

Individual Report

Module Name: Digital Skills and Research Methods

Module Code: LCHS 4007

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According to my research within health and social care, especially in the mental health of children and adolescents, I have noticed a significant increase in mental health issues among adults and adolescents between the ages of 16 and 34. This raises concerns about the depth of the root cause of this issue, according to Professor Peter Fonagy, Head of the Division of Psychology and Language Sciences at UCL, who argues that the mental health crisis among young people cannot be addressed without fundamentally rethinking how we support their development.

Therefore, I believe that this situation regarding the increase in people with mental health problems among young people and adults should be discussed more in schools and companies, as this debate would create a consensus among the population, leading to public policies and obtaining more resources for public health, especially for people whose mental health is compromised.

According to the research, there has been an over 3 million increase in working-age individuals self-reporting long-term mental health conditions. This increase is quite challenging and worrying because it shows that there is a lot of neglect in public health, and this can snowball with high rates of depression and panic disorder, for example. Also, according to my research, stress at work can also lead to burnout, feeling withdrawn, losing your drive and motivation. Therefore, it is important to have efficient public policies to help this entire population, to have quality public policies so that everyone can get fair support and a dignified quality of life.

To improve the quality of life of a person with mental health problems, it is important to involve them in providing support and encouragement for professional treatment (psychiatrist/psychologist), assistance in daily areas, offering active and non-judgmental listening, motivating them to practice physical exercise, and ensuring they maintain sleep and eating routines. Trying to integrate them into social life, such as talking to friends and family and attending social gatherings, also helps somewhat.



Coping strategies and mental health trajectories during the first 21 weeks of COVID-19 lockdown in the United Kingdom

Author links open overlay

panelMeg Fluharty, Feifei Bu, Andrew Steptoe, Daisy Fancourt

Highlights

- Used data from the COVID-19 Social Study in the United Kingdom ($N = 26,505$).
- Mental health symptoms decreased over time for all coping styles.
- Supportive-coping associated with faster decrease in depression and anxiety symptoms.
- Women using avoidant coping displayed faster decrease in mental health symptoms.

Abstract

Rationale

The negative impact of the COVID-19 pandemic on mental health is well evidenced. However, there is little research on how individuals' coping strategies were related to changes in mental health over time.

Methods

The current study used data from the COVID-19 Social Study in the United Kingdom ($N = 26,505$) to explore whether coping strategies (problem-focused, emotion-focused, avoidant, and socially-supportive) were associated with (i) better mental health as lockdown was introduced, and (ii) faster recovery over time.

Results

People with greater use of problem-focused, avoidant, and supportive coping displayed more mental health symptoms, while greater use of emotion-focused coping was associated with fewer mental health symptoms. Symptoms decreased over time for all coping strategies, but only socially-supportive coping was associated with a faster decrease in anxiety and depressive symptoms, indicating a potential protective effect of social support on psychological distress.

Conclusions

Problem-, avoidant- and emotion-focused coping strategies were not associated with faster improvements in mental health. Suggesting the adoption of one of these coping styles in itself is not necessarily a driver of improvements in mental health; rather, specific attributes of the behaviours expressed as part of this coping style appear to be important in and of themselves.

Collaborative Psychiatric Epidemiology Surveys (CPES), 2001-2003 [United States] (ICPSR 20240)

Version Date: Feb 28, 2024 [View help for published](#)

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Series:

- [National Comorbidity Survey \(NCS\) Series](#)

<https://doi.org/10.3886/ICPSR20240.v9>

Summary [View help for Summary](#)

The Collaborative Psychiatric Epidemiology Surveys (CPES) were initiated in recognition of the need for contemporary, comprehensive epidemiological data regarding the distributions, correlates and risk factors of mental disorders among the general population with special emphasis on minority groups. The primary objective of the CPES was to collect data about the prevalence of mental disorders, impairments associated with these disorders, and their treatment patterns from representative samples of majority and minority adult populations in the United States. Secondary goals were to obtain information about language use and ethnic disparities, support systems, discrimination and assimilation, in order to examine whether and how closely various mental health disorders are linked to social and cultural issues. To this end, CPES joins together three nationally representative surveys: the NATIONAL COMORBIDITY SURVEY REPLICATION (NCS-R), the NATIONAL SURVEY OF AMERICAN LIFE (NSAL), and the NATIONAL LATINO AND ASIAN AMERICAN STUDY (NLAAS). These surveys collectively provide the first national data with sufficient power to investigate cultural and ethnic influences on mental disorders. In this manner, CPES permits analysts to approach analysis of the combined dataset as though it were a single, nationally representative survey. Each of the CPES surveys has been documented in a comprehensive and flexible manner that promotes cross-survey linking of key data and scientific constructs.

Citation [View help for Citation](#)

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Inter-university Consortium for Political and Social Research [distributor], 2024-02-28.
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Subject Terms [View help for Subject Terms](#)

[African Americans](#) [anxiety](#) [Asian Americans](#) [crosscultural differences](#) [cultural influences](#) [depression \(psychology\)](#) [health services utilization](#) [Hispanic or Latino Americans](#) [mental disorders](#) [mental health](#) [mental health services](#) [minorities](#)

Geographic Coverage [View help for Geographic Coverage](#)

[United States](#)

Smallest Geographic Unit [View help for Smallest Geographic Unit](#)

FIPS code

Restrictions [View help for Restrictions](#)

The restricted versions of this data collection may not be used for any purpose other than statistical reporting and analysis. Use of the restricted versions to learn the identity of any person or establishment is prohibited. To protect respondent privacy, the names and IDs are restricted from general dissemination. To obtain this file, researchers must agree to the terms and conditions of a Restricted Data Use Agreement in accordance with existing ICPSR servicing policies.

Distributor(s) [View help for Distributor\(s\)](#)

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Time Period(s) [View help for Time Period\(s\)](#)

2001 -- 2003

Date of Collection [View help for Date of Collection](#)

2001 -- 2003

Data Collection Notes [View help for Data Collection Notes](#)

1. The master CPES datasets are updated periodically as various, typically small, errors are detected. Diagnostic algorithms are periodically updated as well. This updating will continue in the future as needed and public users will be informed of these updates. It is important for public users to recognize that, because of these changes, it will not be possible to reproduce results reported in earlier publications.
2. The NATIONAL COMORBIDITY SURVEY REPLICATION (NCS-R) is supported by the National Institute of Mental Health (NIMH, U01-MH60220) with supplemental support from the National Institute of Drug Abuse (NIDA, R01-DA12058-05), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Robert Wood Johnson Foundation (RWJF, grant 044780), and the John W. Alden Trust. Collaborating investigators include Ronald C. Kessler (Principal Investigator, Harvard Medical School), Kathleen Merikangas (Co-Principal Investigator, NIMH), James Anthony (Michigan State University), William Eaton (The Johns Hopkins University),

Meyer Glantz (NIDA), Doreen Koretz (Harvard University), Jane McLeod (Indiana University), Mark Olfson (Columbia University College of Physicians and Surgeons), Harold Pincus (University of Pittsburgh), Greg Simon (Group Health Cooperative), Michael Von Korff (Group Health Cooperative), Philip Wang (Harvard Medical School), Kenneth Wells (UCLA), Elaine Wethington (Cornell University), and Hans-Ulrich Wittchen (Institute of Clinical Psychology, Technical University Dresden and Max Planck Institute of Psychiatry).

3. The NATIONAL SURVEY OF AMERICAN LIFE (NSAL) is supported by the National Institute of Mental Health (NIMH U01-MH57716), with supplemental support from the Office of Behavioral and Social Sciences Research (OBSSR) at the National Institute of Health (NIH), and the University of Michigan. Collaborating investigators include James S. Jackson (Principal Investigator, University of Michigan, Survey Research Center), Harold W. Neighbors (Co-Principal Investigator, University of Michigan, Research Center for Group Dynamics), David R. Williams (Co-Principal Investigator, University of Michigan, Survey Research Center), Robert J. Taylor (Co-Principal Investigator, University of Michigan, Research Center for Group Dynamics), Cleopatra H. Caldwell (Co-Investigator, University of Michigan, Research Center for Group Dynamics), Steven J. Trierweiler (Co-Investigator, University of Michigan, Research Center for Group Dynamics), and Randolph M. Nesse (Co-Investigator, University of Michigan, Research Center for Group Dynamics).
4. The NATIONAL LATINO AND ASIAN AMERICAN STUDY (NLAAS) is supported by the National Institute of Mental Health (NIMH, U01-MH062209, and U01-MH62207), with supplemental support from the Office of Behavioral and Social Sciences Research (OBSSR) at the National Institute of Health (NIH), the Substance Abuse and Mental Health Services Agency (SAMHSA), and the Latino Research Program Project (P01-MH059876). Collaborating investigators include Margarita Alegria (Principal Investigator, Center for Multicultural Mental Health Research at Cambridge Health Alliance), David Takeuchi (Principal Investigator, University of Washington), Sergio Aguilar-Gaxiola (Co-Investigator, California State University-Fresno), Glorisa Canino (Co-Investigator, University of Puerto Rico), Naihua Duan (Co-Investigator, University of California-Los Angeles), Javier Escobar (Co-Investigator, Robert Wood Johnson Medical School), Peter Guarnaccia (Co-Investigator, Rutgers University), Alexander Ortega (Co-Investigator, University of California-Los Angeles), Patrick Shrout (Co-Investigator, New York University), William Vega (Co-Investigator, Robert Wood Johnson Medical School), and Mildred Vera (Co-Investigator, University of Puerto Rico).
5. Other collaborators from the National Institute of Mental Health include Ellen Stover (Acting Director, Division of Adult Translational Research and Treatment Development), Wayne Fenton (Scientific Collaborator and previous Director, Division of Adult Translational Research and Treatment Development), Lisa Colpe (Project Officer, NIMH), and Karen Bourdon (Project Officer, NIMH).

Methodology

Study Purpose [View help for Study Purpose](#)

The purpose of this study was to produce contemporary, comprehensive epidemiological data regarding the distributions, correlates and risk factors of mental disorders among the general population with special emphasis on minority groups.

Study Design [View help for Study Design](#)

Please see the User Guide for more information on the study design.

Sample [View help for Sample](#)

The sample for all three surveys consisted of primary sampling units selected with probabilities proportional to size. Data collection for the three surveys was conducted in a total of 252 geographic areas or primary sampling units across the United States. Only 50 of these areas were shared by all three surveys, those representing the most densely populated areas of the country. These latter areas were selected into all three surveys with certainty. In addition, there were 52 areas unique to NSAL and 18 areas unique to NLAAS. These unique areas were introduced to reflect the particular racial and ethnic focus of those surveys. A more detailed discussion of the CPES sample design and that for the individual surveys can be found in the User Guide.

Time Method [View help for Time Method](#)

Cross-sectional

Universe [View help for Universe](#)

The CPES universe was defined by the union of the following survey populations for the three component surveys: The NCS-R universe included English-speaking adults aged 18 years and older residing in households located in the coterminous United States. The NSAL universe included adults in the three target groups: Black Americans of African descent, Black Americans of Caribbean descent, and White Americans, who were aged 18 years and older residing in households located in the coterminous United States. The NLAAS universe included Latino American, Asian American, and non-Latino, non-Asian White American adults aged 18 and older residing in households located in the coterminous United States and the state of Hawaii.

Unit(s) of Observation [View help for Unit\(s\) of Observation](#)

Individual

Data Type(s) [View help for Data Type\(s\)](#)

[survey data](#)

Mode of Data Collection [View help for Mode of Data Collection](#)

[computer-assisted personal interview \(CAPI\)](#) [computer-assisted telephone interview \(CATI\)](#) [telephone interview](#)

Description of Variables [View help for Description of Variables](#)

Variables in the data pertain to the health and psychological conditions, behaviors, and treatments of respondents. Demographic variables include information on respondents and their families' race, age, languages spoken, and citizenship.

Response Rates [View help for Response Rates](#)

For NCS-R, a sample of 13,054 addresses was fielded. In 98.1 percent (11,222) of occupied housing units (11,443), interviewers were able to determine whether or not the household was eligible for inclusion in the study. A total of 10,622 addresses yielded an eligible household and 9,282 adult interviews were completed: 7,693 interviews with the main respondent and 1,589 interviews with a second adult in the household. An additional 554 interviews were collected using a shortened form of the instrument with a subsample of nonrespondents in an effort to assess nonresponse bias. The final weighted response rate for NCS-R, excluding the short form interviews, was 70.9 percent for primary respondents. The response rate for the second respondents was 80.4 percent. For NSAL, 11,634 eligible households were identified from 26,495 randomly sampled addresses. A total of 6,199 adult respondents were interviewed as part of NSAL (1,006 White respondents, 1,623 respondents of Caribbean descent, and 3,570 African American respondents) although the actual number of cases in the CPES data file is 6,082 (3,570 African American, 1,621 Afro-Caribbean, and 891 non-Hispanic White). An extremely small sample (n = 115) of White adults who were interviewed in households where the White subsample was less than 10 percent of the African American density stratum were excluded from the final dataset as well as two of the Afro-Caribbean interviews when it was later discovered that they were duplicate cases. The overall response rate for the core NSAL national sample was 71.5 percent. The Caribbean Supplement sample, which was designed to target areas with high concentrations of persons of Caribbean origin, yielded a weighted response rate of 76.4 percent. For NLAAS, from a total sample of 27,026 addresses, 4,345 eligible main respondents and 1,234 eligible second adult respondents were identified, and 3,620 main respondent and 1,029 second adult interviews were completed. The weighted response rate for NLAAS was 75.7 percent among main respondents (77.6 percent for Latinos, 69.3 percent for Asians). For second respondents, the final response rate was 80.3 percent (82.4 percent for Latinos, 73.7 percent for Asians).

Presence of Common Scales [View help for Presence of Common Scales](#)

Scales that are utilized in this study include the Normalize Outrole Scale for Role Functioning and Health Rating and Interference Scales. For Group and Personal Identity questions, scales utilized include the Centrality Scale, Private and Public Regard Scales, and Acculturation Rating Scale Adapted (ARSMA-II). Politics and Government questions utilize liberal/conservative scales.

What are the barriers and facilitators to seeking help for mental health in NHS doctors: a systematic review and qualitative study

- Research
- [Open access](#)
- Published: 07 September 2022

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- [Cite this article](#)

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Abstract

Background

The mental health of healthcare professionals is reaching a breaking point, and the COVID-19 pandemic has exacerbated current mental health issues to unprecedented levels. Whilst some research has been carried out on the barriers that doctors face when seeking mental health help, there is little research into factors which may facilitate seeking help. We aimed to expand the research base on factors which act as barriers to seeking help, as well as gain insight into facilitators of help-seeking behaviour for mental health in NHS doctors.

Methods

We conducted a systematic literature review which identified the barriers and facilitators to seeking help for mental health in healthcare professionals. Following this, we conducted semi-structured interviews with 31 NHS doctors about their experiences with mental health services. Finally, through thematic analysis, key themes were synthesised from the data.

Results

Our systematic literature review uncovered barriers and facilitators from pre-existing literature, of which the barriers were: preventing actions, self-stigma, perceived stigma, costs of seeking treatment, lack of awareness and availability of support, negative career implications, confidentiality concerns and a lack of time to

seek help. Only two facilitators were found in the pre-existing literature, a positive work environment and availability of support services.

Our qualitative study uncovered additional barriers and facilitators, of which the identified barriers include: a negative workplace culture, lack of openness, expectations of doctors and generational differences. The facilitators include positive views about mental health, external confidential service, better patient outcomes, protected time, greater awareness and accessibility, open culture and supportive supervisors.

Conclusion

Our study began by identifying barriers and facilitators to seeking mental health help in healthcare workers, through our systematic literature review. We contributed to these findings by identifying themes in qualitative data.. Our findings are crucial to identify factors preventing NHS doctors from seeking help for their mental health so that more can be done on a national, trust-wide and personal level to overcome these barriers. Likewise, further research into facilitators is key to encourage doctors to reach out and seek help for their mental health.

Quality of life of people with mental health problems: a synthesis of qualitative research

- [Review](#)
- [Open access](#)
- Published: 22 November 2012
- Volume 10, article number 138, (2012)
- [Cite this article](#)

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- Abstract
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Purpose

To identify the domains of quality of life important to people with mental health problems.

Method

A systematic review of qualitative research undertaken with people with mental health problems using a framework synthesis.

Results

We identified six domains: well-being and ill-being; control, autonomy and choice; self-perception; belonging; activity; and hope and hopelessness. Firstly, symptoms or 'ill-being' were an intrinsic aspect of quality of life for people with severe mental health problems. Additionally, a good quality of life was characterised by the feeling of being in control (particularly of distressing symptoms), autonomy and choice; a positive self-image; a sense of belonging; engagement in meaningful and enjoyable activities; and feelings of hope and optimism. Conversely, a poor quality life, often experienced by those with severe mental health difficulties, was characterized by feelings of distress; lack of control, choice and autonomy; low self-esteem and confidence; a sense of not being part of society; diminished activity; and a sense of hopelessness and demoralization.

Conclusions

Generic measures fail to address the complexity of quality of life measurement and the broad range of domains important to people with mental health problems.

Enhancing social networks: a qualitative study of health and social care practice in UK mental health services

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Abstract

People with severe mental health problems such as psychosis have access to less social capital, defined as resources within social networks, than members of the general population. However, a lack of theoretically and empirically informed models hampers the development of social interventions which seek to enhance an individual's social networks. This paper reports the findings of a qualitative study, which used ethnographic field methods in six sites in England to investigate how workers helped people recovering from psychosis to enhance their social networks. This study drew upon practice wisdom and lived experience to provide data for intervention modelling. Data were collected from 73 practitioners and 51 people who used their services in two phases. Data were selected and coded using a grounded theory approach to depict the key themes that appeared to underpin the generation of social capital within networks. Findings are presented in four over-arching themes – worker skills, attitudes and roles; connecting people processes; role of the agency; and barriers to network development. The sub-themes which were identified included worker attitudes; person-centred approach; equality of worker–individual relationship; goal setting; creating new networks and relationships; engagement through activities; practical support; existing relationships; the individual taking responsibility; identifying and overcoming barriers; and moving on. Themes were consistent with recovery models used within mental health services and will provide the basis for the development of an intervention model to enhance individuals' access to social capital within networks.

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[Web of Science®Google Scholar](#)

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[Google Scholar](#)

Advantages and Disadvantages in the Management of Mental Illnesses in Rural Areas

- Reference work entry
- First Online: 04 April 2020
- pp 221–235
- [Cite this reference work entry](#)

Abstract

Inhabitants of rural areas live under specific conditions that make them more vulnerable to adverse economic, social, and natural situations. Besides this, the gaps in health care, particularly in mental health management, are bigger than the ones existing in urban areas. However, even though studies have mostly focused on the limitations of mental health management in rural areas, few of them have addressed its strengths and advantages. These advantages include more and better paid jobs than in big cities, a less competitive environment, and a set of interesting and challenging mental health characteristics for the mental health professional who may dispose of various social, community, and religious sources.

On the other hand, the main disadvantages of managing mental problems in rural areas include stigma, isolation, limited resources for interventions, and limited opportunities for training and communication with other colleagues. Also, mental health professionals are unevenly distributed within urban and rural areas because trained psychiatrists work either in the main cities or in their nearest suburbs. Solutions proposed to solve these problems include training for rural service, telemedicine, dissemination of evidence-based treatments to rural clinics, and integration with the local ethnomedical system.

In conclusion, working in health and social care requires constant challenges and numerous updates so that the professional can do a dignified and quality job. Extensive research and updates in the area in which they will work are essential, and it's important to have a range of strategies to deal with situations as humanely as possible, regardless of where the professional will work.

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