African	☐	**OTHER**	
White and Asian	☐	Arab	☐
Any other Mixed background	☐	Any other ethnic group	☐

During the COVID-10 lockdowns, did you?

Attend school/ college/ University	☐	If so,	Full-time	☒	Part-time	☐
Paid work	☐	If so,	Full-time	☐	Part-time	☐
Volunteer	☐	If so,	Full-time	☐	Part-time	☐

Who did you live with during the COVID-19 lockdowns?

Family ☐ Friends ☐ Alone ☐ Other ☐

Appendix 8: Participant interview topic guide

MENTAL HEALTH AMONG YOUNG PEOPLE: AN INTERSECTIONAL PERSPECTIVE

INTERVIEW SCHEDULE

Lead researcher (MK): Hello. My name is Maxine. I'd like to start off by thanking you for taking time to talk to me today. We'll be here for about one hour.

[outline reason for interview]

The reason we're here is to hear your experience of the COVID-19 pandemic and the lockdowns. How you spent that time, your mental health well-being, how your identity – who you are such as your sex, ethnicity, background, etc may have influenced your well-being, and if you spoke to anyone about how you felt. I would also really like to hear your thoughts about how you feel support for young people, such as yourself, could be improved in the future. I will ask questions to get the interview going but before we start I will just run through some housekeeping.

[check recording]

To help me with remembering what was said today I would like to record this interview, are you happy for me to do this? This will be used by me only as the lead researcher and no one else will be able to view this recording. As soon as I have written out what we discuss, the recording will be deleted.

[check if have ID] preferred

[check information sheet and questions]

Firstly, have you read through the information sheet? Did you understand everything that was written on the information sheet? Do you have any questions?

[check consent]

You have completed the consent form which means you are happy to take part in this interview. However, I want to check again now that you are still happy for us to continue today?

[check familiarity with online software]

Operation of camera/ mic; Red circle indication that being recorded; Chat function

[outline expectations]

- Whatever we discuss today is private. No names or who said what to anyone will only be viewed and used by me as the lead researcher. Your name or any other information that might identify you such as a school or work place will not be included in any results or reports from this study.
- You do not have to answer anything you do not want to. I would love to hear your experiences and views on everything I raise today but it is your choice whether you wish to answer. Please feel free to tell me to move on to the next question.
- There are no "wrong answers". Please just say what is true for you.
- If at any point you need a break, please let me know and we can pause the interview.
- We can also stop the interview at any point if you do not want to continue, that's absolutely fine. Again, please let me know
- Finally, do you have any questions?

[start research questions]

- First of all, can I ask a couple of things about you?
    - *How would you describe your sex (female/ male)?*
    - *And has this changed since you were born?*
    - *If yes, how would you describe your gender today?*

  - *How did you come to learn about this study?*
- Ok, What did you do before COVID and we went into lockdowns, what did a normal week in your life look like?
  - *Education/ work*
  - *Activities/ hobbies/ social events*
- And how did this change when we had to go into lockdown?
  - *How did education/ work change?*
  - *How did activities/ hobbies/ social events change?*
  - *Where did they live? Family, friends?*
- Did you feel this change [COVID/ lockdowns] impacted how your health?
  - *How?*
  - *Mental/ physical*
  - *What were your feelings during this time?*
    - *Direct towards mental health and explore feelings: positive (happy, relief, upbeat, etc); negative (sadness, loneliness, anxiety, fear, stress, etc)*
    - *Daily habits (sleeping, eating, drinking, etc)*
    - *Did it change over time*

[STORIES: friends experienced it differently to me – different job, not able to work from home; different home circumstances, large family, restricted living/ working space; some lived alone – loneliness; increase in worries/ anxieties – meant life was very challenging; loss of income; sceptic – refused vaccination]

- Did you feel everyone was impacted the same by COVID and being in lockdown?
  - *Got COVID*
  - *If they did, did you feel anyone suffered more (health)*
- Do you feel your experience was worse/ better than others?
- You have described yourself in the questions you answered as …..[sex; ethnicity, background]….., do you think who you are, your gender, ethnicity, your background, played a part in what you experienced?
  - *[intersectionality aspect] Do you feel as a <u>young person</u> your experience and more specifically your mental well-being was any different to others older/ younger than you?*
  - *Do you feel as a [male/ female], your experience/ MHW was any different to [male/ female]?*
  - *Do you feel as a [ethnicity] person, your experience/ MHW was any different to others who were not [ethnicity)?*
  - *Do you feel where you lived at the time (the Sheffield area), influenced your experience/ MHW? Do you think it was any different to others who lived elsewhere in the city?*
- So your mental well-being changed during COVID?
  - *What you described it was worse/ better/ the same, etc…*
- If poor mental well-being, did you seek/ take any action (i.e. seek support)?
  - *Who/ where did they seek support from?*
  - *Did this help?*
- If they felt they needed support in the future, what sort of support and where would they like to seek it from?
- Do you feel back to 'normal', in terms of mental well-being?
- What does this new 'normal' look like?
  - *More worries/ anxieties than pre-COVID*
  - *Daily habits?*
  - *Resilience/ coping*

    - *Cost of living crisis – do you recognise it as a challenge for you; if so, do you feel better prepared to manage it because of COVID experience?*
- Do you think what you went through during COVID has changed you and where you are now (mental wellbeing)

[closure of interview]

Thank participant for their contribution and time; outline next steps of research; outline reimbursement process; further support information

Appendix 9: Invitation email

Mental health among young people: an intersectional perspective

Email Invitation

Dear [*insert name*]

RE: Mental Health Among Young People: An Intersectional Perspective

Thank you for your interest in this study exploring the experiences of mental well-being in young people during the COVID-19 pandemic.

Your participation will involve attending an online interview, where you will be asked questions about your thoughts and experiences in relation to your mental well-being during the Covid-19 pandemic and the lockdowns. It is an opportunity to tell your 'story' about the feelings you experienced, how you managed these and if you spoke to anyone about how you felt. We also want to hear your views on how mental health support for young people could be improved in the future.

To say thank you for your time, all participants will receive a £20 high-street shopping voucher at the end of the interview, which is expected to last no longer than 60 minutes.

Attached to this email is an information sheet which provides more information about the study. We would be very grateful if you could take the time to read this information sheet and consider whether you might like to take part. Please feel free to discuss this with your family and friends, although the final decision must be yours. If you have any questions about the study, please contact the Lead Researcher, Maxine Kuczawski (Tel: [insert telephone no.] or email: mkuczawski1@sheffield.ac.uk).

If you do wish to take part in the study, please click on the link below or contact Maxine Kuczawski directly using the details above. Your contact information will be requested so that Maxine can contact you to discuss consent for the study, and arrange a date and time for the interview to take place.

Register your interest here: [*insert web link*]

Yours sincerely

Maxine Kuczawski

Lead Researcher

Appendix 10: RREAL (Rapid Research Evaluation and Appraisal Lab) Sheet

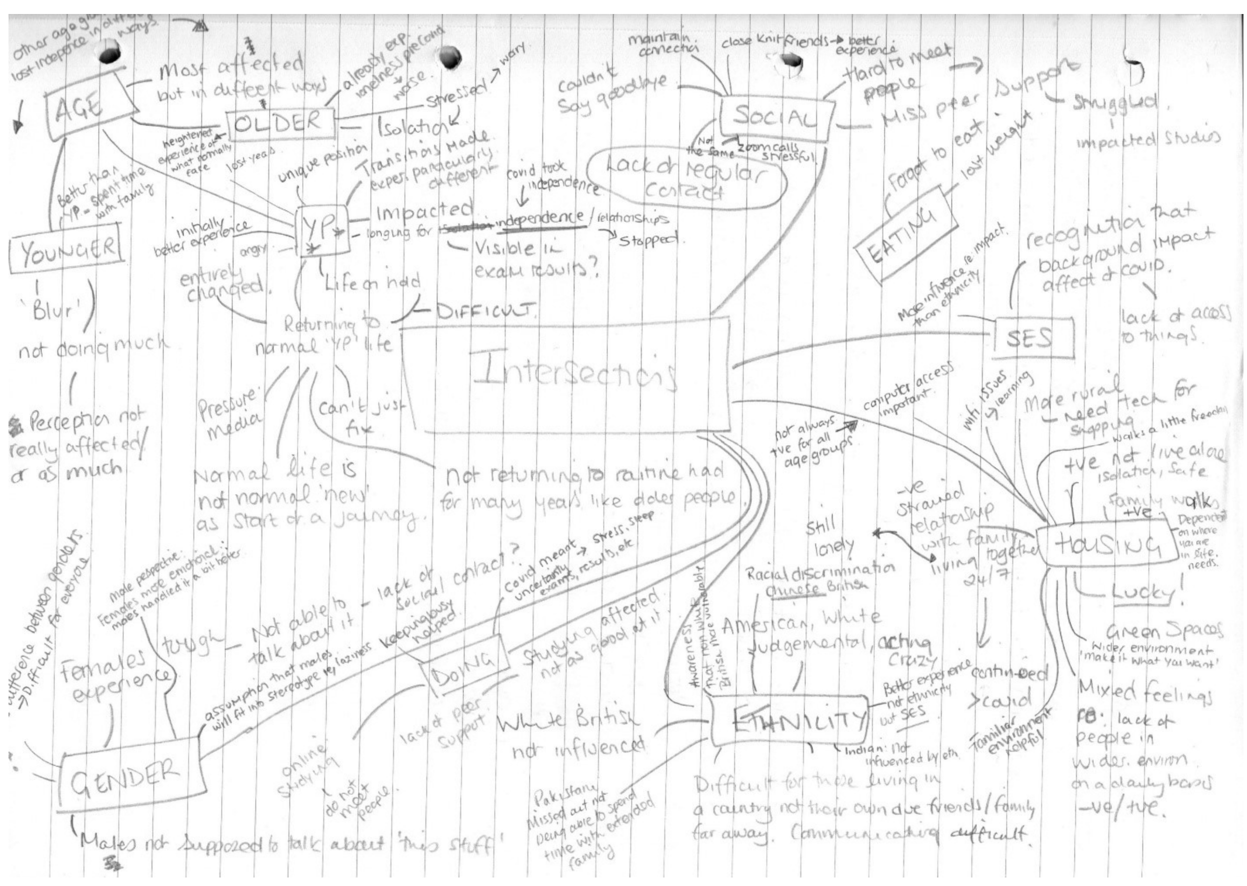
MENTAL HEALTH AMONG YOUNG PEOPLE: AN INTERSECTIONAL PERSPECTIVE

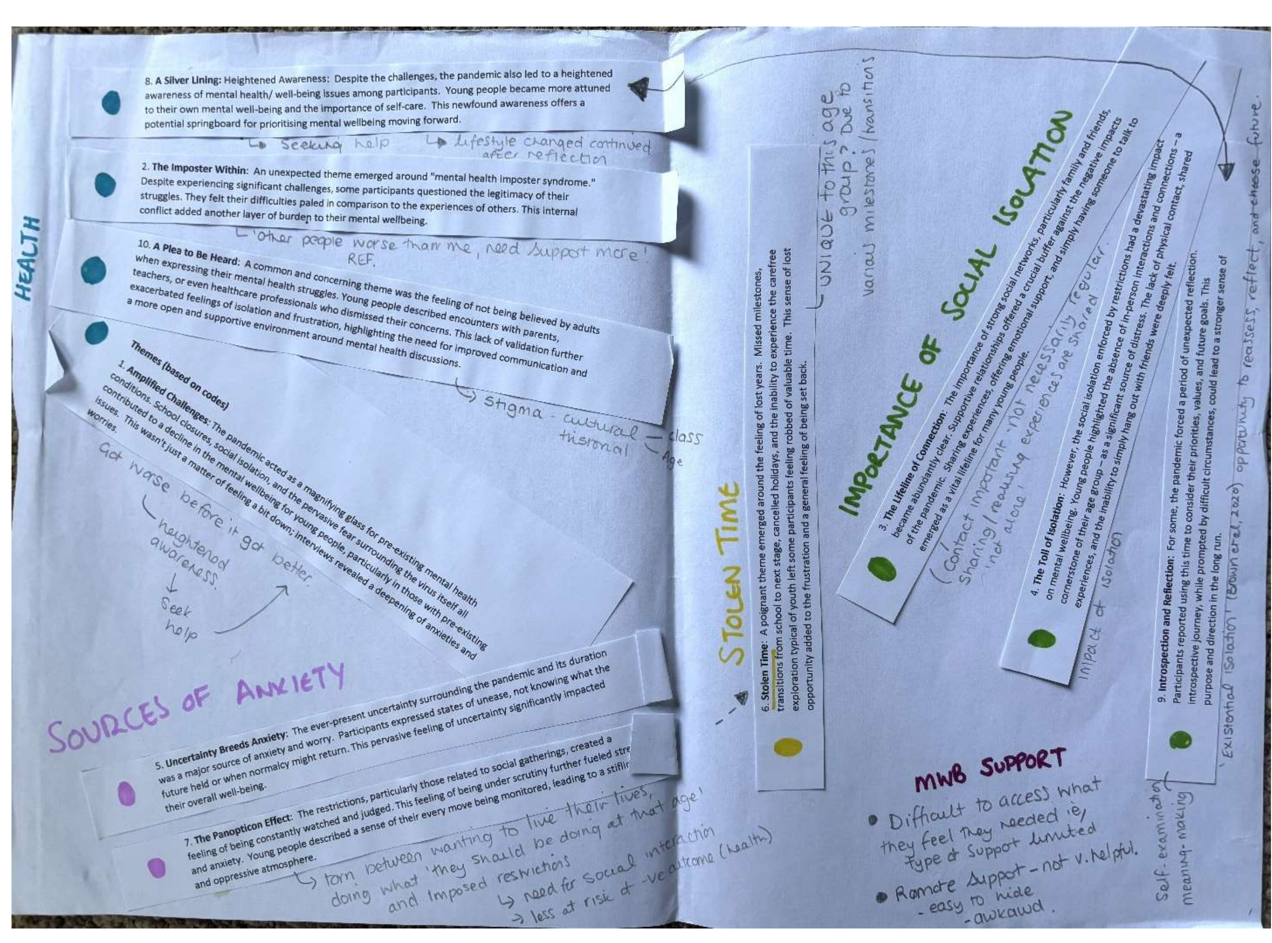
MAIN QCA CATEGORIES: RREAL SHEET

ID	
What was your life like before COVID?	
Do	
Live	
Friends/ family relationships	
Hobbies	
Habits (eat, sleep, drink, activity)	
Health (physical/ mental)	
How did your life change when Covid arrived?	
Do	
Live	
Friends/ family relationships	
Hobbies	
Habits (eat, sleep, drink, activity)	
Health (physical/ mental	
How do you think other people experienced COVID	

Age	
Gender	
Ethnicity	
Housing environment	
Wider environment	
Other	
Whats your life like now?	
Has Covid changed your life trajectory?	

Appendix 11: Qualitative thematic maps





Appendix 12: UKHLS data overview

Variable	UKHLS variable name	UKHLS Datafile	Wave	labels	Values	missing		Include	Reason
						n	%		
sex	sex_dv	youth	7	male; female	1; 2	0	-	P	
		indresp	7			0	-		
		indresp	13			1	0.02		
Age (years) from DOB	dvage	youth	7	Derived.	10-15	0	-	P	
		indresp	7		16-30	0	-		
		indresp	13		16-30	0	-		
Ethnicity	ethn_dv	youth	7	british/english/scottish/welsh/northern irish (White); irish; (white); ; any other white background (white); white and black caribbean (mixed); white and black african (mixed); white and asian (mixed); any other mixed background (mixed); indian (asian); pakistani pakistani); bangladeshi (asian); chinese (asian); any other asian background (asian); caribbean (black); african (black); any other black background (black); arab (other); any other ethnic group (other);	1-17; 97	5	0.14	P	
		indresp	7			50	0.56		
		indresp	13			8	0.16		
Fathers highest qualification	hiqual_dv	youth	7	Degree; Other higher degree; A-level etc; GCSE etc; Other qualification; No qualification	1-5; 9	1395	38.43	O	Too many missing
		indresp	7			5815	65.40		
		indresp	13			3153	62.87		
Mothers highest qualification	hiqual_dv	youth	7	Degree; Other higher degree; A-level etc; GCSE etc; Other qualification; No qualification	1-5; 9	322	8.87	O	Too many missing
		indresp	7			4073	45.81		
		indresp	13			2264	45.14		
Region	gor_dv	youth	7	Derived (from postcode). North East; North West; Yorkshire and the Humber; East Midland; West Midland; East of England; London; South East; South West; Wales; Scotland; Northern Ireland	1-12	2	0.06	O	Focus is on type of home environment rather than region, aligns with qualitative element
		indresp	7			6	0.07		
		indresp	13			3	0.06		

Urban/ rural location	urban_dv	youth	7	Derived. Urban area; rural area	1; 2	2	0.06	P	
		indresp	7			6	0.07		
		indresp	13			3	0.06		
Job status*	jbstat	indresp	7	Self employed; Paid employment (FT/PT); Unemployed; Retired; Mat Leave; Family care/ home; FT student; LT sick/ disabled; Govt training scheme; Unpaid family business; Apprenticeship; Something else;	1-11; 97	15	0.17	O	Only applicable for individuals aged 16 years or older
		indresp	13			35	0.70		
Index of Multiple Deprivation (IMD) England	imd2019qe_dv	indall#	7	Derived. Quintiles	1-5	632	17.41	O	Includes England only and too many missing
		indall^	7			1733	19.49		
		indall^	13			1006	20.06		
Total household net income – no deductions	fihhmnnet1_dv	hhresp#	7	Derived.		28	0.77	P	
		hhresp^	7			120	1.35		
		hhresp^	13			281	5.60		
SDQ Total Difficulties Score	ypsdqtd_dv	youth	7	Derived.	0-35	23	0.63	P	
General Health Questionnaire (GHQ)	scghq1_dv	indresp	7	Derived.	0-36	1263	14.21	P	
		indresp	13			243	4.85		

Note: Datafile totals prior to final cleaning - W7 Youth=3630, W7 Adult=8891, W13 Adult=5015;

*applicable only to those aged 16 years and above

Linked to Youth datafile

^ Linked to adult datafile

Appendix 13: Table of descriptive statistics comparing individuals with and without missing GHQ-12 responses: W7 Adult sample

Variable	Missing	Non-missing	Diff (%, non-miss-miss)	Diff tests (χ_2 unless stated)
Total, n	824	4882		
Age, Mean (SD)	20.1 (2.5)	19.9 (2.6)	0.11	0.031
16-19	353 (42.8)	2286 (46.8)	4.0	0.103
20-24	447 (54.2)	2469 (50.6)	-3.7	
25-30	24 (2.9)	127 (2.6)	-0.3	
Sex, n (%)				
Male	474 (57.5)	2593 (53.1)	-4.4	<0.001
Female	350 (42.5)	2289 (46.9)	4.4	
Ethnic group, n (%)				
Missing	14 (1.7)	2 (0)	-1.7	<0.001
Asian	113 (13.7)	483 (9.9)	-3.8	
Black	66 (8)	339 (6.9)	-1.1	
Pakistani	48 (5.8)	330 (6.8)	0.9	
White	537 (65.2)	3471 (71.1)	5.9	
Mixed	30 (3.6)	189 (3.9)	0.2	
Other	16 (1.9)	68 (1.4)	-0.5	
Urbanicity, n (%)				
Missing	2 (0.2)	3 (0.1)	-0.2	0.257
Urban	676 (82)	3993 (81.8)	-0.2	
Rural	146 (17.7)	886 (18.1)	0.4	
Household income, Mean (SD) £0-£16179.37	1600 (1071)	1584 (1085)	14.0	0.694^

^ t-test performed

Appendix 14: Table displaying Winsorization of Household income

Dataset	Outliers (n)	Pre-Winsorization			Post-Winsorization		
		mean	SD	p-value (t-test)	Mean	SD	p-value (t-test)
W7 Youth	5	3774.1	12252.4	<0.001	3576.0	2371.2	<0.001
W7 Adult	12	3737.6	8187.7	<0.001	3653.0	2589.3	<0.001
W13 Adult	8	4356.5	3529.6	<0.001	4335.8	3152.5	<0.001

Appendix 15: Table displaying Strengths and Difficulties Questionnaire (SDQ)

	Not true	Somewhat true	Certainly true
I try to be nice to other people. I care about their feelings	☐	☐	☐
I am restless, I cannot stay still for long	☐	☐	☐
I get a lot of headaches, stomach-aches or sickness	☐	☐	☐
I usually share with others (food, games, pens etc.)	☐	☐	☐
I get very angry and often lose my temper	☐	☐	☐
I am usually on my own. I generally play alone or keep to myself	☐	☐	☐
I usually do as I am told	☐	☐	☐
I worry a lot	☐	☐	☐
I am helpful if someone is hurt, upset or feeling ill	☐	☐	☐
I am constantly fidgeting or squirming	☐	☐	☐
I have one good friend or more	☐	☐	☐
I fight a lot. I can make other people do what I want	☐	☐	☐
I am often unhappy, down-hearted or tearful	☐	☐	☐
Other people my age generally like me	☐	☐	☐
I am easily distracted, I find it difficult to concentrate	☐	☐	☐
I am nervous in new situations. I easily lose confidence	☐	☐	☐
I am kind to younger children	☐	☐	☐
I am often accused of lying or cheating	☐	☐	☐
Other children or young people pick on me or bully me	☐	☐	☐
I often volunteer to help others (parents, teachers, children)	☐	☐	☐
I think before I do things	☐	☐	☐
I take things that are not mine from home, school or elsewhere	☐	☐	☐
I get on better with adults than with people my own age	☐	☐	☐
I have many fears, I am easily scared	☐	☐	☐
I finish the work I'm doing. My attention is good	☐	☐	☐

Goodman, R., Meltzer, H., & Bailey, V. (1998). The Strengths and Difficulties Questionnaire: A pilot study on the validity of the self-report version. *European Child and Adolescent Psychiatry*, 7, 125-130. https://doi.org/10.1007/s007870050057

Appendix 16: Table displaying General Health Questionnaire (GHQ-12)

How have you been feeling over the last few weeks.

	Better than usual	Same as usual	Less than usual	Much less than usual
Have you recently been able to concentrate on whatever you're doing?	☐	☐	☐	☐
Have you recently lost much sleep over worry?	☐	☐	☐	☐
Have you recently felt that you were playing a useful part in things?	☐	☐	☐	☐
Have you recently felt capable of making decisions about things?	☐	☐	☐	☐
Have you recently felt constantly under strain?	☐	☐	☐	☐
Have you recently felt you couldn't overcome your difficulties?	☐	☐	☐	☐
Have you recently been able to enjoy your normal day-to-day activities?	☐	☐	☐	☐
Have you recently been able to face up to problems?	☐	☐	☐	☐
Have you recently been feeling unhappy or depressed?	☐	☐	☐	☐
Have you recently been losing confidence in yourself?	☐	☐	☐	☐
Have you recently been thinking of yourself as a worthless person?	☐	☐	☐	☐
Have you recently been feeling reasonably happy, all things considered?	☐	☐	☐	☐

Goldberg, D., Gater, R., Sartorius, N., Ustun, T., Piccinelli, M., Gureje, O., & Rutter, C. (1997). The validity of two versions of the GHQ in the WHO study of mental illness in general health care. *Psychol Med*, 27(1), 191-197. https://doi.org/10.1017/s0033291796004242

Appendix 17: Support information

MENTAL HEALTH AMONG YOUNG PEOPLE: AN INTERSECTIONAL PERSPECTIVE

SUPPORT INFORMATION

Thank you for taking part in this study exploring the experiences of mental well-being in young people.

This information sheet provides details of organisations and services that can offer you support and information.

COMMUNITY SUPPORT IN SHEFFIELD

SAYiT Youth Groups

LGBTQ+ or questioning sexuality group support for young people aged 11 to 25.

They provide a range of social opportunities, support and activities including art-making, film nights, games, quiz nights, guest visitors and the opportunity to speak to our team about any issues or difficulties.

Sessions are currently held online: Older Fruitbowl (15 to 17 years old) Thursdays 5.30pm to 7pm

Phone: 0114 201 2633

Email: **info@sayit.org.uk**

Website: **https://www.sayit.org.uk/**

STAMP

STAMP (Support, Think, Act, Motivate, Participate) is a group for young people aged 14 to 25 which works to improve the mental health and emotional wellbeing of young people across the city of Sheffield.

Key contact: Becks Batley (Project Worker)

Phone: 07812 496 066

Email: **batley@chilypep.org.uk**

Website: **https://chilypep.org.uk/stamp**

Golddigger Trust

They provide wellbeing support, courses and programs for young people aged 11 to 18.

Phone: 0114 327 1191

Email: **info@golddiggertrust.co.uk**

Website: **https://www.golddiggertrust.co.uk/**

Door43

Youth information, advice, counselling and support service (YIACS) within Sheffield Futures for children and young people aged 13 to 25.

Wellbeing Wednesdays from 10am onwards on Wednesday mornings. Call or email to book a slot. You will then get a call back for a 20-minute wellbeing chat between 11am to 4pm.

Phone: 0114 201 2800

Email: **Door43@sheffieldfutures.org.uk**

Instagram: **@door43_**

Website: **https://www.sheffieldmentalhealth.co.uk/services/door-43**

GROW

Combines coaching with nature based projects to help young people (ages 16 to 24) to combat social isolation, boost their wellbeing and develop employability skills.

Phone: 0114 3211810

Email: admin@growuk.org

Website: https://www.growuk.org/grow-programme

Register interest: https://www.growuk.org/i-am-signing-up-for-myself/

More specialist support is available from the following organisations listed below

Kooth

Online mental well-being support and counselling for children and young people aged 11 to 24. Support can be anonymous. Live chat available up until 10pm

Website: **https://www.kooth.com/**

The Mix

A wide range of advice and support for young people aged under 25, alongside 1-2-1 chat and helpline services.

Phone: **0808 808 4994** (open 4pm to 11pm Monday to Saturday)

One to one chat: **https://www.themix.org.uk/get-support/speak-to-our-team** (open 4pm to 11pm Monday to Saturday)

Text: '**THEMIX**' to **85258** (Contact the crisis messenger 24 hours a day, 7 days a week if you feel like you can't cope or are worried about how you are feeling)

Website: **https://www.themix.org.uk/**

Rethink

Offers advice and guidance around mental health, alongside a 24/7 helpline specifically for under 18s who live within Sheffield or are under the care of Sheffield Children's NHS Foundation Trust.

Phone: **0808 801 0612**

E-mail: **advice@rethink.org**

Webchat: **www.rethink.org/about-us/our-mental-health-advice** (10am - 1pm Monday to Friday except for bank holidays)

Website: **https://www.rethink.org/**

Shout

24/7 support via text, alongside resources and support for mental health and wellbeing.

Website: **https://giveusashout.org/**

Text: '**SHOUT**' to **85258**

If you feel that you want to end your life, please seek immediate help from the emergency services on 999. You can also contact HopeLine UK on 0800 068 41 41 or Samaritans. If you are being abused you can contact ChildLine on 0800 1111 or Samaritans on 116 123.

Appendix 18: SCS REC Ethics approval

Downloaded: 14/07/2025
Approved: 31/10/2022

Maxine Kuczawski
Registration number: 210197361
Sociological Studies
Programme: WRTDP

Dear Maxine

PROJECT TITLE: Mental health among young people: an intersectional perspective
APPLICATION: Reference Number 049340

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that on 31/10/2022 the above-named project was **approved** on ethics grounds, on the basis that you will adhere to the following documentation that you submitted for ethics review:

- University research ethics application form 049340 (form submission date: 27/10/2022); (expected project end date: 31/08/2024).
- Participant information sheet 1110813 version 3 (13/10/2022).
- Participant consent form 1112517 version 1 (13/10/2022).
- Participant consent form 1112518 version 1 (13/10/2022).
- Participant consent form 1110814 version 3 (13/10/2022).

If during the course of the project you need to deviate significantly from the above-approved documentation please inform me since written approval will be required.

Your responsibilities in delivering this research project are set out at the end of this letter.

Yours sincerely

Rebecca Milner
Ethics Admin
Sociological Studies

Please note the following responsibilities of the researcher in delivering the research project:

- The project must abide by the University's Research Ethics Policy: https://www.sheffield.ac.uk/research-services/ethics-integrity/policy
- The project must abide by the University's Good Research & Innovation Practices Policy: https://www.sheffield.ac.uk/polopoly_fs/1.671066!/file/GRIPPolicy.pdf
- The researcher must inform their supervisor (in the case of a student) or Ethics Admin (in the case of a member of staff) of any significant changes to the project or the approved documentation.
- The researcher must comply with the requirements of the law and relevant guidelines relating to security and confidentiality of personal data.
- The researcher is responsible for effectively managing the data collected both during and after the end of the project in line with best practice, and any relevant legislative, regulatory or contractual requirements.

Appendix 19: Parameter estimates for linear MAIHDA models of outcome including age, SDQ and GHQ-12 scores: All Waves

Table A. Parameter estimates for linear MAIHDA models of outcome, SDQ score, including age (Model C): Wave 7 youth

Predictors	**Model A y7**		**Model B y7**		**Model C y7**	
	Estimates	*(95% CI)*	*Estimates*	*(95% CI)*	*Estimates*	*(95% CI)*
Fixed Effects: Regression Coefficients						
(Intercept)	10.31 ***	(9.91, 10.71)	11.79 ***	(11.06, 12.52)	9.82 ***	(8.16 – 11.48)
Sex						
Male (Ref)			-		-	
Female			0.28	(-0.18, 0.74)	0.28	(-0.18 – 0.75)
Ethnic group						
White (Ref)			-		-	
Asian			-2.33 ***	(-3.12, -1.53)	-2.32 ***	(-3.12, -1.53)
Black			-2.71 ***	(-3.60, -1.81)	-2.71 ***	(-3.61 – -1.81)
Pakistani			-1.99 ***	(-2.83, -1.16)	-2.01 ***	(-2.85 – -1.17)
Mixed			-0.61	(-1.51, 0.28)	-0.6	(-1.49 – 0.30)
Other			-0.4	(-2.62, 1.81)	-0.46	(-2.68 – 1.75)
Household income						
Q1 (Ref)			-		-	
Q2			0.15	(-0.56, 0.87)	0.16	(-0.55 – 0.88)
Q3			-0.61	(-1.33, 0.11)	-0.58	(-1.30 – 0.14)
Q4			-0.77 *	(-1.51, -0.02)	-0.74 *	(-1.48 – 0.00)
Q5			-1.61 ***	(-2.36, -0.86)	-1.57 ***	(-2.32 – -0.82)
Urban/ rural						
Urban (Ref)			-		-	
Rural			-0.14	(-0.73, 0.45)	-0.14	(-0.73 – 0.46)
Age					0.15	(0.04 – 0.27)
Random Effects: Variances						
Stratum-Level (τ_{00})	1.56	(1.52, 1.60)	0.15	(0.13, 0.16)	0.15	(0.14, 0.16)
Individual-Level (σ^2)	32.88	(32.69, 33.07)	32.99	(32.80, 33.18)	32.93	(32.74, 33.13)
Summary statistics						
N	84		84		84	
Observations	3434		3434		3434	
Variance Partition Coefficient (VPC)	4.53		0.45		0.45	
Proportional Change in Variance (PCV)			90.6		90.6	
ICC	0.05		0		0	

**p<0.05 ** p<0.01 *** p<0.001*

Table B. Parameter estimates for linear MAIHDA models of outcome, SDQ score, including age (Model C): Wave 7 adult

Predictors	**Model A ad7**		**Model B ad7**		**Model C ad7**	
	Estimates	*(95% CI)*	*Estimates*	*(95% CI)*	*Estimates*	*(95% CI)*
Fixed Effects: Regression Coefficients						
(Intercept)	10.68 ***	(10.36 – 11.00)	9.63 ***	(9.05 – 10.20)	8.69 ***	(7.39 – 9.99)
Sex						
Male (Ref)			-		-	
Female			1.79 ***	(1.44 – 2.14)	1.78 ***	(1.43 – 2.13)
Ethnic group						
White (Ref)			-		-	
Asian			-0.84	(-1.43 – -0.25)	-0.84 **	(-1.43 – -0.25)
Black			-0.79	(-1.46 – -0.12)	-0.78 *	(-1.45 – -0.11)
Pakistani			-0.82 *	(-1.52 – -0.12)	-0.83 *	(-1.53 – -0.13)
Mixed			0.42	(-0.43 – 1.28)	0.44	(-0.42 – 1.29)
Other			0.13	(-1.24 – 1.50)	0.08	(-1.30 – 1.45)
Household income						
Q1 (Ref)			-		-	
Q2			-0.13	(-0.66 – 0.41)	-0.12	(-0.65 – 0.41)
Q3			0.08	(-0.47 – 0.63)	0.06	(-0.49 – 0.60)
Q4			-0.39	(-0.95 – 0.16)	-0.42	(-0.97 – 0.13)
Q5			-0.35	(-0.92 – 0.23)	-0.38	(-0.95 – 0.19)
Urban/ rural						
Urban (Ref)			-		-	
Rural			0.70 **	(0.23 – 1.17)	0.68 **	(0.21 – 1.14)
Age					0.05	(-0.01 – 0.11)
Random Effects: Variances						
Stratum-Level (τ_{00})	0.96	(1.52, 1.60)	0.05	(0.13, 0.16)	0.04	(0.04, 0.05)
Individual-Level (σ^2)	31.61	(31.45, 31.77)	31.65	(31.49, 31.81)	31.65	(31.49, 31.81)
Summary statistics						
N	79		79		79	
Observations	4789		4789		4789	
Variance Partition Coefficient (VPC)	2.95		0.16		0.13	
Proportional Change in Variance (PCV)			95.2		95.6	
ICC	0.03		0		0	

p*<0.05 ** *p*<0.01 * *p*<0.001*

Table C. Parameter estimates for linear MAIHDA models of outcome, GHQ-12 score, including age (Model C): Wave 13 adult

Predictors	Model A ad13		Model B ad13		Model C ad13	
	Estimates	*(95% CI)*	*Estimates*	*(95% CI)*	*Estimates*	*(95% CI)*
Fixed Effects: Regression Coefficients						
(Intercept)	12.25 ***	(9.91, 10.71)	11.43 ***	(10.77 – 12.09)	11.78 ***	(10.62 – 12.93)
Sex						
Male (Ref)			-		-	
Female			1.93 ***	(1.52 – 2.34)	1.93 ***	(1.53 – 2.34)
Ethnic group						
White (Ref)			-		-	
Asian			-0.41	(-1.09 – 0.26)	-0.42	(-1.09 – 0.25)
Black			-1.28 *	(-2.29 – -0.27)	-1.29 *	(-2.30 – -0.28)
Pakistani			-1.18 **	(-1.96 – -0.40)	-1.19 **	(-1.98 – -0.41)
Mixed			0.93 *	(0.04 – 1.82)	0.92 *	(0.02 – 1.81)
Other			2.02 *	(0.14 – 3.89)	2.02 *	(0.14 – 3.90)
Household income						
Q1 (Ref)			-		-	
Q2			-0.56	(-1.21 – 0.08)	-0.56	(-1.21 – 0.08)
Q3			-0.47	(-1.11 – 0.17)	-0.47	(-1.11 – 0.18)
Q4			-0.62	(-1.27 – 0.03)	-0.61	(-1.26 – 0.04)
Q5			-0.89 **	(-1.55 – -0.24)	-0.88 **	(-1.54 – -0.23)
Urban/ rural						
Urban (Ref)			-		-	
Rural			0.55 *	(0.04 – 1.06)	0.56 *	(0.05 – 1.07)
Age					-0.02	(-0.06 – 0.03)
Random Effects: Variances						
Stratum-Level (τ_{00})	1.3	(1.27, 1.34)	0.07	(0.07, 0.08)	0.07	(0.07, 0.08)
Individual-Level (σ^2)	36.86	(36.69, 37.04)	36.79	(36.61, 37.0)	36.8	(36.62, 37.0)
Summary statistics						
N	85		85		85	
Observations	4496		4496		4496	
Variance Partition Coefficient (VPC)	3.41		0.19		0.19	
Proportional Change in Variance (PCV)			94.3		94.3	
ICC	0.03		0		0	

**p<0.05 ** p<0.01 *** p<0.001*

Appendix 20: Predicted outcome scores (SDQ and GHQ-12) in all Wave cohorts by social strata

Table D. Predicted SDQ score in Wave 7 youth cohort by social strata based on conflated interaction effects and main effects, main effects only, and differences between intersections and main effects, ranked according to the extent to which each interaction effect differs from what is explained by the main effects alone.

Rank	Stratum	Sex	Ethnic group	Household income quintile	Urban/ rural	Stratum size	Mean SDQ	Predicted mean SDQ (I+M effects)	High 95% CI predicted mean SDQ (I+M effects)	Low 95% CI predicted mean SDQ (I+M effects)	Predicted mean SDQ (M effects)	High 95% CI predicted mean SDQ (M effects)	Low 95% CI predicted mean SDQ (M effects)	Predicted mean SDQ (I effects)	High 95% CI predicted mean SDQ (I effects)	Low 95% CI predicted mean SDQ (I effects)
1	2252	Female	Black	5	Urban	10	12.60	7.79	9.06	6.55	11.03	13.17	9.06	-3.23	-4.11	-2.51
2	1252	Male	Black	5	Urban	7	9.29	7.38	8.64	6.10	10.04	12.14	7.87	-2.66	-3.50	-1.78
3	1152	Male	Asian	5	Urban	14	10.71	7.91	8.98	6.76	10.52	12.40	8.63	-2.60	-3.42	-1.87
4	2151	Female	Asian	5	Rural	1	13.00	8.12	9.36	6.93	10.40	13.01	7.85	-2.28	-3.66	-0.92
5	1552	Male	Pakistani	5	Urban	6	9.50	8.11	9.36	6.81	10.15	12.28	8.01	-2.04	-2.92	-1.20
6	1241	Male	Black	4	Rural	2	9.50	8.31	9.68	6.89	10.22	12.54	7.95	-1.91	-2.86	-1.07
7	2142	Female	Asian	4	Urban	20	11.25	9.04	10.13	7.89	10.77	12.58	8.89	-1.73	-2.45	-1.00
8	1242	Male	Black	4	Urban	8	8.88	8.19	9.39	7.02	9.88	12.05	7.69	-1.69	-2.67	-0.68
9	2552	Female	Pakistani	5	Urban	5	8.20	8.33	9.51	7.12	9.91	12.07	7.57	-1.58	-2.57	-0.45
10	1142	Male	Asian	4	Urban	19	10.00	8.68	9.81	7.60	10.14	12.00	8.30	-1.46	-2.19	-0.70
11	2342	Female	Mixed	4	Urban	18	14.17	10.81	12.02	9.56	12.12	13.82	10.39	-1.32	-1.80	-0.83
12	2152	Female	Asian	5	Urban	18	8.06	8.01	8.99	6.89	9.30	11.04	7.52	-1.30	-2.05	-0.63
13	2222	Female	Black	2	Urban	20	11.35	9.53	10.66	8.38	10.82	12.65	8.94	-1.29	-1.99	-0.56
14	2242	Female	Black	4	Urban	23	9.04	8.47	9.77	7.29	9.71	11.44	8.04	-1.24	-1.67	-0.75
15	2542	Female	Pakistani	4	Urban	12	10.67	9.22	10.44	8.04	10.45	12.39	8.44	-1.23	-1.95	-0.39
16	1542	Male	Pakistani	4	Urban	9	7.78	8.86	10.04	7.66	9.53	11.64	7.57	-0.68	-1.59	0.10
17	1522	Male	Pakistani	2	Urban	29	10.76	9.92	11.01	8.78	10.57	12.24	8.85	-0.65	-1.23	-0.08
18	2132	Female	Asian	3	Urban	21	8.62	8.94	10.04	7.78	9.50	11.41	7.73	-0.57	-1.38	0.05
19	1212	Male	Black	1	Urban	31	8.87	8.94	10.09	7.77	9.50	11.14	7.84	-0.55	-1.05	-0.07
20	2221	Female	Black	2	Rural	1	4.00	9.48	10.70	8.05	10.01	12.58	7.49	-0.53	-1.88	0.57
21	2631	Female	White	3	Rural	60	12.75	11.68	12.60	10.71	12.18	13.47	10.85	-0.51	-0.87	-0.14
22	1132	Male	Asian	3	Urban	32	8.28	8.64	9.73	7.52	9.14	10.63	7.55	-0.49	-0.90	-0.03
23	1442	Male	Other	4	Urban	5	14.20	10.57	12.88	8.38	11.04	13.25	8.79	-0.47	-0.37	-0.41
24	1121	Male	Asian	2	Rural	1	5.00	9.61	10.90	8.30	10.07	12.17	7.68	-0.46	-1.28	0.62
25	1512	Male	Pakistani	1	Urban	76	10.36	9.87	10.88	8.81	10.32	11.58	9.09	-0.45	-0.70	-0.28
26	1232	Male	Black	3	Urban	29	7.38	8.17	9.32	7.04	8.61	10.33	6.95	-0.43	-1.00	0.10
27	1452	Male	Other	5	Urban	1	6.00	9.64	11.99	7.32	10.07	12.55	7.77	-0.43	-0.56	-0.45
28	2351	Female	Mixed	5	Rural	1	8.00	9.82	11.12	8.47	10.20	12.78	7.58	-0.38	-1.67	0.89
29	1532	Male	Pakistani	3	Urban	27	8.56	8.99	10.14	7.84	9.35	11.03	7.78	-0.36	-0.89	0.06
30	1352	Male	Mixed	5	Urban	20	9.15	9.40	10.62	8.27	9.76	11.54	7.98	-0.36	-0.92	0.29
31	1451	Male	Other	5	Rural	1	5.00	9.74	12.22	7.33	10.10	12.58	7.69	-0.36	-0.36	-0.37
32	1351	Male	Mixed	5	Rural	5	8.00	9.55	10.85	8.21	9.89	12.03	7.58	-0.34	-1.18	0.64
33	1112	Male	Asian	1	Urban	51	9.45	9.38	10.36	8.32	9.71	11.03	8.38	-0.34	-0.66	-0.06
34	2322	Female	Mixed	2	Urban	19	13.84	11.65	12.91	10.46	11.97	13.69	10.14	-0.31	-0.78	0.32
35	2212	Female	Black	1	Urban	36	8.86	9.16	10.38	8.05	9.43	10.96	7.81	-0.27	-0.58	0.24
36	2532	Female	Pakistani	3	Urban	20	8.65	9.23	10.39	8.15	9.48	11.15	7.70	-0.25	-0.77	0.46
37	1632	Male	White	3	Urban	172	11.61	11.30	12.08	10.40	11.46	12.35	10.63	-0.17	-0.27	-0.23
38	2452	Female	Other	5	Urban	1	5.00	9.91	12.31	7.61	10.05	12.49	7.76	-0.14	-0.19	-0.16
39	1331	Male	Mixed	3	Rural	1	18.00	10.58	11.90	9.19	10.72	13.14	8.30	-0.14	-1.24	0.89
40	1622	Male	White	2	Urban	178	12.47	12.09	12.95	11.24	12.22	13.11	11.39	-0.13	-0.17	-0.15
41	2651	Female	White	5	Rural	114	10.56	10.45	11.43	9.45	10.51	11.60	9.54	-0.06	-0.17	-0.09

Rank	Stratum	Sex	Ethnic group	Household income quintile	Urban/ rural	Stratum size	Mean SDQ	Predicted mean SDQ (I+M effects)	High 95% CI predicted mean SDQ (I+M effects)	Low 95% CI predicted mean SDQ (I+M effects)	Predicted mean SDQ (M effects)	High 95% CI predicted mean SDQ (M effects)	Low 95% CI predicted mean SDQ (M effects)	Predicted mean SDQ (I effects)	High 95% CI predicted mean SDQ (I effects)	Low 95% CI predicted mean SDQ (I effects)
42	1651	Male	White	5	Rural	82	10.13	10.15	11.13	9.18	10.19	11.28	9.07	-0.04	-0.15	0.10
43	1222	Male	Black	2	Urban	21	7.71	8.97	10.20	7.76	9.01	10.71	7.20	-0.04	-0.51	0.56
44	2632	Female	White	3	Urban	174	11.50	11.38	12.28	10.53	11.38	12.28	10.57	0.00	0.00	-0.04
45	2332	Female	Mixed	3	Urban	18	11.28	10.77	11.93	9.51	10.75	12.64	9.06	0.02	-0.72	0.46
46	2352	Female	Mixed	5	Urban	26	9.15	9.67	10.86	8.45	9.65	11.47	8.00	0.03	-0.61	0.45
47	1332	Male	Mixed	3	Urban	21	10.19	10.36	11.59	9.25	10.29	12.02	8.46	0.07	-0.42	0.79
48	1122	Male	Asian	2	Urban	44	8.77	9.35	10.48	8.28	9.27	10.65	7.88	0.08	-0.17	0.39
49	2612	Female	White	1	Urban	130	12.22	12.04	12.98	11.17	11.96	12.95	10.97	0.08	0.02	0.19
50	2442	Female	Other	4	Urban	3	13.00	10.80	13.07	8.56	10.71	12.96	8.44	0.08	0.11	0.12
51	1641	Male	White	4	Rural	91	11.07	11.00	11.96	10.09	10.91	12.03	9.76	0.09	-0.08	0.32
52	1612	Male	White	1	Urban	106	12.00	11.77	12.65	10.91	11.67	12.77	10.55	0.10	-0.13	0.36
53	2642	Female	White	4	Urban	191	11.06	11.10	11.93	10.27	10.99	11.85	10.16	0.11	0.07	0.12
54	1621	Male	White	2	Rural	58	12.59	12.11	13.06	11.13	12.00	13.26	10.73	0.11	-0.20	0.40
55	2232	Female	Black	3	Urban	22	6.23	8.37	9.55	7.26	8.23	9.99	6.42	0.14	-0.43	0.84
56	2652	Female	White	5	Urban	195	10.06	10.21	11.06	9.29	10.07	10.89	9.24	0.14	0.17	0.05
57	1611	Male	White	1	Rural	51	12.39	11.93	12.94	10.93	11.76	13.20	10.40	0.17	-0.27	0.52
58	1652	Male	White	5	Urban	181	9.54	9.80	10.71	8.95	9.61	10.54	8.69	0.19	0.18	0.26
59	1432	Male	Other	3	Urban	3	11.67	10.67	13.03	8.41	10.47	12.70	8.16	0.20	0.33	0.26
60	1341	Male	Mixed	4	Rural	1	7.00	10.38	11.80	9.10	10.15	12.49	7.67	0.23	-0.69	1.43
61	2112	Female	Asian	1	Urban	50	8.76	9.45	10.46	8.36	9.21	10.62	7.78	0.24	-0.16	0.58
62	2512	Female	Pakistani	1	Urban	62	9.29	9.79	10.83	8.72	9.52	10.83	8.26	0.26	0.00	0.47
63	2331	Female	Mixed	3	Rural	3	12.33	10.87	12.17	9.50	10.58	13.08	8.19	0.29	-0.91	1.31
64	2522	Female	Pakistani	2	Urban	37	9.32	10.01	11.17	8.88	9.67	11.23	8.22	0.34	-0.06	0.66
65	2122	Female	Asian	2	Urban	27	8.26	9.58	10.69	8.50	9.23	10.88	7.55	0.35	-0.19	0.96
66	2622	Female	White	2	Urban	171	11.68	11.91	12.79	11.07	11.54	12.43	10.69	0.37	0.35	0.37
67	2441	Female	Other	4	Rural	1	15.00	10.90	13.34	8.53	10.53	13.02	7.96	0.37	0.33	0.57
68	2611	Female	White	1	Rural	37	12.51	12.10	13.16	11.13	11.72	13.27	10.21	0.38	-0.11	0.92
69	1642	Male	White	4	Urban	193	10.10	10.52	11.34	9.71	10.10	11.03	9.16	0.41	0.30	0.55
70	1631	Male	White	3	Rural	80	10.53	10.99	11.91	9.95	10.48	11.59	9.32	0.51	0.32	0.63
71	2621	Female	White	2	Rural	67	11.91	12.11	13.12	11.07	11.56	12.74	10.28	0.55	0.38	0.79
72	2312	Female	Mixed	1	Urban	25	11.12	11.31	12.45	10.11	10.76	12.36	9.17	0.56	0.09	0.94
73	1342	Male	Mixed	4	Urban	6	7.00	10.18	11.47	8.89	9.53	11.74	7.44	0.65	-0.27	1.46
74	2432	Female	Other	3	Urban	1	9.00	10.89	13.21	8.65	10.24	12.64	7.90	0.65	0.57	0.75
75	2641	Female	White	4	Rural	84	10.26	11.03	11.97	10.01	10.31	11.52	9.02	0.72	0.45	0.99
76	1322	Male	Mixed	2	Urban	13	10.38	11.16	12.52	9.97	10.37	12.38	8.56	0.79	0.14	1.41
77	2341	Female	Mixed	4	Rural	3	7.00	10.64	12.00	9.24	9.84	12.34	7.64	0.80	-0.35	1.60
78	1422	Male	Other	2	Urban	1	16.00	11.42	13.90	9.20	10.50	12.95	8.20	0.92	0.96	1.01
79	2311	Female	Mixed	1	Rural	1	15.00	11.48	12.76	9.99	10.49	12.80	8.24	0.99	-0.04	1.75
80	1412	Male	Other	1	Urban	6	9.00	11.21	13.58	9.02	10.00	12.11	7.85	1.21	1.47	1.17
81	2412	Female	Other	1	Urban	3	11.00	11.57	13.87	9.27	10.34	12.70	7.99	1.23	1.17	1.28
82	1312	Male	Mixed	1	Urban	19	8.79	10.90	12.02	9.73	9.60	11.34	7.56	1.30	0.69	2.17
83	2321	Female	Mixed	2	Rural	1	4.00	11.54	12.92	10.16	10.05	12.41	7.61	1.49	0.50	2.55
84	2422	Female	Other	2	Urban	1	5.00	11.66	14.12	9.32	10.02	12.52	7.54	1.64	1.60	1.78

Note. I+M effects = interaction effects and main effects conflated; M effects = main effects only; I effects = differences between intersections and main effects.

Table E. Predicted GHQ-12 score in Wave 7 adult cohort by social strata based on conflated interaction effects and main effects, main effects only, and differences between intersections and main effects, ranked according to the extent to which each interaction effect differs from what is explained by the main effects alone.

Rank	Stratum	Sex	Ethnic group	Household income quintile	Urban/ rural	Stratum size	Mean GHQ-12	Predicted mean GHQ-12 (I+M effects)	High 95% CI predicted mean GHQ-12 (I+M effects)	Low 95% CI predicted mean GHQ-12 (I+M effects)	Predicted mean GHQ-12 (M effects)	High 95% CI predicted mean GHQ-12 (M effects)	Low 95% CI predicted mean GHQ-12 (M effects)	Predicted mean GHQ-12 (I effects)	High 95% CI predicted mean GHQ-12 (I effects)	Low 95% CI predicted mean GHQ-12 (I effects)
1	2151	Male	Asian	5	Rural	2	8.0	8.44	9.36	7.53	10.45	12.33	8.56	-2.01	-2.97	-1.03
2	2542	Male	Pakistani	4	Urban	17	10.8	9.16	9.99	8.18	10.65	12.23	9.01	-1.49	-2.24	-0.83
3	2442	Male	Other	4	Urban	8	14.3	10.05	11.53	8.61	11.39	13.21	9.61	-1.35	-1.68	-1.00
4	2552	Male	Pakistani	5	Urban	6	9.3	9.15	10.03	8.24	10.47	12.28	8.70	-1.31	-2.25	-0.47
5	2132	Male	Asian	3	Urban	37	11.2	9.64	10.42	8.83	10.93	12.24	9.50	-1.29	-1.82	-0.67
6	2532	Male	Pakistani	3	Urban	15	11.4	9.62	10.48	8.72	10.91	12.41	9.30	-1.29	-1.93	-0.58
7	2242	Male	Black	4	Urban	27	10.1	9.15	10.01	8.29	10.38	11.85	8.86	-1.23	-1.83	-0.57
8	2152	Male	Asian	5	Urban	26	9.6	9.15	9.94	8.33	10.20	11.69	8.79	-1.05	-1.75	-0.46
9	2432	Male	Other	3	Urban	6	15.8	10.53	12.00	9.03	11.47	13.18	9.65	-0.95	-1.18	-0.63
10	2522	Male	Pakistani	2	Urban	27	9.8	9.40	10.27	8.52	10.27	11.78	8.84	-0.87	-1.51	-0.31
11	2252	Male	Black	5	Urban	18	8.9	9.16	10.03	8.32	10.01	11.63	8.36	-0.85	-1.60	-0.03
12	2341	Male	Mixed	4	Rural	3	7.0	9.64	10.69	8.49	10.36	12.33	8.57	-0.72	-1.64	-0.09
13	2112	Male	Asian	1	Urban	75	10.1	9.54	10.25	8.81	10.24	11.43	9.16	-0.70	-1.18	-0.35
14	2651	Male	White	5	Rural	96	9.9	9.34	10.02	8.63	10.03	11.08	9.00	-0.69	-1.06	-0.37
15	2142	Male	Asian	4	Urban	37	8.9	9.06	9.86	8.35	9.74	11.05	8.28	-0.68	-1.18	0.07
16	1122	Female	Asian	2	Urban	49	12.6	11.25	11.99	10.47	11.82	13.06	10.61	-0.57	-1.07	-0.13
17	1552	Female	Pakistani	5	Urban	11	14.0	11.01	11.91	10.10	11.54	13.36	9.72	-0.53	-1.45	0.38
18	2512	Male	Pakistani	1	Urban	74	9.7	9.54	10.36	8.72	10.00	11.14	8.89	-0.46	-0.78	-0.17
19	2412	Male	Other	1	Urban	12	11.4	10.43	11.89	8.93	10.87	12.57	9.27	-0.44	-0.68	-0.34
20	2631	Male	White	3	Rural	81	9.9	9.71	10.37	9.05	10.13	11.20	9.08	-0.42	-0.83	-0.03
21	2122	Male	Asian	2	Urban	51	9.2	9.35	10.14	8.61	9.77	10.98	8.48	-0.42	-0.84	0.13
22	2212	Male	Black	1	Urban	72	9.7	9.54	10.31	8.77	9.95	11.14	8.73	-0.41	-0.82	0.04
23	2452	Male	Other	5	Urban	2	6.5	10.04	11.51	8.52	10.44	12.28	8.60	-0.39	-0.77	-0.08
24	1131	Female	Asian	3	Rural	2	17.5	10.65	11.56	9.76	11.01	13.12	9.19	-0.37	-1.56	0.57
25	1611	Female	White	1	Rural	64	12.3	11.45	12.19	10.79	11.80	12.93	10.56	-0.34	-0.74	0.23
26	1252	Female	Black	5	Urban	18	12.6	11.02	11.84	10.10	11.33	12.95	9.75	-0.32	-1.11	0.36
27	1622	Female	White	2	Urban	272	12.7	12.19	12.76	11.61	12.47	13.17	11.71	-0.27	-0.41	-0.10
28	2612	Male	White	1	Urban	231	10.6	10.41	11.05	9.85	10.63	11.32	9.82	-0.22	-0.27	0.03
29	2422	Male	Other	2	Urban	5	9.4	10.26	11.74	8.80	10.48	12.19	8.79	-0.21	-0.46	0.01
30	2641	Male	White	4	Rural	98	8.9	9.17	9.86	8.50	9.35	10.33	8.38	-0.18	-0.48	0.12
31	2222	Male	Black	2	Urban	37	8.4	9.33	10.19	8.53	9.50	10.81	8.15	-0.17	-0.62	0.38
32	2332	Male	Mixed	3	Urban	21	11.6	10.87	11.85	9.82	11.02	12.56	9.52	-0.15	-0.71	0.30
33	1121	Female	Asian	2	Rural	2	8.0	10.41	11.35	9.52	10.54	12.39	8.73	-0.13	-1.04	0.79
34	2342	Male	Mixed	4	Urban	14	9.7	10.33	11.39	9.27	10.46	11.97	8.85	-0.13	-0.58	0.43
35	1221	Female	Black	2	Rural	1	7.0	10.50	11.44	9.50	10.59	12.49	8.71	-0.09	-1.05	0.79
36	2642	Male	White	4	Urban	220	9.9	9.93	10.54	9.31	10.02	10.74	9.22	-0.08	-0.20	0.09
37	1651	Female	White	5	Rural	104	11.3	11.12	11.79	10.36	11.16	12.20	10.29	-0.04	-0.41	0.06
38	1631	Female	White	3	Rural	89	11.9	11.51	12.25	10.82	11.55	12.55	10.59	-0.04	-0.30	0.23
39	1222	Female	Black	2	Urban	47	11.7	11.22	12.09	10.32	11.25	12.45	10.00	-0.03	-0.37	0.32
40	2312	Male	Mixed	1	Urban	24	11.0	10.79	11.75	9.77	10.79	12.36	9.28	0.00	-0.61	0.49
41	2232	Male	Black	3	Urban	20	7.7	9.53	10.37	8.66	9.53	11.04	7.99	0.01	-0.67	0.67
42	1612	Female	White	1	Urban	277	12.3	12.16	12.73	11.62	12.13	12.78	11.41	0.04	-0.05	0.21
43	2611	Male	White	1	Rural	48	8.8	9.55	10.28	8.84	9.51	10.76	8.24	0.04	-0.49	0.61

Rank	Stratum	Sex	Ethnic group	Household income quintile	Urban/ rural	Stratum size	Mean GHQ-12	Predicted mean GHQ-12 (I+M effects)	High 95% CI predicted mean GHQ-12 (I+M effects)	Low 95% CI predicted mean GHQ-12 (I+M effects)	Predicted mean GHQ-12 (M effects)	High 95% CI predicted mean GHQ-12 (M effects)	Low 95% CI predicted mean GHQ-12 (M effects)	Predicted mean GHQ-12 (I effects)	High 95% CI predicted mean GHQ-12 (I effects)	Low 95% CI predicted mean GHQ-12 (I effects)
44	2632	Male	White	3	Urban	247	10.3	10.35	10.93	9.78	10.31	11.06	9.53	0.04	-0.13	0.25
45	1642	Female	White	4	Urban	299	11.8	11.72	12.30	11.14	11.63	12.37	10.98	0.09	-0.07	0.16
46	1242	Female	Black	4	Urban	23	11.1	10.90	11.76	10.12	10.79	12.26	9.39	0.11	-0.50	0.73
47	1142	Female	Asian	4	Urban	37	10.8	10.85	11.58	10.08	10.70	12.10	9.48	0.15	-0.52	0.60
48	2621	Male	White	2	Rural	94	8.8	9.41	10.07	8.75	9.26	10.33	8.23	0.15	-0.26	0.52
49	2652	Male	White	5	Urban	224	9.6	9.86	10.49	9.27	9.70	10.47	8.96	0.16	0.03	0.31
50	2622	Male	White	2	Urban	246	9.9	10.12	10.70	9.56	9.93	10.74	9.26	0.19	-0.04	0.31
51	1542	Female	Pakistani	4	Urban	15	10.7	10.90	11.75	10.06	10.69	12.34	9.12	0.21	-0.59	0.94
52	1632	Female	White	3	Urban	299	12.0	12.13	12.67	11.58	11.88	12.58	11.11	0.25	0.09	0.47
53	1652	Female	White	5	Urban	250	11.6	11.70	12.31	11.10	11.43	12.19	10.72	0.27	0.12	0.38
54	2352	Male	Mixed	5	Urban	16	8.9	10.39	11.40	9.40	10.10	11.75	8.56	0.30	-0.35	0.84
55	2322	Male	Mixed	2	Urban	16	9.6	10.63	11.55	9.62	10.32	11.91	8.69	0.30	-0.36	0.93
56	1212	Female	Black	1	Urban	45	11.3	11.29	12.08	10.49	10.98	12.37	9.81	0.32	-0.29	0.69
57	1522	Female	Pakistani	2	Urban	45	11.0	11.16	11.97	10.31	10.82	12.12	9.55	0.34	-0.15	0.76
58	1621	Female	White	2	Rural	76	11.1	11.27	11.90	10.60	10.92	11.99	9.79	0.35	-0.09	0.81
59	1641	Female	White	4	Rural	104	10.5	10.93	11.61	10.27	10.52	11.45	9.53	0.41	0.16	0.74
60	1232	Female	Black	3	Urban	27	11.3	11.38	12.22	10.53	10.89	12.27	9.50	0.48	-0.05	1.02
61	1352	Female	Mixed	5	Urban	16	13.9	12.22	13.21	11.23	11.69	13.35	10.01	0.52	-0.14	1.22
62	1152	Female	Asian	5	Urban	28	9.9	10.90	11.69	10.07	10.31	11.84	8.93	0.58	-0.15	1.15
63	1421	Female	Other	2	Rural	1	12.0	11.36	12.84	9.83	10.73	12.55	8.75	0.63	0.29	1.08
64	1351	Female	Mixed	5	Rural	1	17.0	11.49	12.54	10.36	10.86	12.74	8.84	0.63	-0.20	1.52
65	1532	Female	Pakistani	3	Urban	22	10.5	11.35	12.18	10.52	10.67	12.08	9.20	0.67	0.10	1.32
66	1112	Female	Asian	1	Urban	68	10.2	11.19	11.92	10.41	10.35	11.51	9.23	0.84	0.41	1.18
67	1512	Female	Pakistani	1	Urban	87	10.1	11.17	11.94	10.35	10.30	11.29	9.26	0.87	0.65	1.08
68	1442	Female	Other	4	Urban	7	12.1	11.78	13.29	10.31	10.90	12.78	9.20	0.87	0.52	1.11
69	1331	Female	Mixed	3	Rural	1	24.0	11.96	12.96	10.85	11.04	12.92	9.19	0.92	0.04	1.66
70	1342	Female	Mixed	4	Urban	16	12.2	12.16	13.11	11.12	11.19	12.86	9.58	0.97	0.25	1.55
71	1332	Female	Mixed	3	Urban	19	13.2	12.63	13.55	11.63	11.57	13.20	10.00	1.06	0.35	1.63
72	1132	Female	Asian	3	Urban	49	9.8	11.24	11.99	10.46	10.15	11.36	8.98	1.08	0.64	1.47
73	1322	Female	Mixed	2	Urban	14	12.6	12.42	13.42	11.43	11.23	12.77	9.43	1.19	0.65	2.00
74	1311	Female	Mixed	1	Rural	1	9.0	11.82	12.87	10.72	10.59	12.63	8.67	1.23	0.24	2.05
75	1412	Female	Other	1	Urban	13	11.5	12.19	13.63	10.72	10.95	12.50	9.15	1.24	1.13	1.57
76	1452	Female	Other	5	Urban	3	7.7	11.82	13.29	10.33	10.43	12.31	8.55	1.39	0.97	1.78
77	1312	Female	Mixed	1	Urban	23	11.6	12.52	13.47	11.50	11.05	12.52	9.45	1.46	0.95	2.05
78	1422	Female	Other	2	Urban	6	8.3	12.04	13.42	10.65	10.37	12.21	8.59	1.68	1.21	2.06
79	1432	Female	Other	3	Urban	5	7.8	12.22	13.79	10.74	10.33	12.08	8.59	1.88	1.72	2.15

Note. I+M effects = interaction effects and main effects conflated; M effects = main effects only; I effects = differences between intersections and main effects.

Table F. Predicted GHQ-12 score in Wave 13 adult cohort by social strata based on conflated interaction effects and main effects, main effects only, and differences between intersections and main effects, ranked according to the extent to which each interaction effect differs from what is explained by the main effects alone.

Rank	Stratum	Sex	Ethnic group	Household income quintile	Urban/ rural	Stratum size	Mean GHQ-12	Predicted mean GHQ-12 (I+M effects)	High 95% CI predicted mean GHQ-12 (I+M effects)	Low 95% CI predicted mean GHQ-12 (I+M effects)	Predicted mean GHQ-12 (M effects)	High 95% CI predicted mean GHQ-12 (M effects)	Low 95% CI predicted mean GHQ-12 (M effects)	Predicted mean GHQ-12 (I effects)	High 95% CI predicted mean GHQ-12 (I effects)	Low 95% CI predicted mean GHQ-12 (I effects)
1	1412	Female	Other	1	Urban	13	14.08	12.84	14.69	11.03	15.87	17.73	13.91	-3.03	-3.04	-2.88
2	1422	Female	Other	2	Urban	2	13.00	12.36	14.43	10.24	15.37	17.20	13.35	-3.00	-2.77	-3.12
3	1442	Female	Other	4	Urban	3	14.00	12.47	14.49	10.20	15.30	17.12	13.33	-2.83	-2.63	-3.12
4	1432	Female	Other	3	Urban	5	15.80	12.74	14.96	10.63	15.48	17.39	13.49	-2.74	-2.44	-2.85
5	1421	Female	Other	2	Rural	1	11.00	12.29	14.55	10.04	14.79	16.71	12.74	-2.50	-2.16	-2.70
6	1341	Female	Mixed	4	Rural	4	7.25	11.67	13.90	9.63	13.63	14.82	12.45	-1.96	-0.92	-2.82
7	1451	Female	Other	5	Rural	1	20.00	12.59	14.67	10.37	14.50	16.54	12.37	-1.91	-1.87	-2.00
8	1452	Female	Other	5	Urban	2	27.50	13.17	15.45	11.06	15.07	16.86	13.06	-1.90	-1.42	-2.01
9	1312	Female	Mixed	1	Urban	23	13.78	12.96	14.72	11.18	14.82	15.84	13.71	-1.86	-1.12	-2.53
10	1311	Female	Mixed	1	Rural	1	24.00	12.57	14.85	10.49	14.32	15.47	13.16	-1.76	-0.62	-2.66
11	1321	Female	Mixed	2	Rural	1	6.00	12.04	14.26	9.74	13.74	14.91	12.59	-1.70	-0.65	-2.85
12	1352	Female	Mixed	5	Urban	14	12.71	12.42	14.20	10.42	13.94	14.91	12.85	-1.52	-0.71	-2.42
13	2432	Male	Other	3	Urban	1	6.00	12.06	14.28	9.81	13.50	15.37	11.48	-1.44	-1.09	-1.67
14	1322	Female	Mixed	2	Urban	17	13.94	12.84	14.56	10.93	14.28	15.35	13.15	-1.43	-0.79	-2.22
15	1331	Female	Mixed	3	Rural	5	15.00	12.61	14.59	10.55	13.88	15.03	12.65	-1.27	-0.44	-2.11
16	2412	Male	Other	1	Urban	9	15.33	12.98	14.87	11.02	14.05	15.89	11.96	-1.06	-1.02	-0.94
17	2452	Male	Other	5	Urban	4	11.75	12.14	14.27	10.05	13.06	15.08	11.00	-0.92	-0.81	-0.95
18	1351	Female	Mixed	5	Rural	2	17.00	12.51	14.84	10.39	13.40	14.59	12.26	-0.89	0.25	-1.87
19	1112	Female	Asian	1	Urban	60	12.85	12.66	14.00	11.31	13.41	14.40	12.59	-0.76	-0.40	-1.28
20	2332	Male	Mixed	3	Urban	11	10.45	11.76	13.60	9.73	12.41	13.47	11.29	-0.65	0.13	-1.56
21	2312	Male	Mixed	1	Urban	16	12.50	12.32	14.28	10.57	12.95	13.98	11.75	-0.64	0.30	-1.19
22	1512	Female	Pakistani	1	Urban	66	11.89	12.06	13.22	10.80	12.66	13.58	11.68	-0.61	-0.36	-0.88
23	1332	Female	Mixed	3	Urban	24	16.00	13.96	15.72	12.31	14.47	15.55	13.39	-0.51	0.17	-1.08
24	2421	Male	Other	2	Rural	1	18.00	12.36	14.49	10.07	12.86	14.79	10.76	-0.50	-0.30	-0.69
25	1342	Female	Mixed	4	Urban	22	15.91	13.84	15.53	12.19	14.33	15.38	13.15	-0.49	0.15	-0.96
26	2322	Male	Mixed	2	Urban	10	11.00	11.88	13.87	10.05	12.34	13.47	11.15	-0.46	0.40	-1.10
27	1632	Female	White	3	Urban	268	12.91	12.84	13.63	12.10	13.26	13.98	12.60	-0.42	-0.35	-0.50
28	2631	Male	White	3	Rural	81	9.80	10.39	11.66	9.17	10.80	11.60	10.02	-0.42	0.06	-0.85
29	1642	Female	White	4	Urban	300	12.85	12.80	13.58	12.06	13.14	13.82	12.49	-0.34	-0.24	-0.43
30	1212	Female	Black	1	Urban	18	12.44	12.29	14.11	10.44	12.62	13.83	11.36	-0.33	0.29	-0.92
31	1122	Female	Asian	2	Urban	38	12.82	12.56	14.10	11.04	12.88	13.89	12.02	-0.32	0.20	-0.98
32	1611	Female	White	1	Rural	64	13.42	13.09	14.32	11.74	13.35	14.19	12.55	-0.26	0.13	-0.81
33	1152	Female	Asian	5	Urban	48	12.40	12.33	13.78	11.04	12.56	13.49	11.69	-0.23	0.29	-0.65
34	1242	Female	Black	4	Urban	10	10.50	11.77	13.63	9.86	12.00	13.10	10.84	-0.23	0.53	-0.98
35	2112	Male	Asian	1	Urban	63	10.83	11.28	12.54	10.00	11.47	12.38	10.58	-0.20	0.16	-0.58
36	1641	Female	White	4	Rural	116	12.66	12.54	13.60	11.54	12.73	13.54	11.88	-0.18	0.06	-0.34
37	1532	Female	Pakistani	3	Urban	37	12.00	12.09	13.61	10.59	12.27	13.32	11.21	-0.18	0.29	-0.62
38	1652	Female	White	5	Urban	314	12.81	12.76	13.50	11.99	12.93	13.56	12.30	-0.17	-0.05	-0.31
39	1621	Female	White	2	Rural	92	12.85	12.70	13.86	11.48	12.79	13.59	12.02	-0.10	0.27	-0.54
40	1612	Female	White	1	Urban	230	14.15	13.92	14.71	13.16	13.99	14.68	13.27	-0.07	0.04	-0.11
41	1232	Female	Black	3	Urban	23	11.96	12.12	13.69	10.37	12.16	13.34	11.08	-0.04	0.35	-0.70
42	1631	Female	White	3	Rural	106	13.19	12.96	14.11	11.97	12.96	13.76	12.19	-0.01	0.35	-0.23

Rank	Stratum	Sex	Ethnic group	Household income quintile	Urban/ rural	Stratum size	Mean GHQ-12	Predicted mean GHQ-12 (I+M effects)	High 95% CI predicted mean GHQ-12 (I+M effects)	Low 95% CI predicted mean GHQ-12 (I+M effects)	Predicted mean GHQ-12 (M effects)	High 95% CI predicted mean GHQ-12 (M effects)	Low 95% CI predicted mean GHQ-12 (M effects)	Predicted mean GHQ-12 (I effects)	High 95% CI predicted mean GHQ-12 (I effects)	Low 95% CI predicted mean GHQ-12 (I effects)
43	1132	Female	Asian	3	Urban	28	13.86	13.03	14.68	11.49	13.04	14.07	12.15	-0.01	0.62	-0.66
44	2652	Male	White	5	Urban	230	10.88	11.05	11.80	10.14	11.03	11.73	10.36	0.02	0.07	-0.22
45	2622	Male	White	2	Urban	196	11.24	11.38	12.16	10.49	11.36	12.08	10.70	0.03	0.08	-0.20
46	2342	Male	Mixed	4	Urban	22	12.64	12.39	14.10	10.75	12.34	13.41	11.13	0.05	0.69	-0.37
47	2611	Male	White	1	Rural	49	11.06	11.46	12.85	10.11	11.39	12.20	10.59	0.08	0.65	-0.49
48	1622	Female	White	2	Urban	295	13.63	13.53	14.24	12.72	13.45	14.13	12.77	0.08	0.11	-0.05
49	1121	Female	Asian	2	Rural	1	17.00	12.45	14.63	10.29	12.37	13.43	11.36	0.09	1.20	-1.07
50	2642	Male	White	4	Urban	228	11.36	11.47	12.29	10.60	11.36	12.04	10.69	0.11	0.25	-0.08
51	2152	Male	Asian	5	Urban	28	9.21	10.71	12.45	9.05	10.58	11.50	9.69	0.13	0.95	-0.64
52	1142	Female	Asian	4	Urban	38	13.66	13.05	14.56	11.68	12.92	13.87	12.01	0.14	0.70	-0.33
53	2641	Male	White	4	Rural	87	10.41	10.88	12.11	9.71	10.73	11.53	9.98	0.15	0.58	-0.27
54	2352	Male	Mixed	5	Urban	25	12.16	12.21	13.90	10.57	12.07	13.12	10.85	0.15	0.77	-0.28
55	2331	Male	Mixed	3	Rural	1	8.00	12.04	14.22	9.96	11.89	13.12	10.70	0.15	1.09	-0.73
56	2621	Male	White	2	Rural	81	10.58	10.99	12.21	9.82	10.82	11.61	10.03	0.17	0.60	-0.21
57	2512	Male	Pakistani	1	Urban	61	10.31	10.91	12.15	9.49	10.73	11.72	9.75	0.18	0.43	-0.26
58	1131	Female	Asian	3	Rural	2	20.50	12.69	15.16	10.63	12.50	13.65	11.50	0.19	1.51	-0.87
59	2132	Male	Asian	3	Urban	32	10.56	11.32	12.86	9.72	11.05	12.02	10.14	0.27	0.84	-0.42
60	1522	Female	Pakistani	2	Urban	38	12.58	12.49	14.05	10.89	12.20	13.20	11.14	0.29	0.85	-0.26
61	2651	Male	White	5	Rural	91	10.42	10.82	12.05	9.68	10.49	11.28	9.71	0.33	0.76	-0.03
62	2351	Male	Mixed	5	Rural	2	6.50	11.79	14.09	9.66	11.45	12.65	10.23	0.34	1.45	-0.57
63	2632	Male	White	3	Urban	259	12.03	12.06	12.91	11.22	11.70	12.39	10.95	0.36	0.53	0.28
64	1222	Female	Black	2	Urban	17	12.94	12.52	14.35	10.72	12.09	13.28	10.87	0.43	1.08	-0.15
65	1552	Female	Pakistani	5	Urban	7	12.86	12.32	14.37	10.34	11.88	12.93	10.82	0.45	1.45	-0.48
66	1542	Female	Pakistani	4	Urban	14	13.36	12.60	14.36	10.69	12.12	13.22	11.16	0.48	1.14	-0.47
67	1252	Female	Black	5	Urban	12	12.33	12.21	14.08	10.38	11.72	12.94	10.53	0.50	1.14	-0.15
68	1651	Female	White	5	Rural	119	13.42	13.21	14.23	12.12	12.65	13.42	11.88	0.56	0.81	0.24
69	2122	Male	Asian	2	Urban	52	11.27	11.61	12.99	10.27	11.01	11.90	10.07	0.60	1.10	0.20
70	2522	Male	Pakistani	2	Urban	30	9.77	10.92	12.61	9.35	10.23	11.22	9.19	0.70	1.38	0.15
71	2612	Male	White	1	Urban	160	13.17	13.00	13.89	12.08	12.27	12.95	11.54	0.73	0.93	0.53
72	1521	Female	Pakistani	2	Rural	1	15.00	12.38	14.65	10.22	11.60	12.75	10.52	0.77	1.90	-0.30
73	2222	Male	Black	2	Urban	25	9.44	10.92	12.63	9.29	10.07	11.30	8.99	0.85	1.34	0.30
74	2242	Male	Black	4	Urban	13	7.77	10.85	12.71	9.06	10.00	11.14	8.87	0.85	1.57	0.19
75	2212	Male	Black	1	Urban	26	11.58	11.87	13.52	10.25	10.76	11.87	9.59	1.11	1.65	0.66
76	2341	Male	Mixed	4	Rural	2	26.00	13.17	15.45	10.87	11.84	13.01	10.72	1.33	2.44	0.16
77	2532	Male	Pakistani	3	Urban	27	11.67	11.95	13.77	10.41	10.42	11.41	9.40	1.52	2.37	1.01
78	2142	Male	Asian	4	Urban	31	12.90	12.56	14.12	11.03	11.04	11.94	10.15	1.53	2.18	0.88
79	2542	Male	Pakistani	4	Urban	16	11.25	11.96	13.71	10.17	10.24	11.28	9.19	1.72	2.44	0.98
80	2232	Male	Black	3	Urban	7	11.29	12.03	14.07	10.13	10.26	11.39	9.04	1.77	2.68	1.09
81	2121	Male	Asian	2	Rural	1	15.00	12.26	14.41	10.07	10.46	11.46	9.43	1.80	2.94	0.64
82	2151	Male	Asian	5	Rural	1	5.00	11.93	14.11	9.69	10.07	11.11	8.99	1.86	3.00	0.70
83	2141	Male	Asian	4	Rural	1	17.00	12.47	14.63	10.25	10.40	11.41	9.39	2.07	3.22	0.85
84	2552	Male	Pakistani	5	Urban	7	10.71	11.99	14.04	9.89	9.90	10.93	8.82	2.09	3.11	1.07
85	2252	Male	Black	5	Urban	7	12.57	12.42	14.35	10.42	9.84	11.04	8.61	2.58	3.31	1.81

Note. I+M effects = interaction effects and main effects conflated; M effects = main effects only; I effects = differences between intersections and main effects.

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