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'Feeling down one evening doesn't count as having mental health problems'—Swedish adolescents' conceptual views of mental health

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Abstract

Aims: To explore Swedish adolescents' conceptual views of mental health and mental health problems.

Design: A qualitative descriptive study design.

Methods: Semi-structured focus group interviews and individual interviews were conducted with, in total, 32 Swedish adolescents (15–18 years old) in October–November 2020. Data were analysed using systematic text condensation.

Results: Three themes were identified through the analysis: *Mental health is about how we feel*; *One's mental health depends on one's situation, thoughts and ways of coping*; and *Mental health problems should be taken seriously and can get severe*.

Conclusion: The results indicate that adolescents understand the complexity and holistic nature of mental health and mental health problems. According to the participating adolescents, positive mental health and mental health problems should be considered simultaneously to understand a young person's mental health state. Good health was described as having both absence of mental health problems and high levels of well-being: *feeling well*. Mental health problems were defined as something other than normal difficulties in life, but ranging from minor difficulties to more severe conditions. However, all kinds of mental health problems were termed as *feeling unwell*. The results suggest that adolescents are in need of support to cope with normal difficulties in life rather than lectures about life sometimes being challenging. In addition, the results highlight the need to prevent school-related stress and offer adolescents support for minor mental health problems.

Impact: The findings have implications for nurses and other professionals who encounter adolescents in their profession, for example specialist nurses, school nurses and public health professionals. The findings add knowledge that could be useful for communication with adolescents about their mental health and methods to assess their mental health status.

Patient or Public Contribution: The preliminary results were presented to three classes, in year nine in lower secondary school, for validation.

KEYWORDS
adolescents, focus group, mental health, mental health problems, nurses, perceptions, public health, qualitative interview

1 | INTRODUCTION

More than 13% of adolescents worldwide suffer from diagnosed mental disorders (United Nations Children's Fund [UNICEF], 2021). The prevalence is highest in the Middle East, North Africa, North America and Western Europe. In addition, about 19% of adolescents internationally report having mental difficulties, for example feelings of depression. In recent decades, the prevalence of registered diagnoses and treatment for mental disorders has increased among adolescents in high-income countries (Collishaw, 2015). Further, an increase has been detected in adolescents' self-reported psychosomatic symptoms in Northern Europe (Potrebny et al., 2017). At the same time, many adolescents do not seek help for their mental health problems, that is, symptoms of medically defined mental disorders or self-reported mental difficulties which cause suffering and have negative impact on daily life (Swedish Association of Local Authorities and Regions [SKR], 2022; Teng et al., 2017).

When nurses meet adolescents in specialized and primary healthcare settings, a shared understanding of young people's mental health is essential to achieve person-centred care and health promotion (International Council of Nurses, 2021). However, lay and professional terms for mental health and mental health problems do not always match (Duby et al., 2021; Kuo et al., 2019; Lindholm & Wickström, 2020). Previous research indicates that adolescents sometimes find it difficult to describe mental health (Armstrong et al., 2000; Johansson et al., 2007) and that their descriptions of mental health problems derive from their lived experiences and preconceptions related to, for example. cultural context. Therefore, their descriptions may not always conform with medical terms for mental disorders (Duby et al., 2021; Kuo et al., 2019; Lindholm & Wickström, 2020). Moreover, adolescents may use medical terms to describe their mental health, attributing them different meanings than the medical definitions (Lindholm & Wickström, 2020). Further, adolescents may use other words than medical terms to label mental disorders, for example if a medical term is rarely used in the cultural or linguistic context that the adolescents find themselves in (Duby et al., 2021; Kuo et al., 2019).

It has also been shown that some adolescents perceive psychosomatic symptoms as everyday problems, whereas others regard them as indicators of mental health difficulties—in accordance with the definition of mental health problems (Lindholm & Wickström, 2020).

More insight into adolescents' perceptions of mental health concepts might support healthcare professionals to use a language familiar to adolescents in communication (Duby et al., 2021) and when planning surveys, public health policies and interventions to improve adolescents' mental health (Armstrong et al., 2000; Duby et al., 2021; Svirydzenka et al., 2014; Teng et al., 2017; Wickström & Lindholm, 2020).

2 | BACKGROUND

The term 'mental health' is commonly used both to describe the positive dimension of mental health and as a broader concept involving both positive and negative mental health (SKR et al., 2020; World Health Organization [WHO], 2013). Since 2020, Swedish health authorities promote use of the term 'mental health' only as a holistic concept describing mental status, encompassing both positive mental health and mental health problems (SKR et al., 2020).

The positive dimension of mental health has traditionally been regarded as the opposite of mental health problems (Westerhof & Keyes, 2010). However, nowadays, mental health is described as a state in itself, more complex than merely the absence of mental illness (SKR et al., 2020;Westerhof & Keyes, 2010; WHO, 2013). WHO (2013) defines mental health as: 'A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community' (WHO, 2013, p. 6). This definition contains a view of mental health which encompasses positive mental health (Westerhof & Keyes, 2010; WHO, 2013) and can be used synonymously with mental well-being (SKR et al., 2020). Positive mental health involves both emotional well-being, that is, hedonic well-being, and optimal functioning, that is, eudaimonic well-being (Westerhof & Keyes, 2010). Emotional well-being includes feelings of happiness, satisfaction and interest in life, whereas optimal functioning involves psychological functioning and social functioning. Psychological functioning contains six factors: (1) self-acceptance, (2) purpose in life, (3) autonomy, (4) positive relations with others, (5) environmental mastery and (6) personal growth. Social functioning involves five factors: (1) Social coherence: being able to make meaning of what is happening in society; (2) social acceptance: a positive attitude toward others while acknowledging their difficulties; (3) social actualization: the belief that the community has potential and can evolve positively; (4) social contribution: the feeling that one's activities contribute to and are valued by society; and (5) social integration: a sense of belonging to a community. (Westerhof & Keyes, 2010, p. 111). A person with high levels of positive mental health has high subjective well-being and good perceived psychological and social functioning, that is, flourishing mental health (Westerhof & Keyes, 2010). The opposite, languishing mental health, occurs when a person has low levels of subjective well-being and suboptimal psychological and social functioning.

'Mental health problems' is a term used to describe various problems and symptoms, ranging from mental health difficulties to diagnosed mental disorders (Collishaw, 2015; SKR et al., 2020). Mental health problems include symptoms which cause suffering for

individuals or people in their surroundings, which in turn leads to problems in maintaining relationships and engaging in daily activities (SKR et al., 2020).

Mental health difficulties can be defined as symptoms, often related to strains in life, not meeting diagnostic criteria for mental disorders. Some examples are psychosomatic symptoms like headache, stomach ache or back pain, sleeping problems and anxiety and depressive symptoms (SKR et al., 2020). Mental difficulties among adolescents are usually measured through self-reports (Lindholm & Wickström, 2020; UNICEF, 2021). There are, however, methodological difficulties with such measures due to differing preconceptions and individual perceptions of symptoms among adolescents in different cultural contexts (Duby et al., 2021; Lindholm & Wickström, 2020).

Mental disorders are defined as mental health problems causing symptoms that correspond to an established set of diagnostic criteria, as described in the classification system *International Classification of Diseases* (ICD) or *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Some examples are depressive disorders, anxiety disorders, substance abuse, obsessive compulsive disorders, trauma- or stress-related disorders, psychotic disorders and neuropsychiatric disabilities, for example attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (Collishaw, 2015; SKR et al., 2020).

A person's mental health is best understood by creating a holistic description through combining levels of positive mental health with the presence or absence of symptoms of mental health problems (SKR et al., 2020; Westerhof & Keyes, 2010). In this two-continua model of mental health, a person with high levels of positive mental health and absence of symptoms of mental health problems is described as having 'complete mental health' (Westerhof & Keyes, 2010).

Mental health problems are common in young people and their perceptions of mental health concepts are of importance to develop contextually relevant interventions (Armstrong et al., 2000; International Council of Nursing, 2021; Svirydzenka et al., 2014; Teng et al., 2017; Wickström & Lindholm, 2020). Nonetheless, few studies have explored adolescents' conceptualizations of mental health and mental health problems in high-income countries in the last decade. Sweden is no exception, despite the fact that Swedish adolescents' mental health and increasing mental health problems have been highlighted in societal discussions (Public Health Agency of Sweden, 2018; SKR et al., 2020; Wickström & Lindholm, 2020). There has been a larger increase in mental health difficulties among adolescents in Sweden than in other European and Nordic countries (Potrebny et al., 2017). There is also a generally strong awareness and understanding of mental health problems, with a corresponding ability to discuss the prevalence and increase of these problems among Swedish adolescents (Hellström & Beckman, 2021). In our study, we therefore attempted to expand and nuance knowledge by exploring Swedish adolescents' views on mental health and mental health problems.

3 | THE STUDY

3.1 | Aim

The aim of the study was to explore adolescents' conceptual views of mental health and mental health problems in a Swedish context.

3.2 | Design

This study used a qualitative descriptive study design. The data were analysed using systematic text condensation (Malterud, 2012).

3.3 | Sample/participants

The study was conducted on Gotland, the largest Swedish island, situated in the Baltic Sea, with approximately 60,000 inhabitants. Maximal variation sampling was used to recruit adolescents. The inclusion criterion was attendance at lower or upper secondary school on Gotland. The exclusion criterion was age under 15 years. In an effort to capture the heterogeneity in the focal population, schools targeted for recruitment included both publicly and privately run schools, theoretical and vocational education classes, and schools in both rural and urban parts of Gotland. The background characteristics of the participants are summarized in Table 1.

To provide information about the study and recruit participants, the first author visited nine classes in five schools, after receiving permission from the head teachers. During the class visits, a total

TABLE 1 Background characteristics of the participants ($n = 32$)

	n (%)
Gender	
Boys	14 (44)
Girls	18 (56)
Age	
15 years	17 (53)
16 years	6 (19)
17 years	8 (25)
18 years	1 (3)
Participants attending schools located in indicated parts of Gotland	
Northern Gotland	7 (22)
Southern Gotland	7 (22)
Visby	18 (56)
Participants attending lower secondary school	18 (56)
Participants attending upper secondary school	14 (44)
On a 'vocational' upper secondary program	7 (22)
On a 'preparatory' upper secondary program for further studies	7 (22)

of 41 students agreed to participate (see the *Ethical considerations* section for details). Three students withdrew their participation before individual interviews were held and one focus group was cancelled because of COVID-19 pandemic restrictions, with the loss of another six participants. Although one focus group could not be conducted as planned, the data were considered rich and saturated enough to provide a broad range of descriptions of the participants' views, without excessive redundancy.

3.4 | Data collection

In total, five focus group interviews and five individual interviews were conducted in October–November 2020. The interviews were divided into two parts, which were performed on the same day or during the same week. Each part of the individual interviews lasted 17–61 min (mean: 38 min) and each part of the focus group interviews lasted 40–78 min (mean: 57 min). Numbers and genders of the participants are presented in Table 2.

To create a familiar setting for the focus groups, each group comprised students from the same class. An interview guide was used, with the same questions used in the focus group interviews and the individual interviews (Table 3). The interview guide was pilot-tested in the first focus group interview. All authors read the interview transcripts and found the interview guide to be suitable, with no need for modifications. Therefore, data obtained from the first focus group were included in subsequent analyses.

The first author moderated the focus group interviews and conducted the individual interviews. An observer attended the focus group sessions and took notes on interactions, which were discussed immediately after the interviews. The interviews were held in Swedish, as all participants spoke Swedish fluently. All interviews were audio-recorded and transcribed verbatim.

All interviews were conducted at the schools, except two individual interviews, of which one was held in Region Gotland municipal premises (where the interviewer works), following a request from the participant, and the other online, because of COVID-19 restrictions. All interviews were held in a secluded room, except the online interview, during which the interviewer and the participant were in separate secluded rooms.

The interview sessions were designed to establish a trustful environment (Kreuger & Casey, 2015), starting with small talk and snacks. After information had been given about the aim and opportunity to withdraw from the study at any time, each interview began with an introductory question to open discussions (Table 3).

TABLE 2 Numbers and genders of participants in the focus groups (FG) and the individual interviews (I) ($n = 32$)

	Boys (*n*)	Girls (*n*)
FG1	0	4
FG2	2	2
FG3	0	7
FG4	4	3
FG5	5	0
I1	1	–
I2	1	–
I3	–	1
I4	–	1
I5	1	-
Total (*N*)	14	18

TABLE 3 Questions in the interview guide

Questions, part one
• What made you agree to participate in this study?
• What is the first thing that comes to mind when I say mental health problems?
• What is the first thing that comes to mind when I say mental health?
• What do you think is the difference between (good) mental health and mental health problems?
• We can think differently about people who have mental health problems. What do you think about that?
• What we've been talking about, how do you think it is on Gotland?
• If you had at most a minute to tell me the most important thing that came up in the conversation now, what would you say?
• How do you think I/the observer captured what you've been talking about? [*after the observer/interviewer summarized what was said in the interview.*]
• Is there anything we have not talked about that should have been included?
• Is there anything you want to add to what you've already told me?
Questions, part two
• Have you come to think of anything since the last conversation that you want to add?
• What do you think we should ask adolescents in a survey to get answers about (good) mental health and mental health problems?
• What should we definitely not miss asking about?
• Do you think these questions would work? [*showing questions from specific instruments to measure positive mental health, symptoms of mental health problems and stigma toward people with mental health problems.*]
• How did you feel answering the questions?
• What do you think of the questions?
• How do you think I/the observer has captured what we have been talking about?
• Is there anything you want to add?

3.5 | Ethical considerations

The study was carried out in accordance with the Declaration of Helsinki and ethics approval was granted by the Swedish Ethical Review Board.

Participation in the study could initiate thoughts about own or others' mental health problem, but did not entail any actual risks. After each interview, the participants were asked how they felt and were given information about the opportunity to receive counselling from the school's student health organization. The adolescents were given both verbal and written information about the study during

recruitment and just before being interviewed. They were informed that they could withdraw their participation at any time with no explanation and were given contact information to the researchers. Students who wished to participate in the study gave written consent, as required under the Swedish law for people aged 15 years or over. In this paper, participant names have been replaced with pseudonyms in the quotations used to illustrate the results.

3.6 | Data analysis

The transcripts were subjected to inductive data analysis through systematic text condensation, an approach influenced by Giorgi's psychological phenomenological analysis (Malterud, 2012). In the first step, all transcripts were read by all authors and preliminary themes describing the essence of the adolescents' views were identified. The preliminary themes were discussed and agreed upon by all authors. In a second step, the first author marked meaning units in the texts, sorted them into preliminary themes and further into code groups. In a third step, the first author summarized the meaning units in each code group and identified subgroups, extracting each one into a short condensed text in the form of a synthetic quote. All authors then discussed the code groups and themes and made adjustments as needed. In the fourth (and final) analytical step, the first author formulated the results, with categories as subheadings, as an analytical text. The results were then compared with the original transcripts. To enhance concordance between the analytical text and the original transcripts, some minor adjustments were made. The preliminary results were presented and discussed with other research colleagues, which resulted in some additional adjustments to one theme and some of the categories. The preliminary results were also presented by the first author to two classes in year nine in lower secondary school, including some study participants. The students were asked to give anonymous feedback on the results and some minor changes were made to the result presentation based on this. In addition, the students in a third class in school year nine were presented the preliminary results by their teacher, based on a PowerPoint summary. Their reactions to the results were discussed in class and the teacher stated that the students acknowledged the results and found them relevant.

To include interactions in the focus groups in the analysis, the first author developed a code scheme that was used to mark interactions associated with meaning units extracted from the focus group transcripts during the second step of the analytical process. For example, meaning units were marked with different symbols depending on if there was consensus in the group, differing opinions or the discussion increased the group's liveliness. The interaction codes were considered when completing steps three and four of the analysis. Details on the code scheme for focus group interaction analysis will be presented in a separate paper.

All responses to the questions in the interview guide (Table 3), from both individual interviews and focus groups, were analysed together. This paper presents results about the adolescents' conceptualizations of mental health and mental health problems. The results about thoughts about prevalence, stigma and measurements of mental health problems will be presented in a separate paper.

3.7 | Rigour

To improve trustworthiness, study credibility, dependability and transferability were addressed when planning and conducting the study (Polit & Beck, 2022). *Credibility* (Polit & Beck, 2022) was supported by using both focus groups and individual interviews as data collection methods. Focus groups have a recognized strength as regards obtaining data on participants' perceptions (Kreuger & Casey, 2015), whereas individual interviews can add detailed descriptions. The combination of focus groups and individual interviews has been used in previous studies with adolescents (Armstrong et al., 2000; Johansson et al., 2007; Teng et al., 2017) to obtain rich and detailed data (Lambert & Loiselle, 2008). Use of an interview guide ensured that the same set of questions was included in all interviews. All authors discussed interview techniques and the interview guide in an effort to maximize the quality of the data collection procedure, in the limitations of any interview-based study (Lambert & Loiselle, 2008). Further, the first author (who conducted the individual interviews and moderated the group discussions) had prior experience of addressing mental health issues and moderating group discussions as a nurse and midwife, which might have contributed to a safe atmosphere where the adolescents could freely discuss their thoughts. However, the fact that the first author was a woman in her fifties, currently working with public health strategies at the regional office on Gotland, might have caused the participants to perceive an imbalanced power dynamic and hampered them from sharing their thoughts or answering the questions truthfully. Nevertheless, the first author and the two persons involved in observing the focus group interviews found the participants to be talkative, as they shared both broad and deep thoughts as well as spontaneous comments. The conversations were found to flow easily and resulted in a rich data material.

Dependability (Polit & Beck, 2022) was supported by the clear decision trail of the study, documented by the first author, and the discussion between all authors during the analysis, to reduce research bias. Further, it was especially important to consider reflexivity (Malterud, 2001) as all authors but one had theoretical preconceptions about mental health and mental health problems, and the first author was working with public health strategies on Gotland, at the time of the study. The observer and moderator evaluated each focus group interview immediately after it's conclusion, thereby enhancing researcher reflexivity. Reflexivity was also specifically considered throughout the data analysis in discussions between the authors about how to distinguish between possible preconceptions and genuine emanations from the data.

Transferability (Polit & Beck, 2022) of the results to other settings was facilitated by the inclusion of a heterogeneous sample in terms of gender, age, educational orientation, location and school type. In

addition, the results revealed substantial diversity in experiences of mental health problems among the adolescent participants.

4 | FINDINGS

A total of 32 adolescents aged 15–18 years were interviewed to answer the research question: How do adolescents describe mental health and mental health problems? Three Themes were identified from the analysis: *Mental health is about how we feel; One's mental health depends on one's situation, thoughts and ways of coping*; *Mental health problems should be taken seriously and can get severe*. Identified themes and categories are presented in Table 4.

4.1 | Mental health is about how we feel

4.1.1 | Mental health is an umbrella term

The adolescents regarded mental health as a concept describing a person's mental status, encompassing a wide range of possible states, from various kinds of mental health problems to good mental health, or even both at the same time.

> My mental health can be both good and bad (…). I see it as neutral and as a question (…) It can be very happy, and it can be very bad, and it can be anything in between. (David, 16 years old, individual interview).

Although the adolescents recognized that 'mental health' was sometimes used as a positive term for good mental health, they suggested that it should rather be used as a neutral concept referring to a person's state of mind.

> Feeling well is just simply feeling well (…) You can't kind of say mental health and think it means that someone feels well. (Beatrice, 16 years old, individual interview).

However, the participants found it difficult to think of a term for positive mental health other than 'feeling well' or 'good mental health'. A few participants suggested the term 'well-being' but expressed uncertainty about if it was the best term to use. When talking about mental health problems (either minor mental health problems or more severe conditions), the adolescents referred to *not feeling well* or *feeling unwell*. They found it harder to explain good mental health than to define mental health problems.

4.1.2 | Mental health is more complex than just feeling well or unwell

The adolescents suggested that mental health is complex and cannot be described solely in terms of having mental health problems or not, indicating that good mental health and mental health problems are not opposite poles on a continuum. Moreover, they recognized a need to consider aspects of good mental health, as well as diagnoses and symptoms of mental health problems to establish an individual's mental health state.

> It's not black or white (…) They [good mental health and mental illness] are not like opposites. And as I said, I do not think that you are either healthy in the head or not. (Sara, 16 years old, individual interview).

According to the adolescents, a person's perception of their current mental health depended on many factors, for example the situation in school, relationships with friends and family, leisure activities, support from others, current stress levels, previous traumatic experiences, lifestyle, self-care and views of oneself and the world. They suggested that all these factors should be considered when talking about a person's mental status.

4.2 | One's mental health depends on one's situation, thoughts and ways of coping

4.2.1 | When you are in control and on a roll, you feel well

Many participants described good mental health as *feeling well*—a state of being pleased with oneself and feeling happy. Other

TABLE 4 Identified themes and categories

Themes	Categories
Mental health is about how we feel	Mental health is an umbrella term Mental health is more complex than just feeling well or unwell
One's mental health depends on one's situation, thoughts and ways of coping	When you're in control and on a roll, you feel well When you can deal with difficult situations in life, you can feel well Loss of balance in life and thoughts can cause mental health problems
Mental health problems should be taken seriously and can get severe	Mental health problems encompass a wide spectrum Mental health problems can be serious conditions Those with mental health problems need support and care

factors they associated with feeling well included having a sense of control, meaning and structure in life, some sort of plan for the future, someone to talk to and the ability to function well with others.

> Feeling understood and that you can share your thoughts and kind of get the views of others on different things. I think that's like one of the most important parts of (…) [good] mental health. (Peter, 16 years old, individual interview).

Some participants suggested that good mental health was the absence of symptoms of mental health problems, such as stress, anxiety or trouble sleeping.

Denise: -When you feel well (…) having fun.
Estelle: -And aren't that stressed.
Denise: -Exactly.
Estelle: -Life is good. (…)
Kate: -Rolling along.
Estelle: -Yes, like in summer vacation. (…) No school.

(Participants in focus group 1, all 15 years old).

4.2.2 | When you can deal with difficult situations in life, you can feel well

Many participants suggested that feeling well did not necessarily mean feeling great all the time, but rather having the ability, mental stability and skills to deal with difficulties, knowing what to do to feel better, having someone to turn to and knowing where to get help if needed. One adolescent in a focus group reacted to other participants' description of good mental health as a state of feeling joy and happiness as follows:

> Yes, I agree and don't agree. I also think that it's not always like this (…) but that you have some sort of self-awareness and know how you feel, have figured out how you function, so you know when you start feeling unwell and how to deal with it (…) So more (…) self-awareness than that you feel great. (Jennifer, 15 years old, focus group 4).

According to the adolescents, it is possible to feel well while having mental health problems if one is aware of the problems and can cope. The participants gave examples of coping methods, such as eliminating factors that caused mental health problems, increasing factors that helped one feel well and accepting oneself with the difficulties one had. In one focus group, the participants discussed their strategies to feel well while living with neuropsychiatric disorders:

Vincent: -I have ADD (…) before, I exercised so much that I got enough dopamine that I never needed such a large dose of it [medication].
Oscar: -I guess it's about finding something that makes you feel good and kind of finding good people you like and hang out with.
Ted: -You need to find a hobby. Mine has been exercise, too. Keeps you kind of busy in a way you like.
Jim: -But exactly (…). If you feel unwell, you do not think as much about it if you are around people all the time and like, doing things you like.

(Participants in focus group *5*, 17 and 18 years old).

4.2.3 | Loss of balance in life and thoughts can cause mental health problems

The adolescents described mental health problems as conditions caused by various factors in combination with individual vulnerability. They particularly mentioned factors related to family, friends and school as potential causes of mental health problems, if they were unsupportive or problematic at levels leading not only to normal difficulties in life, but also to more persistent problems.

> I usually think of a chair when thinking of my mental health. (…) One leg is family, one leg is school, one leg is leisure activities and one leg is friends. (…) One of those legs can wobble and be bad, but you can still sit on the chair. (…) When all the legs are wobbly (…) that's when the bad part takes over. (David, 16 years old, individual interview).

Most of the adolescents also mentioned stress and pressure to live up to expectations at school and difficulties in finding time for family, friends and leisure activities as risk factors for developing mental health problems. Many particularly emphasized stress from school, for example due to high workload and pressure to get good grades, as a risk factor for symptoms such as anxiety and sleeping problems.

> You feel incompetent because you don't have time for school and don't have time to see your friends and then at the same time you should relax and just be at home being yourself (…). And you feel that you don't have the time to do everything you want and you feel inadequate, and you don't feel well. (Beatrice, 16 years old, individual interview).

Genetic factors, prior traumatic experiences and difficult upbringing were also mentioned as factors that could contribute to the development of mental health problems. Both boys and girls intensely discussed prejudice and stereotypic norms, such as gender norms, rumours and the impossibility of being anonymous

in a small community, as causing or aggravating mental health problems.

> But when it [the island Gotland] is so small, talk gets around sort of. And I think that also can do harm (…) if rumours spread that (…) within just a day, everyone on Gotland will know that your nude pictures have leaked. (…) So, it actually can affect mental health. (Sara, 16 years old, individual interview).

The participants in one focus group strongly agreed that low self-esteem was a severe risk factor for the development of mental health problems. Many expressed beliefs that mental health problems could be caused by negative attitudes and constantly thinking about how bad a situation is. On the other hand, they also identified not expressing emotions as a risk factor for developing mental health problems.

> When I was much younger, my mum had a thing that as long as I didn't kind of cry my heart out (…) if I fell and hurt myself, she wasn't too concerned. (…) So, I got the impression that, okay, you shouldn't cry, you shouldn't be weak. (…) Sort of every time I feel unwell it's like asking (…) 'Why am I not feeling well? Why can't I just feel well?'. So, it can be things like that. Just automatic thoughts (…) when you put yourself down in some way. (Celine, 17 years old, focus group 2).

4.3 | Mental health problems should be taken seriously and can get severe

4.3.1 | Mental health problems encompass a wide spectrum

The adolescents distinguished between normal difficulties in life and mental health problems. The latter were described as symptoms lasting for a longer time and affecting one's ability to maintain normal everyday life.

> For me, feeling down one evening doesn't count as having mental health problems. Then you're down one night a week for many weeks (…) To me, mental health problems are more severe and last for a longer period of time. (David, 16 years old, individual interview).

The adolescents also regarded mental health problems as a spectrum ranging from minor mental health problems, for example anxiety related to stress, to more severe problems and mental illness, like depression or schizophrenia. They did not define a difference or threshold between severe mental health problems and mental illness, but regarded both as being at the opposite end of the spectrum from minor mental health problems.

Neuropsychiatric disorders were recognized by some participants as both mental health problems per se and conditions causing mental health problems, for example depression. Moreover, according to some participants, all conditions on the spectrum of mental health problems could be perceived as either minor or more severe, depending on the person and situation. Many strongly emphasized the importance of taking symptoms of stress or other seemingly minor problems seriously.

> Mental health problems can be both small and big things. You might feel like 'But I'm not into self-harming, so I'm not important. It's better that you attend to the others' kind of. But I might also have a sort of mental health problem. It's still important, even if it's not that big. (Emelie, 15 years old, focus group 3).

4.3.2 | Mental health problems can be serious conditions

Depression was mentioned by most of the adolescents as a severe mental health problem and an illness. However, in one focus group, there was a lively discussion about whether depression is really a psychiatrically diagnosed condition or just a description of ongoing feelings. One participant in an individual interview said that adolescents commonly self-diagnose depression without knowing what the condition really entails.

Furthermore, the adolescents cited various examples of what they regarded as severe mental health problems, including anxiety disorder, panic disorder, post-traumatic stress disorder, fatigue syndrome, self-harm behaviour, eating disorder, suicidality and schizophrenia. They also mentioned the following symptoms of severe mental health problems: inability to manage daily life or work, severe fatigue, isolation, doing nothing at all or too many things and having strange thoughts or bodily pain. When talking about symptoms, they also expressed beliefs that it is possible to have severe mental health problems without realizing it and that people with mental health problems often keep them quiet or try to hide them, for example putting up a facade to avoid negative reactions from others.

> My mum, she was sick for a hell of a long time before she got help. And when she did get help at last almost everyone's reaction was 'What, was she sick?'. (…) And as for me, when I felt sick, everything went on as usual, except that I locked myself in my room and stared up at the ceiling, so nobody noticed anything. (Celine, 17 years old, focus group 2).

4.3.3 | Those with mental health problems need support and care

The adolescents recognized mental health problems as conditions that negatively affected not only those suffering from them but also other people, and argued that people with mental health problems need support from people close to them, as well as professional help. Many mentioned the need for some kind of therapy or counselling, but opinions about medication were divided. Several adolescents pointed out that medication was not enough and some sort of therapy was also required. Some adolescents, especially those with personal experiences of medication, regarded support and other non-medical interventions (e.g. physical activity and familiarization with coping strategies) as better than medication.

When reasoning about medication, one participant said:

> I think it's kind of more important to look at what's causing this [the problem(s)]. (…) When it comes to mental health problems, they are not quite kind of like physical illness (…) a standard model for how to fix it sort of. But you have to kind of personalize it for this person. (Peter, 16 years old, individual interview).

In one focus group, there was a long and very intense discussion about medication. One participant, who said she had no previous experience of mental health problems, claimed that only severe mental illness like schizophrenia should be treated with medication. That opinion was strongly questioned by others, who said they had experience of personal mental health problems.

Jennie: -But you can still get away from it, but you can't get rid of schizophrenia, for example, and so like I still think you shouldn't kind of become addicted to a drug.

Evelyne: -But we told you, (…) not everyone can get away from their depression or anxiety. (…)

Jessica: -And then you're stuck.

Evelyne: -And you can't get away from it and you'll die.

(Participants in focus group 3, all 15 years old).

5 | DISCUSSION

The results indicate that adolescents in the current study had a broad understanding of mental health and mental health problems. The adolescents understood good mental health as both the absence of mental health problems and the presence of positive mental health. They recognized mental health problems as a spectrum, ranging from minor to severe, but also saw a need to take all conditions on the spectrum seriously. The adolescents argued for a holistic approach in addressing mental health, with consideration of social, family and individual factors to elucidate whether experienced symptoms should be regarded as 'normal' or a loss of balance and a sign of problems requiring intervention. The results contribute with knowledge of importance when assessing, discussing and interpreting adolescents' mental health as well as when planning for interventions.

5.1 | Mental health—What is it and what is it not?

5.1.1 | Mental health is a neutral concept

In addition to asking the adolescents about their views of mental health problems, we intended to acquire knowledge of their understanding of good mental health by asking them to describe or define mental health. However, they regarded mental health as a neutral concept related to how one feels, in accordance with previously reported views among adolescents (Teng et al., 2017) and the definitions of Swedish authorities (SKR, 2020).

5.1.2 | What is good mental health?

When talking about good mental health, the adolescents mostly used the terms 'feeling well' or 'good mental health'. The term 'positive mental health' was not used at all and general 'well-being' was only suggested by a few adolescents when specifically asked to think of another term.

The participants in the current study described a range of factors that they associated with good mental health. Their descriptions were in line with the WHO's definition of positive mental health (Westerhof & Keyes, 2010; WHO, 2013). Emotional well-being, a part of the WHO's definition of mental health, encompasses feelings of happiness, satisfaction and interest in life (Westerhof & Keyes, 2010; WHO, 2013). Narratives matching that definition were found in the category '*When you're in control and on a roll, you feel well*'. Similar descriptions by adolescents have been recorded in previous studies in Australia (Bourke & Geldens, 2007; Teng et al., 2017), Scotland (Armstrong et al., 2000) and Sweden (Johansson et al., 2007; Landstedt et al., 2009; Wickström & Lindholm, 2020).

Optimal social functioning, also part of the WHO's definition of mental health, has been described as including social coherence ('being able to make meaning of what is happening in society'), social acceptance ('a positive attitude toward others while acknowledging their difficulties'), social actualization ('the belief that the community has potential and can evolve positively'), social contribution ('the feeling that one's activities contribute to and are valued by society') and social integration ('a sense of belonging to a community') (Westerhof & Keyes, 2010, p. 111). In our study, the adolescents' statements about having friends and functioning well with others could be interpreted as describing aspects of social coherence, acceptance and integration. However, there were no clear references to social actualization or social contribution in the adolescents' narratives of good mental health. That is somewhat surprising, given current societal discourses about climate change

and the ongoing COVID-19 pandemic. However, descriptions of social functioning (Westerhof & Keyes, 2010) have rarely featured in previously reported adolescents' perceptions of positive mental health (Armstrong et al., 2000; Johansson et al., 2007; Landstedt et al., 2009; Svirydzenka et al., 2014). This suggests that adolescents reflect on factors influencing positive health as being close to the self, rather than as factors affecting them—or with them as agents—at a broader societal level. These results are in line with previous observations by Bourke and Geldens (2007), which they associated with increased individualization in society and a focus on one's own choices and actions. The fact that Sweden is the country with the most secular and self-expressional values in the world (World Values Survey Association, 2020) might have influenced the participants in our study.

The adolescents also described good mental health as the absence of symptoms of mental health problems, for example anxiety, in line with findings in a previous Swedish study (Johansson et al., 2007).

5.1.3 | The importance of coping skills

Findings about the second theme, *One's mental health depends on one's situation, thoughts and ways of coping*, indicate that adolescents understand that life is not always easy and that good mental health is not necessarily a state of total happiness. Psychological functioning, part of the WHO's definition of positive mental health, has been defined as having self-acceptance, a purpose in life, autonomy, positive relations with others, environmental mastery and personal growth (Westerhof & Keyes, 2010). Descriptions matching that definition were found in the following categories: *When you're in control and on a roll, you feel well* and *When you can deal with difficult situations in life, you can feel well*. Several other studies have found that British (Armstrong et al., 2000; Svirydzenka et al., 2014) and Swedish (Johansson et al., 2007; Landstedt et al., 2009; Lindholm & Wickström, 2020) adolescents included coping abilities in features of good mental health. Our findings highlight the need of interventions to bolster adolescents' resilience and abilities to cope with difficulties in life. To promote resilience, a holistic approach is preferred, combining school-based programmes designed to increase resilience with interventions affecting social determinants of health, for example a safe and supportive school environment (Khanlou & Wray, 2014; UNICEF, 2021).

5.2 | Mental health problems are conditions beyond normal difficulties

In line with findings of both a Scottish study (Armstrong et al., 2000) and a Swedish study (Johansson et al., 2007), the adolescents in our study found describing good mental health more difficult than describing mental health problems. In the comments assigned to the third theme *Mental health should be taken seriously and can get severe*, mental health problems were described as a broad spectrum of conditions that persist over a long time and affect one's everyday life as well as people in one's surroundings, matching the descriptions commonly used in the literature. However, the adolescents conceptualized mental health problems as a continuum, indicating that even minor mental health problems can be perceived as severe and severe mental health problems can be perceived as minor, depending on individual circumstances and experiences.

Like previously surveyed Australian adolescents (Teng et al., 2017), most of our participants mentioned depression as a mental health problem. They mostly talked about it as a severe condition and did not use it with a meaning differing from the diagnostic criteria, in contrast to other recently interviewed Swedish adolescents (Lindholm & Wickström, 2020). In line with previous findings (Johansson et al., 2007), our participants used the term 'feeling unwell' when speaking about mental health problems. They also used it when talking about psychiatric conditions like depression and schizophrenia. This is another important example of how adolescents use wording other than the professionally accepted terms. As highlighted in previous research, it is of importance to allow and encourage adolescents to use their own words when discussing their mental health (Duby et al., 2021; Kuo et al., 2019). Further, the results imply the need to probe and listen carefully when adolescents talk about feeling 'unwell' or 'depressed', to establish whether the feelings are related to normal emotions of not feeling fine or to mental health problems. In addition, it is essential to talk to adolescents about how they feel, as both this and another previous study (Teng et al., 2017) indicate that they might often refrain from showing their true feelings, to avoid negative reactions from others.

5.3 | Mental health as a holistic concept

When describing mental well-being and mental health problems, the adolescents referred to various causal factors, in addition to describing conditions and symptoms. These descriptions included factors related to the general structural environment, living conditions, social factors, lifestyle and fixed individual factors, in accordance with Dahlgren and Whitehead's model of determinants of health (Dahlgren & Whitehead, 1991).The adolescents mentioned factors affecting mental health related to all the layers in the model, reflecting their lived experiences in a society where adolescents' mental health is discussed vigorously (Public Health Agency of Sweden, 2018; Wickström & Lindholm, 2020). Adolescents in another cultural setting might have addressed other factors. For instance, in a previous study, South African adolescents mentioned bewitchment as a cause of depression (Kuo et al., 2019).

About factors related to the *general structural environment* (Dahlgren & Whitehead, 1991), the adolescents in our study highlighted prejudice, stereotypic norms and cultural factors in a small community as causing or exacerbating mental health problems, in accordance with the theoretical understanding of the determinants of mental health (WHO, 2013).

Living conditions (Dahlgren & Whitehead, 1991) were mentioned in distinct narratives about stress. The adolescents identified stress as a factor affecting mental health problems, as also found in previous studies (Johansson et al., 2007; Landstedt et al., 2009; Svirydzenka et al., 2014). Stress explicitly associated with school performance has been reported in Swedish studies (Johansson et al., 2007; Landstedt et al., 2009). In accordance with findings in one of the cited Swedish studies (Landstedt et al., 2009), our participants strongly related stress to difficulties in finding time for family, friends, leisure activities and schoolwork. Moreover, like in another Swedish study (Lindholm & Wickström, 2020), the adolescents in our study stated that school-related stress caused anxiety. According to the adolescents, anxiety due to school-related stress could be severe enough to fit the definition of a mental health problem, albeit at the relatively mild end of the spectrum. There is support in the literature for school-related stress causing mental health problems (Gustafsson et al., 2010). In Sweden, the recent school reforms, including changes in the curriculum and grading system, have been described as a factor contributing to the increased prevalence of mental health problems among adolescents (Högberg et al., 2021; Public Health Agency of Sweden, 2018). One important factor to reduce school-related stress is using a grading system that makes it easy for students to understand the requirements for a certain grade and gives them better control of their performance (Gustafsson et al., 2010; Högberg et al., 2021). Further, school-based interventions on social and emotional learning and a safe and supporting environment can prevent various kinds of stress and mental health problems among adolescents (UNICEF, 2021; WHO, 2022).

The participants often mentioned the importance of *social factors* (e.g. family and friends), in accordance with the model of determinants of mental health (Dahlgren & Whitehead, 1991) and in line with previous findings (Armstrong et al., 2000; Wickström & Lindholm, 2020). They emphasized that these factors could be important both in terms of the (in)sufficiency of support to prevent the development of mental health problems and as potential triggers of mental health problems.

Physical activity was a *lifestyle factor* mentioned to support good mental health and reduce symptoms of mental health problems.

The greater focus on external factors than internal factors suggests that the participants did not regard the high prevalence of mental health problems among adolescents as inevitable. Rather, they recognized an opportunity to decrease problems through supportive interventions and prevention in different layers of the determinants of mental health.

In addition to the insight that various factors affect mental health, the adolescents' reasoning about the first theme, *Mental health is about how we feel*, implies that they had a holistic understanding of mental health. They found it to be a complex concept encompassing notions of positive mental health and mental health problems, which were not seen as merely two poles of a continuum. Moreover, they suggested that it was possible to have mental well-being simultaneously with symptoms of mental health problems or prolonged psychiatrically diagnosed conditions, for example neuropsychiatric disorders. This is consistent with the two-continua model of mental health (Westerhof & Keyes, 2010). The participants described good mental health to have absence of mental health problems and, at the same time, presence of high levels of positive mental health, which is consistent with the description of complete mental health (Westerhof & Keyes, 2010).

5.4 | Limitations

Due to time constraints, the results were not shown to and confirmed by the participants through structured member-checking. Transferability to multicultural settings and urban areas is limited, as the participants were living in a rural area with a small proportion of foreign-born residents. We did not have access to data on participants' ethnic backgrounds and prior experiences of mental health problems, which could be considered a limitation. Despite the sampling procedure seeking heterogeneity, another limitation that could affect transferability is the risk that only adolescents with particular interest in mental health participated in the study. Thus, transferability to less interested adolescents with lower capacity to verbalize and reflect on their experiences may be limited.

The study did not aim to specifically explore differences between boys' and girls' descriptions of mental health and mental problems. However, no patterns of gender differences were found in our analysis. The fact that the first author categorized the participants into the genders boys or girls is another limitation. As gender was not self-identified, there is no information on whether each participant had a gender identity consistent with their gender expression or whether they had a binary or other gender identity. Further, in the sampling procedure, we aimed to have an equal gender distribution in the sample, based on binary gender, and adolescents with non-binary gender identity were not specifically sought for. Hence, transferability to, for example transgender adolescents is limited.

6 | CONCLUSION

Participating adolescents understood good mental health as including both the absence of mental health problems and the presence of positive mental health. Mental health problems were understood as a spectrum, ranging from minor to severe conditions, all of which should be taken seriously. The adolescents advocated a holistic approach for assessing and discussing mental health, including consideration of social, family and individual factors to understand whether experienced symptoms were 'normal' or a loss of balance and a sign of problems needing intervention. Further, the adolescents suggested that the holistic approach should be applied in the treatment of those suffering from mental health problems.

The adolescents' holistic view of mental health indicated a need to use a clear terminology for concepts, symptoms and descriptors associated with mental health. Such use is warranted when assessing

adolescents' mental health in clinical settings or when measuring adolescents' mental health as a basis for public health interventions. Use of clearly defined and well-known terms (understood and accepted by adolescents, as well as both lay and professional adults), mirroring a holistic and two-continua model of mental health, could increase precision and prevent misconceptions when talking to adolescents about mental health or reporting mental health statistics.

Further, the results highlighted the need to prevent school-related stress and to provide support and care for adolescents with mental health problems, across the entire spectrum.

In conclusion, the results indicated that adolescents understand the complexity of mental health even though they use simplified language, and thus should not be patronized and 'informed' that challenges of life are not the same as mental health difficulties. Rather, they need support to effectively communicate how they feel and to cope with normal strains in life. In addition, they need to receive professional support relevant to their cultural context, when they deem this necessary.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE*): (1) Substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data; (2) drafting the article or revising it critically for important intellectual content. *Veronica Hermann*: Conceptualization, methodology, formal analysis, investigation, resources, data curation, writing—original draft, writing—review & editing, visualization, project administration. *Natalie Durbeej*: Conceptualization, methodology, formal analysis, writing—review & editing. *Ann-Christin Karlsson*: Formal analysis, investigation, writing—review & editing. *Anna Sarkadi*: Conceptualization, methodology, formal analysis, writing—review & editing, funding acquisition.

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CONFLICT OF INTEREST

No conflict of interests has been declared by the authors.

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