Understanding help seeking and clinical recognition in young people with, and at risk of, mood and bipolar disorders

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Thesis Portfolio Abstract

Background: Young people face frequent delays in receiving appropriate support for early signs of mood or bipolar disorder, which can cause distress and lead to worsening health outcomes. This thesis explores how young people seek help and how early identification occurs with youth mental health services.

Methods: A systematic review was carried out, examining how young people aged 12 to 25 seek help for mood disorders and bipolar disorder. Then a qualitative study was conducted, taking testimonies from clinicians' experiences recognising and responding to early signs of bipolar disorder. These interviews were examined using reflexive thematic analysis.

Results: Amongst the ten studies included in the systematic review, the findings consistently showed that young people would rarely seek help at an early stage of recognising difficulty in mood and would only tend to engage when symptoms became more severe. Family members, teachers and trusted adults were central roles in encouraging young people to engage in support. Within the qualitative study, clinicians reported that signs of bipolar disorder were observed over extended periods, and not as a single diagnostic moment. Clinicians described their challenges of recognising early symptoms of mood disorders, limited options for appropriate services and ethical concerns around premature labelling of young people with a condition.

Conclusion: In conclusion, this thesis supports the suggestion that services need to manage signs of at risk symptoms and monitor changes over time, rather than defaulting to premature labelling as referral options are limited with diagnosis. Future research is encouraged to explore long term and flexible methods to identify

risks, as well as new service approaches that allow for monitoring and support prior to clear diagnostic being made.

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CHAPTER ONE: Introduction

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Mental health in young people

For young people in England mental health difficulties have taken a significant rise in recent years, with 1 in 5 young people aged between 8 and 25 years old having a probable mental health disorder (NHS England, 2023). In 2017 this statistic was 1 in 8 young people aged between 5 and 19 years old (NHS Digital, 2018), this rise has placed additional pressure on the mental health service with increased demand for support (NHS England, 2023). Long waiting times also remain, recent NHS figures show that young people still waiting for support had already been waiting an average of six months, with nearly one third waiting more than a year for treatment (Children's Commissioner for England, 2025). Alongside this, voluntary sectors such as YoungMinds (2024) have reported increasing levels of probable mental health conditions among young people, contributing to a rising demand for support (YoungMinds, 2024). Access to specialist care also varies across the country, and too often children are coming to services when they are already in crisis rather than receiving the support they need earlier on (Children's Commissioner for England, 2025). These service pressures are having a knock-on effect to the practises themselves, whereby clinicians are expected to identify and respond to emerging mental health difficulties at an earlier stage, often without a clear diagnostic certainty. To improve the support for young people, it is important to understand how early indicators of complex conditions are being recognised and responded to.

Help seeking

For mental health services, understanding help seeking behaviours is another challenge they must understand in order to improve patient outcomes. Consistently found across research, young people delay or avoid seeking support for mental health difficulties due to stigma, uncertainty about confidentiality, and practical barriers to accessing support (McPhail et al., 2024). O'Neill and colleagues (2023) conducted a qualitative study exploring how young people understand and respond to emotional distress, which identified four primary categories for help-seeking. These included 'guided by others who have taken notice', 'sceptical with unmet needs', 'motivated and solution focused' and 'preference for self-regulation'. The 'preference for self-regulation' type describes young people who prefer to manage their difficulties independently through coping strategies, distraction, or withdrawal. The study also found that young peoples' beliefs about what causes their difficulties influenced their help-seeking responses. Those who blamed themselves were less likely to seek help than those who viewed their problems as resulting from external factors. (O'Neill et al., 2023). McPhail et al. (2024) similarly reported that stigma, concerns of confidentiality and the practical barriers within school settings (such as the sessions being at the same time as classes, or therapy rooms being in visible areas) can limit young people's access to school based mental health support.

These findings suggest that it's not only the individual attitudes that shape how young people seek help, but also social, cultural and structural factors. By gaining a better understanding of these overlapping influences, young people may gain better access to timely and effective care when experiencing mental health difficulties.

Bipolar disorder in adolescence and early adulthood

Mental health difficulties that begin during adolescence are often linked to more severe symptoms and long-term difficulties in later life compared to those that develop a disorder in adulthood. Research has shown that early onset of mood disorders can increase the likelihood of ongoing mental health difficulties, which gives good argument for the importance of early identification. Alongside emotional and behavioural changes, research has also suggested that cognitive and neuropsychological difficulties may help identify young people at increased risk of experiencing mood symptoms (Kaiser et al., 2024). Supporting this, a longitudinal study found that poorer executive functioning in preadolescents predicted increases in general psychopathology over a two year period, suggesting that executive dysfunction may be an early risk marker for the development of mental health difficulties (Romer & Pizzagalli, 2021). Jamet and colleagues (2024) found that people who experienced a major depressive episode earlier in life were more likely to report having developed further psychiatric difficulties in adulthood. This finding supports earlier research which also showed that experiencing depression during adolescence increased the risk of affective disorders later on (Dunn & Goodyer, 2006). Other research suggests that this pattern is not limited to mood disorders alone. A systematic review by Mulraney et al. (2021) found that children who show mental health difficulties before the age of 14 have an increased risk of experiencing mental health problems in adulthood.

Bipolar disorder is one example where these challenges are clearly seen. Bipolar disorder is characterised by changes in mood including episodes of depression and periods of mania or hypomania (Singh et al., 2025), with onset typically occurring during adolescence or early adulthood (Yatham et al., 2018).

Earlier onset of bipolar disorder has been associated with poorer health outcomes, including greater functional difficulties and increased risk of suicide (Cirone et al., 2021). Despite this, research has shown there is often a long delay between first onset of symptoms and receiving a diagnosis or treatment (Bipolar UK, 2022; Conus et al., 2013). During this delay, young people can experience worsening symptoms, disruptions to their education and strain in their relationships. Therefore, identifying bipolar disorder as early as possible is so important in order to support appropriate intervention and treatment (Keramatian & Morton, 2023). However, due to the fluctuation of symptoms and overlapping of other mental health conditions, bipolar disorder in young people can be difficult to identify. Mood instability, irritability and behavioural changes can appear similar to the presentation of ADHD, depression or early signs of a personality disorder. In some cases, changes in behaviour may be portrayed as 'normal' adolescent development resulting in no clinical support offered at all. Thus, young people face the problem of misdiagnosis and inappropriate treatment, if treatment is offered at all (Youngstrom et al., 2009).

Early identification and the at risk mental state

The 'At Risk Mental State' (ARMS) framework was developed to identify people who are showing early, subthreshold signs of psychosis who may benefit from monitoring and receiving preventative interventions (Yung et al., 2021). Individuals are typically referred to ARMS services when they are showing early or mild signs of psychosis, such as unusual experiences or changes in thinking, or experiencing reduced functioning or social withdrawing (Yung et al., 2021). Research suggests that this model can support earlier detection and contribute to a shorter duration of untreated psychosis, which is associated with improved longer-term outcomes (Yung et al., 2021).

Although ARMS was posited for psychosis, there is increasing interest in whether a similar approach could be used for bipolar disorder. Although there is research that suggests that bipolar disorder also has a prodromal phase, often involving mood instability, disrupted sleep patterns, and other fluctuating symptoms that can appear before a first episode, research in this area is less established that in psychosis (Conroy et al., 2018; Vieta et al., 2018).

Research suggested that early-stage presentations of bipolar can develop in highly variable ways. For example, initially presenting as recurrent depression, brief hypomanic symptoms, or fluctuating mood instability making transition to a full bipolar episode difficult to predict (Vieta et al., 2018). So, whilst early markers can be observed, transition rates remain uncertain.

Applying similar ARMS models to other conditions is not without its own ethical and practical considerations. Although identifying young people who may be at increased risk of developing bipolar disorder could enable earlier access to support, it also has potential risks. For example, labelling someone as ‘at risk’ may create unnecessary anxiety, contribute towards stigma, or lead to clinical involvement for individuals who may never develop the disorder (Vieta et al., 2018). Furthermore, as current methods cannot reliably predict who may go on to develop bipolar disorder, there is a risk that some young people could be labelled as ‘at risk’ even though they do not go on to develop the disorder (Vieta et al., 2018). This could lead to normal changes in mood being treated as a medical problem unnecessarily. However, with a stronger evidence base and clearer risk indicators, a structured early identification model may offer similar benefits to those already seen in ARMS.

Clinicians' Perspectives

Clinicians play a vital role in shaping a person's health journey by being responsible for identifying early behaviour that may indicate risk of developing bipolar disorder. Their decision on whether to monitor symptoms or refer to specialist services, directly influences how early identification occurs in practice (Hoppe et al., 2025). A recent study conducted in the UK reported that clinicians often feel unsure about how to identify early signs of bipolar disorder, especially when presentations are less clear, and described frustration with referral pathways for further assessment (Hoppe et al., 2025). This uncertainty is often linked to limited understanding and confidence and wider pressures within services, where clinicians are managing high caseloads and do not always have enough time to explore symptoms in depth (Hoppe et al., 2025).

These pressures do not only affect confidence, but also the practical likelihood that early signs are noticed, explored and acted on. Reports continue to show that mental health services are operating with staff shortages and increasing demand, which means clinicians are often working with time constraints that limit the opportunity to build a full picture of a young person's experience (CQC, 2025). Service reviews have also noted variation in how clinical supervision is defined, delivered and supported across NHS trusts, meaning the level of support clinicians receive is not always consistent (White & Winstanley, 2021). Clinicians describe wanting to intervene early whilst also being wary that ridged thresholds and long waiting lists can mean young people do not receive support until their needs have escalated (Kew-Simpson et al., 2023). This highlights that early identification depends not only on clearer criteria but also on whether clinicians have the training, time and support to apply them confidently.

Thesis Aim and Overview

By addressing the gaps in both evidence and understanding, this thesis aims to extend the literature on early identification of bipolar disorder in young people. Although there is sufficient research examining the risk factors and prodromal features of bipolar disorder, there is limited qualitative data into how UK clinicians detect early signs or uncertain presentations in routine practice. Given the increasing policy focus on earlier intervention in children and young people's mental health (NHS England, 2023), alongside ongoing concerns about diagnostic delays in bipolar disorder (Bipolar UK, 2022), this thesis aims to close the gap between current research and clinical experiences. The thesis adopts a critical realist position, assuming that early risk for bipolar disorder has a real clinical basis, but that the ways it is recognised, named and responded to are influenced by social, organisational and relational factors (Fletcher, 2017). Reflexive thematic analysis is used as the central analytical method for the empirical paper, allowing attention to both shared patterns and the individual reasoning that clinicians bring to complex and uncertain presentations (Braun et al., 2022).

To the author's knowledge, there has not yet been a systematic review focused specifically on help-seeking in young people experiencing mood disorders or 'at risk' bipolar disorder. The first study therefore presents a pre-registered systematic review that examines the barriers and facilitators to accessing support among young people experiencing mood disorders or 'at risk' bipolar disorder (PROSPERO ID: CRD420251183822). Using qualitative interviews from mental health clinicians who have experience working with young people between the ages of 12-25 in an NHS context, the second study builds on the systematic review by exploring how clinicians recognise and respond to young people who may be at risk

of developing bipolar disorder. Together, the two studies aim to develop a clearer understanding of how early signs are interpreted in practice and how early identification might be supported in a way that is realistic for services and acceptable to young people and their families.

CHAPTER TWO: Systematic Review

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Understanding help seeking in youth with, and at risk of, mood disorders and bipolar disorder: a systematic review

Running title

Help seeking and emerging mood disorders

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Abstract

Introduction: Many young people do not seek support for diagnosed or emerging mood disorders until their symptoms have escalated and require more immediate intervention. Despite policies committing to timely access and early intervention, delayed help seeking persists. This systematic review examined how young people aged 12 to 25 recognise emerging mood difficulties and when and how they choose to seek formal or informal support.

Methods: A mixed methods systematic review was conducted in accordance with PRISMA guidelines and registered on PROSPERO (CRD420251183822). PsychINFO, MEDLINE and PubMed were searched for English language qualitative, quantitative and mixed methods designs published up to 2025. Studies examined help seeking behaviours, experiences or intentions among young people experiencing, or at risk of developing mood disorders. Quality appraisal was assessed using the Mixed Methods Appraisal Tool (MMAT).

Results: Ten studies met inclusion criteria (four qualitative, three quantitative and three mixed methods), comprising of a pooled sample of 56,331 participants. Studies were conducted across the UK, Australia, Japan, Norway, Spain, the Netherlands, Canada and the United States. Typically, help seeking was delayed, most often occurring once symptoms had escalated or it was instigated by trusted adults. Young people frequently attempted to manage their distress independently. Confusion, stigma and uncertainty were all barriers preventing young people from seeking help, whilst supportive and validating relationships encouraged engagement.

Conclusion: Help seeking in young people with diagnosed or emerging mood difficulties is shaped by interacting individual, relational and structural factors.

Improving early access requires clear pathways, supportive relationships and approaches to care that are tailored for young people.

Keywords: Help seeking; Adolescence; Emerging adults; Mood disorders; Bipolar risk

Introduction

Research has shown that many young people do not seek support for difficulties with anxiety, depression or early mood disorders, often delaying help due to stigma, uncertainty, and difficulties with recognising the seriousness of their symptoms (Radez et al., 2021). As a result, there has been a growing focus in recent years to understand what encourages young people to seek support for emotional and mental health wellbeing.

Adolescence is a critical period for the onset of mental health problems, including mood disorders. Research suggests that around half of all mental health disorders first develop during their mid-teens (Holte, 2024; Grimm et al., 2022). Research also indicates that the earlier young people access intervention the better the outcomes are (Hudson et al., 2023). Despite this, this pattern of delayed help seeking seems to persist. National UK strategies such as NHS England's Long Term Plan (2019) and the Children and Young people's Mental Health Implementation Framework (Department for Education & NHS England, 2023) both emphasise the importance of timely and equitable access to care, however, barriers such as long waiting lists, service pressures, and unequal access across different geographical areas continue to appear, highlighting the need to synthesise current evidence on help seeking to inform practice and policy (Grimm et al., 2022).

Help seeking in young people

Help seeking is the process of recognising distress and seeking assistance from both formal and informal sources (Yamauchi et al., 2023). In young people, help seeking can be influenced by multiple different factors, including self-perception, family dynamics, peer attitudes and service structure (Cavelti et al., 2025). Furthermore, research consistently shows that stigma, uncertainty and limited

mental health knowledge or understanding prevents help seeking (Baldofski et al., 2024). In addition to these individual barriers, larger service and social factors also influence access to care. Research has found that ethnicity and socioeconomic status affect patterns of mental health service use and access (Grimm et al., 2022). For example, young people living in a more disadvantaged socioeconomic area, report experiencing higher levels of need and show higher levels of referral rates, and crisis presentations, which highlights the inequalities in service use and access (Grimm et al., 2022). Similarly, differences in how young people from different demographic groups interact with services suggest that some young people only seek formal help when their difficulties have escalated to crisis levels. This is often because they have different levels of trust in services, awareness of the support options, or confidence that help will be acceptable or useful (Radez et al., 2021).

Models of help seeking

There are several theoretical frameworks which attempt to explain the process and decisions a young person will make when considering seeking support. For example, Rickwood's four step help seeking model describes help seeking as a staged process (recognising symptoms, identifying a need for external help, deciding to seek help, and selecting a source of support; Rickwood et al., 2005). Research suggests that many young people will struggle at the earlier stages of recognising their symptoms and determining whether these symptoms warrant professional input. Studies have found that this may be because young people often misinterpret or normalise early signs of distress for either 'normal' stress or personal weakness, making it difficult for them to differentiate day-to-day emotional fluctuation from symptoms that might require professional help (Radez et al., 2021). Furthermore, some young people have also reported uncertainty about whether their experiences

are ‘serious enough’ to seek help, particularly when they have limited awareness of mental health or difficulties interpreting their internal experiences (Baldofski et al., 2024).

Another framework used to help understand help seeking is the COM-B model (Michie et al., 2011), which conceptualises help seeking as a behaviour driven by psychological capability, social environmental opportunity, and personal motivation. The COM-B model can be used to help understand why some young people access services while others do not. For young people, psychological capability depends on their understanding of mental health to confidently seek help, while opportunity reflects the accessibility and perceived confidentiality of services available. Motivation may also be shaped by beliefs about the consequences of disclosure and experiences of stigma. These factors have been widely identified as barriers to help seeking among young people (Gulliver et al., 2010; Rickwood et al., 2015). Therefore, the COM-B model provides a useful framework for distinguishing between internal barriers (such as one’s own stigma or understanding) and external barriers (such as referral pathways and service accessibility).

By combining the four-step help seeking model and the COM-B model together we can better understand why help seeking behaviours vary across individuals and settings, and what structural barriers prevent young people from seeking help once they have recognised their need for support.

Help seeking in mood and bipolar disorders

Help seeking can be particularly complex in the context of mood disorders, because fluctuation in symptoms can create uncertainty about when intervention is needed. Depression is one of the most common presenting mental health difficulties among young people (Yang et al., 2024). If left untreated it can lead to higher risk of

suicide and self-harm, therefore early intervention for depression is important. For some young people it may represent the early phases of bipolar disorder (de Pablo et al., 2024). Research suggests that the average delay between symptom onset and a diagnosis of bipolar disorder can be approximately nine years (Nierenberg et al., 2023). During this period, young people often experience multiple service contacts without receiving targeted support. For example, a recent cohort study conducted in Wales, found that nearly half of individuals later diagnosed with bipolar disorder or psychosis had previously accessed Child and Adolescent Mental Health Services (CAMHS), highlighting missed opportunities for earlier identification and intervention (O'Hare et al., 2025). This is particularly important because early presentations of bipolar disorder often overlap with other mood disorders, particularly depression, making it difficult to distinguish between presentations during the early stages. Therefore, young people who later develop bipolar disorder may initially seek support for symptoms that are not yet recognised as part of an emerging bipolar presentation, highlighting the importance of understanding help seeking across mood disorders.

Compared to adult populations, there is limited research into understanding the behaviours of young people with emerging mood symptoms seeking help. Some research found that young people experiencing emotional distress often attribute these difficulties to a perceived lack of control, other people's actions or themselves rather than seeing them as a mental health condition (O'Neill et al., 2023). Research has also found varying approaches with family involvement. While some families were supportive, others were found to resist formal help seeking due to stigma, shame or concern about psychiatric treatment and medication (Samari et al., 2022).

Therefore, gaining more insight into the perceptions of both young people and their families may help shape assessment pathways and the barriers to entering them.

Barriers and facilitators to help seeking

Young people face several barriers when seeking help for mental health across varying conditions, including mood disorders. These barriers can occur at the level of the individual, relationships with others, or the wider health system. At the individual level, young people may not recognise their symptoms, have fears of being judged, or may feel they are able to manage and cope on their own rather than asking for support (Gulliver et al., 2010). Interpersonal barriers relate to the influence of others, for example, the beliefs of their parents or friends on mental health. Systematic barriers include long waiting times, higher referral thresholds, and differences in service availability. A recent UK review found significant delays in access to specialist mental health service, reporting that many young people wait over a month for support, with some experiencing serious deterioration, including suicide attempts, whilst waiting on service waiting lists (Valentine et al., 2024).

There are also important factors that can facilitate help seeking, including having supportive relationships with family or others, clear information about what help is available and previous positive experiences with services (Rickwood et al., 2015). Cultural understanding and trust can also help facilitate willingness to seek help, especially for young people in minority or marginalised groups (Hardy et al., 2025). Community-based peer support programmes may be helpful in reaching these groups and making services feel more approachable for young people (Murphy et al., 2023). This research suggests that support systems need to be flexible and culturally informed when being designed, so that the support can feel relevant and easy to access for the young person.

Aims of the Review

Despite it being widely understood within health services that early identification of all illnesses is vital to implement the most effective intervention, there are limited reviews with a specific focus on help seeking in the early stages of mood disorders, including at risk bipolar disorder. This review considers mood disorders more broadly, whilst giving particular attention to bipolar disorder. This is because early presentations of bipolar disorder often overlap with other mood disorders before a clearer bipolar presentation emerges. Understanding help seeking during these early and uncertain stages may therefore help identify opportunities for earlier recognition and intervention.

Although there have been strides in recent years with research on how young people seek help, the majority of studies have focused on the individual and structural factors rather than examining how they interact.

This mixed-methods systematic review aims to address these gaps within research by evaluating the evidence of help seeking behaviours amongst young people aged 12 to 25 who are experiencing or at risk of developing mood disorders, including bipolar disorder. It will examine the experiences and barriers these young people have from engaging in early support as well as the perceptions from their parents or guardians. The review will explore how demographic factors including gender identity and socioeconomic status as well as clinical factors may affect these experiences. This will involve qualitative, quantitative and mixed methods research to understand how help seeking or lack of help seeking equates across formal, informal and digital settings.

This review brings together findings from varying methodologies, populations and settings, and by doing so aims to provide a comprehensive review of how young

people with or at risk of mood disorders and bipolar disorder, recognise their difficulties, access support early on and engage with services. Information gained from this review will inform recommendations for clinical practice, policy development and help shape the design of services aimed at improving early access to support.

Materials and Methods

The systematic review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta Analyses (PRISMA; Page et al., 2021; Appendix B). The review protocol was prospectively registered on the International Prospective Register of Systematic Reviews (PROSPERO; registration number CRD420251183822).

Search strategy and procedure

Searches were undertaken across PsycINFO, MEDLINE, and PubMED, and with additional searches conducted through EBSCOhost platforms. Each database was searched using a combination of keywords and subject headings related to young people, at risk mood and bipolar disorders and help seeking. Search terms were developed using existing literature in the field and were designed to capture the wide range of terms used to describe early mood related symptoms. The terms were then discussed and refined during supervision discussions to ensure sensitivity and relevance. The finalised search strategy included combinations of the following terms: terms for help seeking ("help seeking" or "service use" or "service utili$ation" or "access to care" or "access to healthcare" or "mental health service use"); young people ("young pe*" or "youth" or "adolescen*" or "teen*" or "emerging adult* " or "young adult*"); mood disorders ("mood disorder*" or "depress*" or "bipolar" or "affective disorder*" or "anxiety"); and at-risk terms ("at risk" or "high risk" or "risk"

or "prodromal" or "subthreshold" or "early sign" or "early signs" or "vulnerable" or "clinical staging"). Searches were carried out on 27.06.2025. No additional date limits were applied; however, searches were restricted to papers published in English language as the team did not have access to translation services.

Inclusion and Exclusion Criteria

The following inclusion criteria were applied: 1) primary empirical studies published in English, 2) studies focused on young people aged 12-25 years, 3) include data from those experiencing a diagnosed mood disorder or bipolar disorder, or those considered at risk of developing a mood disorder or bipolar disorder. Risk included subthreshold affective symptoms, emerging mood instability, prodromal features consistent with early bipolar presentations and any clinical staging of early mood disorder, including depressive symptoms or distress. As the review aimed to include young people who may be at risk of developing a mood disorder, studies were not limited to those using formal diagnostic criteria (e.g., DSM-5 or ICD-10). Therefore, studies were also eligible if they included young people experiencing early or subthreshold symptoms consistent with an at-risk presentation of a mood disorder. 4) studies were required to describe or relate to help seeking behaviour, experience or intention, whether in formal, informal or digital contexts. Both qualitative and quantitative studies were included.

Studies were excluded if they did not describe or relate to help seeking, if they examined unrelated psychiatric conditions, or if data could not be separated for the target age group.

Screening

See Figure 1 for PRISMA diagram summarising the screening process. Search results (k=960) were imported into Rayyan, a tool used to support efficient

screening whilst completing a systematic review (Rayyan, n.d.). After uploading to Rayyan all duplicate papers were removed (k=15). Abstracts (k=945) and full texts (k=149) were screened against the inclusion criteria by JG. Twenty percent of full-text articles screened for eligibility, were checked independently by SA, with two discrepancies resolved following discussions between JG and SA. A third reviewer was not required as all discrepancies were resolved between the two reviewers.

Quality Appraisal

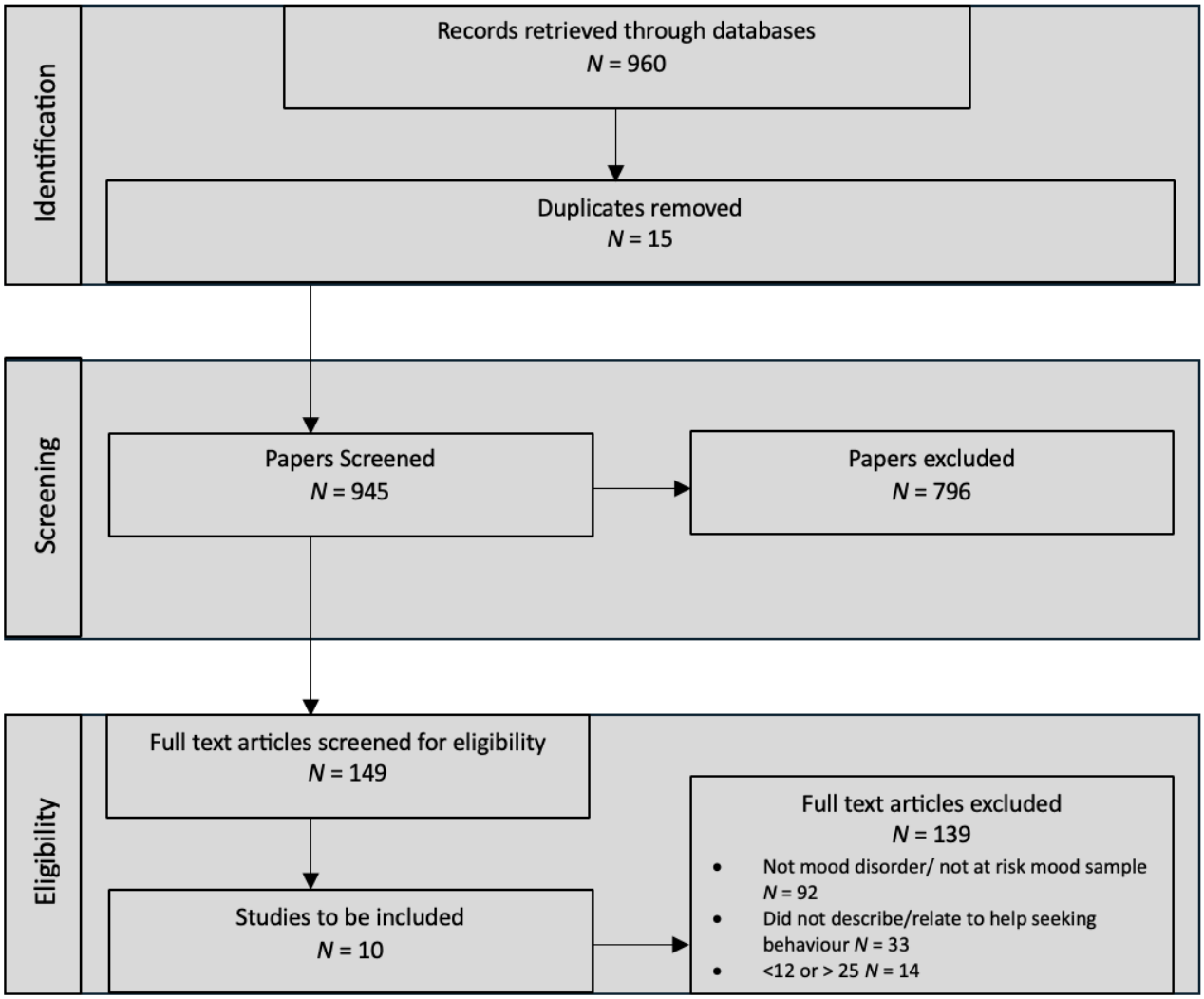
Quality appraisal was conducted using the Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018; Appendix C). The MMAT is used to assess methodological quality across qualitative, quantitative and mixed methods research. It consists of two core screening questions, followed by five criteria specific questions to each study design. All papers were appraised by JG, with thirty percent (k=3) independently checked by SA. Inter-rater agreement was assessed using Cohen's Kappa which indicated perfect agreement (k = 1.00). Using a scoring system adopted by Gronholm and colleagues (2017), MMAT scores were added together and converted into a percentage ranging from 0-100% with higher percentages indicating better methodological quality.

Data Extraction

Data extracted from the studies which met the inclusion criteria (k=10) included the following: study aims, design, country and theoretical framework. Evidence of help seeking included: definitions used, measures, data collection and analysis methods and service system level. Key findings were extracted, including barriers and facilitators to help seeking, qualitative themes, quantitative results, perceptions of service and reported implications and limitations.

A narrative synthesis approach was used to bring the findings together across studies. This approach was chosen due to the heterogeneity of the included studies in their design, populations, outcome measures and definitions of help seeking, meaning the findings could not be meaningfully combined using a quantitative approach, such as a meta-analysis. Extracted data was compared and grouped according to recurring patterns in help seeking behaviours and barriers and facilitators.

Figure 1. PRISMA Diagram.



Results

Database searches returned 960 papers (945 without duplicates; see Fig. 1). Of these, 149 full texts were screened for eligibility, with 10 meeting the inclusion criteria, comprising a pooled sample of 56 331 participants (Arcaro et al., 2017; Eigenhuis et al., 2021; Farr et al., 2021; Loades et al., 2025; Martinez Hernaez et al., 2014; Moen & Hall-Lord, 2019; Munson et al., 2012; Narendorf et al., 2018; Sawyer et al., 2012; Yamaguchi et al., 2023).

Study Characteristics

Study characteristics are presented in Table 1. The ten included studies comprised of four qualitative studies (Eigenhuis et al., 2021; Farr et al., 2021; Loades et al., 2025; Martinez Hernaez et al., 2014), three quantitative studies (Moen & Hall-Lord, 2019; Sawyer et al., 2012; Yamaguchi et al., 2023) and three mixed methods studies (Arcaro et al., 2017; Munson et al., 2012; Narendorf et al., 2018). Research was conducted across a broad range of countries including Japan, Spain, the Netherlands, the United Kingdom, Australia, Canada, Norway, and the United States (see Table 1).

Help seeking was examined using a variety of methodological approaches. Quantitative studies typically used vignette-based questionnaires or validated self-report scales to assess intentions or likelihood of seeking help (Moen & Hall-Lord, 2019; Sawyer et al., 2012; Yamaguchi et al., 2023). Qualitative studies used in-depth or semi-structured interviews to explore young people's experiences of recognising early mood changes, understanding their distress and deciding whether and how to seek support (Eigenhuis et al., 2021; Farr et al., 2021; Martinez Hernaez et al., 2014). One study explored online mental health information seeking as an initial step in the

help seeking process (Loades et al., 2025). Mixed methods studies combined structured symptom measures with qualitative questionnaires or interviews to examine how young people with ongoing or recent mood difficulties described their distress when initially accessing services (Arcaro et al., 2017; Munson et al., 2012; Narendorf et al., 2018).

In terms of population, four studies drew on large school or community populations experiencing a broad range of depressive symptoms (Martinez Hernaez et al., 2014; Moen & Hall-Lord; 2019; Sawyer et al., 2012; Yamaguchi et al., 2023). Moen and Hall-Lord (2019) included the largest sample in the review (n = 46,961), with participants recruited from a large community school-based population. Two studies recruited young people attending clinical or early intervention services or CAMHS for first episode or early-stage mood difficulties and suicidality (Arcaro et al., 2017; Farr et al., 2021). Two papers focused on socially marginalised young adults with a childhood diagnosis of mood disorders and involvement in the public care system (Munson et al., 2012; Narendorf et al., 2018). One study focused on young adults who had direct contact with services across educational and clinical settings (Eigenhuis et al., 2021). One qualitative study was conducted entirely online with participants recruited across the UK (Loades et al., 2025). None of the included studies focused specifically on young people at risk of bipolar disorder.

Sample sizes across all studies ranged from 8 (Farr et al., 2021) to 46,961 (Moen and Hall Lord, 2019; see Table 1), with a pooled sample size of 56,361. Mean ages of participants were generally in the teenage or emerging adult years (range = 10-25 years). Of the studies reporting gender (k = 9), there were predominantly more females represented than males, the mean percentage of male participants was 35.1% (range = 20.8% -53.1%). Detailed ethnicities were reported in only five of the

studies, with the remaining papers providing little or no information about the ethnic composition of their samples. Of those reporting ethnicity, studies conducted in Canada and the UK described predominantly White samples (Arcaro et al, 2017; Loades et al., 2025). Both studies conducted in the United States included majority of black or minority ethnic participants, with 68% of participants identified as Black or multiracial (Munson et al., 2012; Narendorf et al., 2018).

Help Seeking information

Help seeking information for the included studies is summarised in Table 2. Help seeking was conceptualised in diverse but overlapping ways throughout the papers. Often, the form of help seeking was dependent on how a young person perceived their distress, recognised their difficulties and decided on their form of support.

Several studies assessed help seeking as a stated intention or likelihood of seeking assistance in response to their emotional problems. Findings from Moen and Hall-Lord (2019), which included the largest community school-based sample included in the review, found that adolescents experiencing significant distress reported lower use of informal support, although they were more likely to access formal services than their peers. Compared to just 2.3% of non-distressed peers, 23.4% of distressed adolescents reported contact with a psychologist or psychiatrist more than six times in the previous year. These assessments would typically involve structured questionnaires or short scenario-based items asking participants about who they would approach if they were experiencing symptoms of low mood (Sawyer et al., 2012; Yamaguchi et al., 2023). Whilst the papers were focused on hypothetical situations rather than enacted behaviour, both studies found that young people with higher levels of depressive symptoms were less willing to ask for help or seek help at

all. Comparable findings were reported by Sawyer et al. (2012). In this moderate methodological quality, school-based cohort, adolescents with high depressive symptoms were four times more likely to report that they would not seek help from anyone compared with those with low symptoms. Similarly, Yamaguchi et al. (2023), who also had a sound methodological quality, found that higher depressive symptoms consistently predicted lower subsequent help seeking intentions across all four waves, while the reverse direction was observed only at some intervals. Other studies afforded insights into the cognitive, emotional and relational processes involved in help seeking in young people by exploring the accounts of their lived experiences (Eigenhuis et al., 2021; Martinez-Hernaez et al., 2014). Some participants explained the difficulty of recognising the early stages of mood decline as they would often interpret withdrawal, irritability and tiredness as standard daily stress or the expected experience of puberty, opposed to the symptoms of a mental health disorder. Consequentially, these initial interpretations of their symptoms meant delays in recognising the need for support (Eigenhuis et al., 2021; Martinez-Hernaez et al., 2014). Accounts emphasised that external recognition, typically by parents, teacher or peers, often played an important role in prompting initial contact with services (Eigenhuis et al., 2021; Farr et al., 2021).

When young people found it difficult to articulate their distress or were worried about their experiences being misunderstood, it is reported that these such adults would step in to help influence initial pathways into support (Martinez-Hernaez et al., 2014). Furthermore, for young people who were involved in public services, their use of support was also influenced by past experiences of care. Some had already had to navigate fragmented or confusing services, had lack of trust in

professionals and had a history of repeated cycles of disengagement (Munson et al., 2012).

Across the papers there was a large variation in how help seeking was measured or described, however an overall pattern was reported consistently. Young people would rarely seek out help during the early stages of their mood difficulties. Instead, help seeking tended to happen only after a period of symptom escalation, a noticeable functional decline or being promoted by others. Most young people attempted to manage distress alone. Barriers to seeking help included feelings of stigma and shame, a strong desire to manage problems alone, fears of being judged, difficulties recognising symptoms and previous negative experiences with services. Wider problems within service systems also created barriers to timely support. However, help seeking was encouraged among young people particularly when there was positive early intervention with professionals and trusted adults that noticed distress early on, could provide clear information on where and how to get help and actively assisted the young people in engaging with intervention.

Table 1. Characteristics of included studies

Study	Study objectives	Country	*N*	Population	Setting	Measure/screening tool	Age Range	Gender (%)	Ethnicity
Arcaro et al. (2017)	Describe presenting concerns of emerging adults seeking treatment at an early intervention programme for mood disorders	Canada	548	Emerging adults attending FEMAP	Outpatient Clinic	BDI-II; STAI; ASRS; SDS	16 - 26	Male = 37.9%	Caucasian 88.4% - 88.6% Black .5% - .9% Hispanic 1% - .3% Asian 4.9% - 4.5% Native .5% - 1.8% Other 6.8% - 3.9%
Eigenhuis et al. (2021)	Identify barriers and facilitators to help seeking in young people with depressive symptoms	Netherlands	32	Adolescents and young adults with current or past depressive symptoms	Educational institutions and outpatient mental health clinc	QIDS-SR	16 - 23	Male = 34.4%	62.5% Western European 3.1% Eastern European 6.3% Northern African

Study	Study objectives	Country	*N*	Population	Setting	Measure/screening tool	Age Range	Gender (%)	Ethnicity
									6.3% South American 6.3% Southern Asian 12.5% Western Asian 3.1% Southeastern Asian
Farr et al. (2021)	Explore processes shaping help seeking for suicidality in young people	United Kingdom	8	Young people with suicidality supported by CAMHS	NHS community CAMHS hubs	NR	17 - 23	Male = 25%	NR
Loades et al. (2025)	Explore online mental health information seeking among adolescents for low mood/depression	United Kingdom	24	Adolescents	Online	PHQ-2	13 - 18	Male = 20.8%	White = 45.8% Asian = 16.7% Black = 29.2%

Study	Study objectives	Country	*N*	Population	Setting	Measure/screening tool	Age Range	Gender (%)	Ethnicity
									Mixed ethnicity = 8.3%
Martinez-Hernaez et al. (2014)	Explore cultural meanings of non-professional help seeking and avoidance of professional help among youth with depressive symptoms	Spain	105	Young adults with diagnosed, self-perceived distress and control group	Community	BDI-II; MISS	17 - 21	Male = 31.4%	NR
Moen & Hall-Lord. (2019)	Describe adolescent mental health, help seeking, service use and family functioning	Norway	46961	Adolescents from national school survey	Schools	HSCL-10	13 - 19	NR	NR
Munson et al. (2012)	Understand mental health service utilisation among young adults formerly involved in public systems of care	United States	60	Young adults with childhood mood disorder diagnosis and prior public system involvement	Community	SACA; CES-D; CTQ	18 - 25	Male = 33.3%	68% Black/African American/ Multi-racial

Study	Study objectives	Country	*N*	Population	Setting	Measure/screening tool	Age Range	Gender (%)	Ethnicity
Narendorf et al. (2018)	Examine race and gender differences in help seeking attitudes among marginalised young adults with mood disorders	United States	60	System involved young adults with childhood mood disorder diagnoses	Community	CES-D; IPQ-R; IAMSMHS; SACA	18 - 25	Male = 33.3%	Black and minority backgrounds 68% White 32%
Sawyer et al. (2012)	Examine help seeking intentions across levels of depressive symptoms in early adolescents	Australia	5362	Year 8 students from 50 schools	Schools	CES-D; MPSS and vignette	12 - 14	Male = 47%	NR
Yamaguchi et al. (2023)	Examine reciprocal longitudinal associations between depressive symptoms and help seeking intentions in adolescents	Japan	3171	Community adolescents from Tokyo	Community	SMFQ and vignette-based help seeking intention item	10 - 16	Male = 53.1%	NR

Abbreviations: ASRS = Adult ADHD Self-Report Scale; BDI-II = Beck Depression Inventory II; CED-D = Centre for Epidemiological Studies Depression Scale; CTQ = Childhood Trauma Questionnaire; DSRS-C = Depression Self-Rating Scale for children; HSCL-10 = Hopkins Symptom Checklist-10; IASMHS = The Inventory of Attitudes toward Seeking Mental Health Services; IPQ-R = Illness Perceptions Questionnaire Revised; MISS = Manheim Interview on Social Support; MPSS = Multidimensional Perceived Social Support scale; QUIDS-SR = Quick Inventory of Depressive Symptomatology Self Report; SACA = The Service Assessment for Children and Adolescents; SCID-I = Structured Clinical interview for DSM-IV; SMFQ = Short Mood and Feelings Questionnaire; STAI = Spielberger State Anxiety Inventory; SYED-P = System for the Youth Evaluation of Depressive Prodrome.

Table 2. Help Seeking Behaviours

Study	Help seeking definition/concept	Stages of help seeking	Types of help considered	Help seeking behaviours reported	Help seeking barriers	Help seeking facilitators	Relational influences	Structural or System influences
Arcaro et al. (2017)	Help seeking was examined as how emerging adults described their distress at the point of entering an early intervention service	Focused on presentation at service entry	Formal help only	Young adults most often described presenting concerns as interpersonal relationships and academics, rather than specific symptoms	NR	NR	Not examined as influences, relational difficulties were a common presenting concern but not a driver of help seeking	NR
Eigenhuis et al. (2021)	Help seeking was conceptualised as a process that involved symptom recognition, attitudes and social influences over time	The study examined early recognition, the decision making process and eventual attempts to seek help	Formal and informal	Help seeking was often prompted by increased disease burden and functional impairment (e.g., poor academic performance)	Difficulty interpreting symptoms, fear of judgement and uncertainty about what was 'serious enough' contributed to delays	Encouragement from trusted adults, emotional validation, and having information about support options facilitated help seeking	Parents, peers and teachers frequently recognised deterioration earlier than the young people themselves and promoted help seeking	Limited availability of early support and long waiting times caused delays

Study	Help seeking definition/concept	Stages of help seeking	Types of help considered	Help seeking behaviours reported	Help seeking barriers	Help seeking facilitators	Relational influences	Structural or System influences
Farr et al. (2021)	Help seeking was understood as a relational process shaped by communication between young people and primary care professionals during suicidal distress	Explored recognition, initial disclosure and early contact with professional support	Formal help via GPs	Most young people were supported by family/friends to access GP support, and adults often initiated or help to initiate contact with services	Fears on dismissal, concerns about confidentiality and mistrust of professional discouraged disclosures.	Reassurance, clear explanations and empathic GP communication encouraged help seeking	Parents, GP's and teachers play a major role in prompting help seeking and guiding young people into services	Time constraints in primary care and uncertainties about referral pathways shape access to follow up care
Loades et al. (2025)	Help seeking was framed as the process of recognising mood changes, interpreting their meaning and deciding whether to access support	Focused on early recognition of mood decline and the point at which young people considered seeking further support	Formal and informal help	Young people typically initiated online help seeking by googling symptoms then used the NHS for basic trusted information, social media was seen as validating but often untrustworthy	Mismatch between what young people hoped to find and what they experienced. NHS content could feel overwhelming for them	Clear and visually appealing and easy to navigate resources. Well known charities.	Peer perspectives and lived experiences were valued for validation. Trusted adults (e.g. teachers) could help influence trust via recommendations.	NR

Study	Help seeking definition/concept	Stages of help seeking	Types of help considered	Help seeking behaviours reported	Help seeking barriers	Help seeking facilitators	Relational influences	Structural or System influences
Martinez-Hernaez et al. (2014)	Help seeking was described in terms of cultural emotional and social interpretations of distress	Examined how young people recognised difficulties, evaluated their seriousness and decided whether to seek help	Informal and formal	Young people tended to normalise symptoms and relied on self reliance rather than approaching formal services.	Stigma, fear of being judged and minimising symptoms discouraged help seeking	Support from family and friends helped young people evaluate the severity and whether professional help was warranted	Family and peers shaped whether symptoms were interpreted as ordinary stress or sings of a problem warranting help	Difficulties in getting appointments, referral delays, uncertainty about who to consult, and cost as a barrier for private treatment.
Moen & Hall-Lord. (2019)	Help seeking was examined as both the intention to seek help and the actual use of formal and informal support	Examined help seeking intentions and past service use among adolescents with varying levels of distress	Informal and formal help	23.4% of distressed adolescents vs 2.3% of non distressed young people had accessed a psychologist/psychiatrist in the past year. Distressed adolescents were also less likely to seek help from friends or family	Distressed young people were more likely to report to not seek help from anyone	Not directly examined. But the role of school nurses and facilitating help seeking was discussed	Family dynamics influences whether adolescents felt able to seek help	Availability of school based support and collaboration with other services
Munson et al. (2012)	Help seeking was defined in relation	Explored long term patterns	Formal help only	Participants described cycles of help seeking	Mistrust of professional,	Stable, supportive	Trusting relationship were	System fragmentation,

Study	Help seeking definition/concept	Stages of help seeking	Types of help considered	Help seeking behaviours reported	Help seeking barriers	Help seeking facilitators	Relational influences	Structural or System influences
	to young adults' experiences navigating public systems while living with mood disorders	of accessing, withdrawing from and re-entering services		and disengagement, often driven by past experiences. Despite 75% scoring above the CES-D clinical cut off, help seeking remained inconsistent	perceived coercion and memories of negative encounter deterred help seeking	relationships with individual workers improved engagement	significant for sustained help seeking	bureaucratic obstacles and inconsistent provision hindered engagement.
Narendorf et al. (2018)	Help seeking was examined through attitudes towards professional help and perceptions of innless among marginalised young adults	The study captured attitudes related to accessing services and views about ongoing need for support	Formal and informal support	The study examined attitudes towards seeking professional help and perceptions of illness among marginalised young adults with prior service use	Higher stigma, lower openness to discuss psychological difficulties, preference for self reliance	NR	Qualitative accounts suggested social expectations and identity norms shaped attitudes towards help seeking	NR
Sawyer et al. (2012)	Young people's stated intentions to seek support for emotional difficulties	Examined hypothetical help seeking intentions in response to symptoms of low mood	Formal and informal	Young people with high depressive symptoms were 4.55 times more likely to say they would seek help from no one.	Higher depressive symptoms reduced willingness to seek help	Better social support was associated with increased help seeking intentions	Support from friends and family helped increase help seeking	School structures, including counselling availability shaped perceived options

Study	Help seeking definition/concept	Stages of help seeking	Types of help considered	Help seeking behaviours reported	Help seeking barriers	Help seeking facilitators	Relational influences	Structural or System influences
Yamaguchi et al. (2023)	Intention to seek help from others for depressive symptoms	Examined how intention changed over four waves and how depressive symptoms shaped help seeking over time	Formal and informal	Higher depressive symptoms significantly predicted lower help seeking intention across all time intervals	NR	NR	Parents, teacher and other close others were highlighted as important for proactive recognition and support	limited access to GP's and school counsellors make access to service more difficult

Help Seeking Patterns and Delays

Although there were varying behaviours of help seeking across the studies, several features were repeated, which demonstrated that services are perceived as being reactive rather than preventative. Across papers, help seeking in young people typically occurred after they had functional decline, external prompting, or their symptoms escalated, as opposed to pursuing help at the first point of mood change. For example, in school-based and community-based cohorts, substantial proportions of adolescents reported that they would not seek help for emotional difficulties, even when symptoms were elevated (Sawyer et al., 2012; Yamaguchi et al., 2023). In Sawyer et al. (2012), adolescents with high symptoms had 58% lower odds of seeking help from friends and 71% lower odds of seeking help from family than those with lower symptoms. Similar patterns were found in broader surveys. For example, distressed adolescents in Norway were significantly less likely to seek support from parents or peers but interestingly were more likely to engage with formal healthcare (Moen & Hall-Lord, 2019). This indicates that help seeking may occur later and through formal channels, rather than informal and early support.

Munson et al. (2012) found that for young people who experienced ongoing involvement across mental health services, child welfare and youth justice systems, 75% scored above the CES-D cut off for clinically significant depressive symptoms. They also described prolonged cycles of disengagement and seeking help, shaped by previous negative encounters with services (Munson et al., 2012).

Across all studies, young people would frequently attempt to self-manage distress, through withdrawal, distraction or emotional suppression. This would be particularly noticeable when emotional expression conflicted with their cultural or

gender norms (Martinez-Hernaez et al., 2014; Narendorf et al., 2018). Online help seeking would often emerge as a preliminary stage, young people would often search for mental health information before actually seeking help or telling others of their difficulties (Loades et al., 2025).

Factors influencing help seeking

Across the community samples, normalisation of symptoms was widespread, with many adolescents assuming their experiences were ordinary stress (Martinez-Hernaez et al., 2014). In one longitudinal study, higher depressive symptoms significantly predicted reduced help seeking intentions at subsequent time points, highlighting how higher symptoms can impact motivation to seek help (Yamaguchi et al., 2023). Stigma, embarrassment and preference for self-reliance were significant barriers among boys and young men (Martinez-Hernaez et al., 2014; Narendorf et al., 2018). Furthermore, black and multiracial men reported the lowest levels of psychological openness compared to women and other male demographic groups (Narendorf et al., 2018).

Facilitators to seeking help included supportive relationships. Parents, peers and teachers often played a pivotal role in helping to recognise early decline and encourage the young person to access services (Eigenhuis et al., 2021), although family conflict or limited family awareness at times hindered disclosure (Moen & Hall-Lord, 2019).

Online and digital environments both facilitated and impeded help seeking. Young people valued accessible and relatable online content but were deterred by overwhelming or contradictory information (Loades et al., 2025). For some, online engagement served primarily as a space for private reflection and understanding, rather than acting as a direct route to formal support.

Perceptions of Mental Health Services

In primary care, young people at risk of suicide described positive experiences when consultations were empathic and validating, whereas dismissive or rushed encounters intensified avoidance (Farr et al., 2021). Arcaro et al. (2017) found that emerging adults attending early intervention services, rarely described their main concerns in terms of psychiatric symptoms, they would instead emphasise that they were having relational and academic difficulties. Young people attending outpatient services in the Netherlands valued relational care but were discouraged by long waiting times (Eigenhuis et al., 2021). Young people who had been involved in multiple different systems and services described previous experiences that affected their trust and engagement with professionals. These experiences contributed to some young people viewing services as fragmented and inconsistent (Munson et al., 2012). School-based support was perceived variably, often depending on the visibility and accessibility of services and the willingness to engage with school-based professionals (Moen & Hall-Lord, 2019).

Digital services were viewed as accessible. Young people regarded charity and youth-focused websites as most trustworthy, though they typically used online resources as preparatory rather than substitutive steps towards help seeking (Loades et al., 2025).

Across all studies, it was clear that relational qualities such as empathy, continuity and collaborative engagement were key determinants of positive service perceptions.

Quality Appraisal

Methodological quality varied across the ten studies included (see Table 3). Overall MMAT rating ranged from moderate to high. The qualitative studies were

strong (all 100%): they all provided clear research aims, transparent recruitment information and coherent descriptions of analytic procedures (Eigenhuis et al., 2021; Farr et al., 2021; Loades et al., 2025; Martinez Hernaez et al., 2014).

Quantitative studies were generally of sound methodological quality (71.43%-85.71%), frequently using large sample sizes and established symptom measures (Moen & Hall-Lord, 2019; Sawyer et al., 2012; Yamaguchi et al., 2023). However, limitations were observed which raised concerns on reporting and recall bias, as all the papers relied exclusively on self-report questionnaires.

Mixed methods studies demonstrated reasonable integration of components (71.43%-100%; Arcaro et al., 2017; Munson et al., 2012; Narendorf et al., 2018). As in previous reviews, some inadequate reporting of participant selection, non-response and reflexivity was common. Despite these limitations, methodological quality was sufficient to allow careful interpretation of convergent patterns across studies.

Table 3. Quality Appraisal

Domain	Quality Criteria	Arcaro et al. 2017	Eigenhuis et al. 2021	Farr et al. 2021	Loades et al. 2025	Martinez-Hernaez et al. 2014	Moen & Hall-Lord. 2019	Munson et al. 2012	Narendorf et al. 2018	Sawyer et al. 2012	Yamaguchi et al. 2023
Screening Questions	Are there clear research questions†?	+	+	+	+	+	+	+	+	+	+
	Do the collected data allow to address the research questions†?	+	+	+	+	+	+	+	+	+	+
Qualitative Studies	Qualitative approach appropriate to answer research question†?	n/a	+	+	+	+	n/a	+	+	n/a	n/a
	Qualitative data collection methods adequate to address the research question†?	n/a	+	+	+	+	n/a	+	+	n/a	n/a
	Findings adequately derived from the data?	n/a	+	+	+	+	n/a	+	+	n/a	n/a
	Interpretation of results sufficiently substantiated by data?	n/a	+	+	+	+	n/a	+	+	n/a	n/a
	Coherence between qualitative data sources, collection, analysis and interpretation?	n/a	+	+	+	+	n/a	+	+	n/a	n/a
Quantitative Descriptive Studies	Sampling strategy relevant to address the research question?	+	n/a	n/a	n/a	n/a	+	n/a	+	+	+
	Sample representative of target population?	+	n/a	n/a	n/a	n/a	+	n/a	?	?	+
	Measurements appropriate?	+	n/a	n/a	n/a	n/a	+	n/a	+	+	+
	Risk of nonresponse bias low?	?	n/a	n/a	n/a	n/a	?	n/a	?	?	?
	Statistical analysis appropriate to answer the research question?	+	n/a	n/a	n/a	n/a	+	n/a	+	+	+
Mixed Methods	Adequate rationale for using mixed methods design to address the research question?	n/a	n/a	n/a	n/a	n/a	n/a	n/a	+	n/a	n/a
	Different components effectively integrated to answer the research question?	n/a	n/a	n/a	n/a	n/a	n/a	n/a	+	n/a	n/a
	Outputs of the integration of qualitative and quantitative components adequately interpreted?	n/a	n/a	n/a	n/a	n/a	n/a	n/a	+	n/a	n/a
	Divergence and inconsistencies between quantitative and qualitative results adequately addressed?	n/a	n/a	n/a	n/a	n/a	n/a	n/a	?	n/a	n/a
	Different components adhere to the quality criteria of each tradition of the methods involved?	n/a	n/a	n/a	n/a	n/a	n/a	n/a	+	n/a	n/a
Total percentage		85.71	100	100	100	100	85.71	100	71.43	71.43	85.71

†also taken to mean research objectives and aims. Mixed Methods criteria were appraised but, following Gronholm et al. (2017) were not included in the percentage score. + yes, - no, ? can't tell

Discussion

This systematic review examined how young people aged between 12-25 years old recognised emerging mood difficulties and what influenced them to seek support. Across 10 of the studies, help seeking appeared as fragmented, delayed and often instigated by others.

Previous reports have shared difficulties accessing mental health support, despite policy commitments to timely access and early intervention (NHS England, 2019; Children and Young People's Mental Health Implementation Framework, 2023). This review aimed to add to the limited research specifically on help seeking in early or emerging mood disorders, including the prodromal period, the stage before bipolar disorder fully develops.

Interpretation of Findings

Although only ten studies met the inclusions criteria, similar patterns emerged across the papers. The findings aligned with broader literature showing that help seeking at early stages of symptom development is often avoided by young people (Rickwood et al., 2015). Within qualitative accounts, young people explained uncertainty around recognising early signs of mood changes, often assuming them to be the normative of everyday stress, fatigue or what is seen as adolescent fluctuations (Martinez Henaez et al., 2014). Somewhat predictably, across school-based studies, those with higher symptoms of depression resulted in lower intentions to seek support (Sawyer et al., 2012). The apparent inability for these young people to identify the need for early-stage support brings into question the effectiveness of

current mental health literacy, which is important because poor mental health literacy may delay recognition of difficulties and reduce the likelihood that young people seek support (Gulliver et al., 2010)

Delays in seeking help were particularly prevalent in young people who had experience of the public care system. These young people explained that due to previous negative experiences and lack of trust in professionals, they went through cycles of wanting to engage with services then withdrawing. Alongside these negative experiences, stigma and an attitude of self-reliance were also barriers to engaging with services (Munson et al., 2012; Narendorf et al., 2018). Similarly to findings in literature around adult bipolar disorder, these young people experienced delays between initial service contact and diagnosis, suggesting prolonged diagnostic pathways (Nierenberg et al., 2023; O'Hare et al., 2025). These findings suggest that delays in intervention were not solely based on individuals' reluctance to engage, but also the structural and relational processes involved.

Young men were another nuance in relation to mood difficulties, reflecting previous literature suggesting that gender norms and preferences for self-reliance may influence attitudes towards help seeking (Rickwood et al., 2015). Although many factors were consistent throughout the research, stigma, self-reliance and uncertainty were significant barriers (Martinez Hernaez et al., 2014; Narendorf et al., 2018). This echoed the testimonies of young people that worried that their experiences or symptoms weren't severe enough to warrant intervention (Baldofski et al., 2024).

Relational context played a significant role in young people accessing services. Parental communication, supportive teachers and peer encouragement all aided in recognition of mood changes and symptoms (Eigenhuis et al., 2021). However, those

without parental understanding or strong relationships, did not always disclose their emotions, therefore managing difficulties alone (Moen & Hall-Lord, 2019). These positive relationships all align with the 'opportunity' component of the COM-B model, suggesting an enabling social environment is required for behaviour change as well as internal motivation (Michie et al., 2011). Similarly to national reports of prolonged delays within CAMHS (Valentine et al., 2024), fragmented referral systems and prolonged waiting time shaped pathways to care (Munson et al., 2012). For some marginalised young people, these structural barriers increased their distrust with professional services and reinforced the pattern of getting help at a later stage or when in crisis.

There was a positive use of digital context where online searching was used as an initial attempt to understand one's symptoms, but this did not guarantee formal help seeking, as overwhelming or contradictory information could delay disclosure (Loades et al., 2025). This highlights the complexity of digital context and mental health, as although accessibility and anonymity may allow for early recognition, unless clear signposting and trusted relational support is accompanied, there is no certainty of transition into formal care (Pretorius et al., 2019). Young people often used online resources as a first step to understand their experiences and validate their symptoms before considering whether professional support was needed (Loades et al., 2025). This suggests that digital environments may contribute to earlier recognition of emerging mood difficulties and provide an opportunity to encourage help seeking. However, their potential to support early intervention is likely to depend on whether they are accompanied by clear information and accessible pathways into appropriate services.

Young people's views on engaging with health services were a mixture of hope and uncertainty. When they encountered positive relationships within primary care or early intervention setting, onward engagement was encouraging. However, when they were met with dismissive interactions, rushed appointments or inconsistent delivery, they reverted to avoidance of help seeking (Farr et al., 2021). This highlights the importance of safety and validation at first point of contact in care. Perceived severity thresholds were another barrier for young people seeking help. Even when experiencing significant or persistent symptoms, they were unsure whether this was enough to merit clinical attention (Eigenhuis et al., 2021). This paralleled findings from research on early bipolar presentations, whereby fluctuating symptoms and diagnostic vagueness discouraged help seeking (Keramatian & Morton, 2023). These findings indicate a review is needed on how messaging should be made to young adults and adolescents, to ensure information is clearer on how and when to seek support. These findings align closely with Rickwood's four stage model, emphasising the need for recognition of symptoms and the assessment of need as early factors for help seeking (Rickwood et al., 2005). It appears that both of these two key stages are absent in young people experiencing difficulties with mood, especially when symptoms develop gradually, mood fluctuates or symptoms are misinterpreted as normal functioning. The COM-B model (Michie et al., 2011) further explains why help seeking may be inconsistent, as it provides a framework suggesting that ability can be reduced by limited mental health literacy, motivation may decline in conjunction with the severity of depression, and opportunity can be constrained without supportive relationships and accessible services. Both frameworks evidently illustrate why young people delay seeking help despite significant distress.

Strengths and Limitations

A key strength of this review is that it is the first of its kind to bring together evidence on help seeking among young people experiencing, or at risk of, mood disorders. By including qualitative, quantitative and mixed method designs, the review was also able to reflect both young peoples lived experiences and broader patterns in help seeking.

This review should consider some limitations when interpreting the findings. Whilst ten studies met the inclusion criteria, the evidence base that focuses specifically on help seeking in young people with mood disorders, including those at risk of bipolar disorder, remains limited. This reflects wider gaps in the literature and limits the extent to which findings can be generalised across different clinical and demographic groups. Whilst the search strategy was comprehensive, it is possible that additional relevant studies may have been missed, particularly given the variability in the terminology used to describe early mood difficulties. In future research, including alternative search terms related to emotional distress may have broadened the number of eligible papers. Furthermore, the search strategy also included the term ‘anxiety’ because anxiety symptoms can often overlap with early presentations of mood disorders, particularly during the initial stages when diagnostic differentiation may be difficult. However, broader anxiety-specific terms, such as panic disorder, were not included because anxiety disorders were not the primary focus on the review. Whilst this approach reflected the aims of the review it may have influenced which studies were identified and should therefore be considered when interpreting the findings.

The included studies were conducted across a wide range of countries that have different healthcare structures, referral pathways and cultural attitudes towards mental health. Although this diversity offers strong insight into how help seeking may vary across settings, the variation could introduce substantial differences which may make direct comparisons difficult and limits the extent to which findings can be interpreted in a consistent way. Differences in service models, thresholds for care and cultural expectations mean that patterns observed in one context may not fully generalise to another, which should be considered when interpreting the findings.

Although the MMAT provided a structured approach to assessing study quality, it does not require a cut-off score. The MMAT requires reviewers to apply judgement when interpreting overall quality. Dual rating of all included studies would have strengthened reliability, however, that was not possible within the scope of this project. That being said to help increase reliability SA did review 20% of the full texts.

Lastly, reflecting the wider gaps in research, none of the included studies specifically examined young people at risk of bipolar disorder, which limits the conclusions that can be drawn regarding bipolar disorder. This means conclusions relating to bipolar disorder should be interpreted in the context of the limited evidence available, as they are informed primarily by the broader literature on mood disorders rather than evidence specific to bipolar disorder. Despite these limitations, the review offers a meaningful synthesis of current research and highlights the important patterns in how young people recognise difficulties and seek support.

Clinical Implications

The findings from this review highlight some of the reasons why help seeking may be delayed and the importance of early recognition, particularly in school settings where there is opportunity to observe early signs, but due to problems with current mental health literacy those signs are not properly understood.

To help prevent delays in an already complex system, service structures and their users would benefit from creating clearer referral pathways, reduce waiting times and guidance on building greater relational stability. Furthermore, digital resources were shown to be widely used as a first action point but no guaranteed onward action. Embedding supported digital triage or signposting may strengthen the link between online searching and beginning the process for formal assessment.

Research implications

The small number of eligible studies identified in this review highlights the need for further research in this area. Future research should examine help seeking in earlier and more ambiguous phases of mood disorder, including subthreshold bipolar symptoms. Longitudinal designs would help clarify how recognition, motivation and opportunity can shift over time. Research that focuses on socioeconomic and cultural contexts would also be beneficial, given the persistent inequalities in access and engagement. In addition, it would be recommended for future studies to report on the ethnicity of the participants, to establish generalisability of the research and to identify any possible inequalities in accessing services.

Conclusion

Help seeking among young people experiencing or at risk of mood disorders is best understood as a complex and dynamic process shaped by intertwined

personal, relational and structural influences. Delays are common, barriers are multifaceted and support is often accessed only after significant escalation or external promoting. Improving early help seeking therefore requires coordinated action across education, families, digital services and clinical services to promote recognition, reduce stigma and create accessible youth-centred pathways to care.

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Chapter Three: Bridging Chapter

Word count: 576

The systematic review presented in Chapter Two aimed to develop an understanding of how young people with, or at risk of, mood disorders recognise their difficulties, accessed support, and engage with care. Existing research on help seeking in youth mental health have explored a wide range of mental health difficulties, including anxiety and depression across different settings, including primary care and youth mental health services (Rickwood et al., 2015). While current literature provides a broad understanding of help seeking behaviour among young people, signs of early mood difficulties are not easy to distinguish, as symptoms can overlap with other disorders (Nierenberg et al., 2023). If findings from these reviews are generalised across different diagnostic groups and populations, then important details regarding development, clinical presentation and service structures could be overlooked. To tackle this concern, the present systematic review focused on help seeking behaviours among young people aged 12 to 25, that were experiencing or at risk of developing mood disorders, including early or emerging bipolar disorder.

The studies within the literature review examined the experiences of young people in varying contexts including different countries, schools' settings and health services, and although varying methodologies were used throughout, a consistent pattern of help seeking was observed across most studies. Help seeking rarely happened early on when mood changes first occurred for young people, instead they would manage difficulties themselves. Young people were more likely to engage with health services once their symptoms had become more severe and when an adult figure intervened. One barrier young people described to preventing them seeking help was their inability to recognise mental health difficulties, which was tested further as their functioning and mood gradually declined. Even when they did

recognise their mental health decline, they were hesitant to engage with services as they assumed their condition was not serious enough to warrant support.

Although the review offers useful insight into young people's experiences of recognising difficulties and seeking help, it also highlights clear gaps in the existing literature. With relatively little attention given to bipolar disorder or early bipolar presentations, most studies focussed on depressive symptoms or general emotional distress.

Some studies explored the experiences of family members, however there was limited research examining the perceptions of clinicians to understand how they respond to early or uncertain mood presentations. Given the amount of influence clinicians have in shaping a young person's pathway through care, it is arguably vital that we understand clinicians' perceptions of presentations (Keramatian & Morton, 2023). While working within under resourced services, clinicians are required to decipher ambiguous presentations, choose whether their concerns should be monitored or escalated, and clearly communicate their concerns (Campbell et al., 2019). However, there is little qualitative research exploring the experiences of clinicians and how they manage these challenges in practice, particularly within UK youth and mental health services.

The empirical study presented in the following chapter was designed to address these gaps. It explores clinicians' experiences of identifying and responding to early indicators that may suggest bipolar risk in young people within UK mental health services. Due to the central role in recognising emerging mood difficulties and their experience navigating service pathways, the study included clinicians working across CAMHS, early intervention services (including early intervention in psychosis services) and primary care. This empirical study builds on the findings of the

systematic review by examining the clinician's perspectives on early mood difficulties and possible bipolar risk and how these are managed in clinical practice.

Chapter Four: Empirical Paper

Clinicians' Perceptions of 'At Risk' Bipolar Disorder in Young People: a Thematic Analysis

Prepared for submission to 'Qualitative Psychology'

(see Appendix D for author guidelines)

Word count: 8017

Abstract

Introduction: Identifying bipolar disorder early in young people remains particularly difficult. Early presentations are often difficult to distinguish from normal adolescent development or other mental health challenges. This study explored how clinicians working in UK health services recognise and interpret early signs that may suggest bipolar risk, how they manage uncertainty, ethical issues and communication with young people and families when discussing possible bipolar disorder or risk, and how service structures, resources and culture influence their capacity to identify and support young people who may be 'at risk'.

Method: Semi-structured interviews were conducted with nine clinicians working across child and adolescent mental health services, early intervention services and primary care, all with experience of working with young people aged between 16 and 24. Data were analysed using reflexive thematic analysis.

Results: Five themes were identified: noticing patterns over time; making sense of mood changes; holding concern without clear options; feeling unsure and underprepared; and deciding what to say and when. Clinicians recognised bipolar risk, through noticing patterns and contrasts in mood over time rather than at initial assessment. Early mood changes were often understood using developmental or alternative diagnostic frameworks. When concern about bipolar risk emerged, clinicians reported uncertainty, limited confidence and unclear pathways, alongside high service thresholds and careful consideration of whether and how to use the term 'at risk' bipolar.

Conclusion: These findings suggest a need for clear pathways and better support for clinicians to manage diagnostic uncertainty when identifying and responding to possible bipolar risk in youth mental health.

Keywords: bipolar disorder, at risk bipolar disorder, young people, early identification

Introduction

Youth mental health and early identification

Over the past decade, national surveys in the UK and elsewhere have reported rising levels of mental health need among young people (NHS Digital, 2023). This rise in need has placed additional pressure on mental health services, where demands for support often exceed capacity (Cosma et al., 2025). As a result, young people face prolonged waiting times, rejected or closed referrals and reduced opportunities for early intervention. National studies in Europe and North America have also reported high levels of clinical need, particularly anxiety and depressive symptoms among children and adolescents (Barican et al., 2022; Racine et al., 2021). Dror et al. (2022) noted similar trends to the UK where a steep rise in referrals to child and adolescent psychiatric emergency services was observed, reflecting an increased demand for adolescent mental health services.

Internationally, research has consistently found that early identification of mental health conditions is associated with improved access to appropriate intervention and better long-term outcomes (Colizzi et al., 2020; Nierenberg et al., 2023). Early recognition and treatment can support young people to maintain social relationships, remain engaged in education and improve quality of life (Owens & Waters, 2020; World Health Organisation, 2022). With policy-level emphasis on early identification, there is an expectation that clinical staff will identify and respond to emerging and complex symptoms earlier in the care pathways. As a result, early identification and intervention have become a central focus for health policies and clinical care (Cosma et al., 2025). With these challenges in mind, it is important

to understand how early identification is implemented in practice within services that young people already find difficult to access.

Bipolar disorder in young people

Bipolar disorder typically first presents in late adolescence or early adulthood (Martini et al., 2021; Yatham et al., 2018) and is characterised by episodes of depression and mania or hypomania (Rantala et al., 2021). The early onset of this condition, particularly before the age of 18, is associated with a more severe set of symptoms, greater functional decline and an increased risk of comorbid difficulties (Cirone et al., 2021). Research has shown that many young people may receive alternative diagnoses before bipolar disorder is considered (Keramatian & Morton, 2023), often leading to a substantial delay between the emergence of symptoms and a formal diagnosis of bipolar disorder (Scott et al., 2022). A recent survey estimates the average waiting timing from first seeing a doctor about symptoms to a diagnosis is approximately 9.5 years (Bipolar UK, n.d.). The suggested reasons for this delay include people not disclosing symptoms, clinicians not querying hypomanic episodes, misdiagnosis, and not seeking support for bipolar due to stigma of the disorder, these findings reflect the broader bipolar population rather than young people specifically (Bipolar UK, n.d.).

Although recognising bipolar disorder early in young people is a key goal for services, it remains challenging in practice as many of the early features of bipolar disorder overlap with other mental health conditions or are misinterpreted as typical adolescent development. For example, mood instability, irritability and reduced sleep can also be present within depression, attention deficit hyperactivity disorder (ADHD) and emerging personality difficulties (Youngstrom et al., 2009). Such

overlaps in behaviour increases the likelihood of misdiagnosis, delays of treatment or even an absence of intervention altogether. Considering that the current clinical guidance for bipolar disorder is to provide a combination of both pharmacological and psychological interventions, there is particular concern that misdiagnosis or discharge from services could lead to adverse health outcomes for young people as they would not be receiving the appropriate intervention (NICE, 2017).

The at-risk mental state framework and early bipolar presentations

The At-Risk Mental State (ARMS) framework was developed in the 1990s for early psychosis services to support young people experiencing early signs of risk or lessened symptoms of psychosis with the aim of reducing distress and shortening the duration of untreated psychosis (Shah et al., 2022; Yung et al., 2021). Individuals who met the ARMS criteria would typically receive psychological support, psychoeducation and monitoring. Evidence suggests that this approach can support early intervention and improve functional outcomes (Yung et al., 2021).

There is a growing interest in developing a similar framework to this for bipolar disorder as it shares features to psychosis. Studies have shown that a prodromal phase for bipolar disorder may involve disrupted sleep, fluctuating energy and activity levels and mood instability, particularly in the context of a family history of bipolar disorders or other affective conditions (Conroy et al., 2018; Vieta et al., 2018). However, compared to psychosis, this area of research is less developed. Early presentations appear highly variable and, as in ARMS for psychosis, not all young people that appear to show early bipolar-like symptoms go on to develop the disorder (Martini et al., 2024).

The prominent proposed benefit of introducing an early intervention pathway is the ability to intervene during the 'at risk' phase which enables the possibility to stall the development of psychosis (Yang et al., 2015). Conversely, labelling a young person 'at risk' may contribute to anxiety and stigma, or could lead to those that may never go on to develop bipolar disorder having unnecessary involvement with services (Yang et al., 2015). Without reliable predictive tools or biomarkers, we run the risk of over pathologizing normal fluctuations in mood and behaviour during adolescence. These factors highlight the importance of understanding how clinicians interpret early or uncertain presentations and how they consider the implications of language used in practice to communicate diagnostic uncertainty. This includes using the terms 'risk' or 'uncertainty' with young people and families and how risk related language is documented within clinical decisions.

Clinician perspectives and service context

Recent research highlights that clinicians working in CAMHS, early intervention and related youth services may face challenges in identifying early bipolar presentations or knowing when to raise concerns around bipolar risk (Keramatian & Morton, 2023). This uncertainty may reflect limited awareness of early or subthreshold presentation and the challenges clinicians face in recognising early bipolar features (Keramatian & Morton, 2023). Other explanations include service level pressures, such as limited time and expertise in primary care settings and long waiting times for specialist assessments, meaning that clinicians may have reduced opportunity to explore the complex patterns in great depth (Hoppe et al., 2025; Keramatian & Morton, 2023). Early recognition of an evolving bipolar disorder and decision about monitoring, referral or diagnosis can have a lasting

impact on patient and their families. This is because delays in accurate diagnosis and appropriate treatment are associated with worsening illness progression, and increased functional impairment (Berk et al., 2009).

Most of the research to date on early bipolar detection has focused on risk markers or predictive modelling, rather than understanding the day-to-day experiences and reasoning of clinicians working within services. Some clinicians may face the conscious battle of wanting to intervene early but may be concerned about whether emerging symptoms are sufficient enough to warrant a diagnosis (Keramatian & Morton, 2023). Navigating these dilemmas requires clinical, ethical and relational judgement.

Rationale for the present study

Despite UK mental health policies, early intervention service frameworks, and a broad understanding that early identification of bipolar disorder is central for improving health outcomes, most research has focused on treatment outcomes in the adult population, with comparatively little research on youth focused services (Saraf et al., 2021; Wrobel et al., 2022).

In response to these gaps, the systematic review in this portfolio addresses help seeking behaviour among young people ‘at risk’ of bipolar disorder or experiencing difficulties in mood and examines what factors can influence the way support is accessed and at what point.

A qualitative approach is well suited to examining these questions. Reflexive thematic analysis allows detailed attention to both shared patterns and the nuances of individual accounts, while a critical realist stance recognises that clinicians work within real organisational constraints and also bring their own experiences, values and assumptions to clinical decision-making (Braun et al., 2022; Fletcher, 2017).

Aim of the study

The present empirical study explores how clinicians working in UK youth mental health services understand and respond to early or uncertain indicators of bipolar disorder in young people. Specifically, it aims to:

1. Examine how clinicians recognise and interpret early signs that may suggest bipolar risk.
2. Explore how they navigate uncertainty, ethical dilemmas and communication with young people and their families when discussing possible bipolar disorder or risk.
3. Consider how service structures, resources and cultures influence their capacity to identify and support young people who may be at risk.

Method

Design and Epistemology

A qualitative methodology was used, with data collected through semi-structured interviews (Appendix E). This approach was considered appropriate given the exploratory aim of understanding clinicians' experiences of working with people considered to be 'at risk' of bipolar. Reflexive thematic analysis was used, following Braun and colleagues' (2022) approach to thematic analysis. This allowed patterns of shared meanings across clinicians' accounts to be constructed, whilst also reflecting upon how the lead researcher's professional background as a trainee clinical psychologist influenced the research process. The lead researcher has no personal experience of bipolar disorder.

A critical realist stance was adopted (Archer et al., 2013), recognising that systematic and organisational barriers within mental health services exist independently of clinicians' perceptions, whilst also acknowledging that clinicians' accounts reflect subjective meaning shaped by professional experience, training and service context.

Patient and Public Involvement

Patient and Public Involvement (PPI) was incorporated during the development of the study, in the form of engagement with clinicians who were not participants in the study. PPI involvement in doctoral research has been shown to enhance research quality, relevance and impact (Coupe & Mathieson, 2019), and reflects an ethical commitment to involving individuals in research that relates to their experiences.

To inform the development of the interview schedule, two clinicians, working across adult community and youth services, were recruited via the project's supervisors through existing professional networks. They took part in a structured discussion lasting up to one hour, conducted online via Microsoft Teams. These discussions focused on the relevance and sensitivity of the proposed research questions, including feedback on which areas should be included or excluded. PPI contributors also reviewed and approved the wording of the Participant Information Sheet (Appendix F) and consent materials (Appendix G) to support clarity and accessibility. To complete the feedback process, all PPI contributors were informed of the study findings via email and will be provided with copies of the final thesis and any resulting publications.

Service and Professional Context

This study was conducted across UK mental health services, with clinicians recruited from CAMHS, early intervention services and primary care. With differing referral thresholds, resources and levels of specialist provision amongst these services, they have a direct impact on routine practice regarding how concerns about emerging health difficulties are recognised and responded to.

Participants

Participants (n = 9) were clinicians working within UK mental health contexts who had experience of working with young people. The sample comprised of six clinical psychologists, one general practitioner, one mental health nurse and one cognitive behavioural therapist. Inclusion criteria were: 1) qualified clinicians who had experience working in NHS services, and 2) experience working clinically with young people (defined as individuals aged between 16 and 24). Exclusion criteria were: 1) clinicians who did not have experiences working in an NHS setting, or 2) clinicians who did not have experiences working with young people aged between 16 and 24. Participants did not require direct experience of working with bipolar disorder, as this study sought to understand the clinicians experience of recognising mood presentations and how they interpret behaviour which could be classified as ‘at risk’. This was because young people who may be at risk of developing bipolar disorder can present with a range of overlapping symptoms and may not have an existing diagnosis. Therefore, clinicians may have experience working with young people showing early indicators of bipolar risk, even when bipolar disorder has not yet been considered. This allowed the study to capture a broader range of clinical experiences around recognising and respond to emerging

mood difficulties. It was explained to participants that the study was undertaken as part of a clinical psychology doctorate and was intended to deepen understanding of how clinicians identify and respond to early indicators of bipolar disorder in young people. Participant demographic characteristics are summarised in table 1.

Table 1.
Participant Demographics

Participant ID	Age	Gender	Professional role	Years of clinical experience	Current service context
C1	30-39	Male	Clinical Psychologist	5-10 years	Community mental health services
C2	30-39	Female	Clinical Psychologist	5-10 years	CAMHS
C3	30-39	Male	Nurse	11-15 years	CAMHS
C4	39-49	Female	Clinical Psychologist	15-20 years	CAMHS learning disability service
C5	30-39	Female	Clinical Psychologist	5-10 years	Specialist consultative youth service
C6	30-39	Female	Clinical Psychologist	11-15 years	CAMHS
C7	30-39	Female	CBT Therapist	15-20 years	Early intervention service
C8	40-49	Female	General Practitioner	20+ years	Primary care
C9	30-39	Female	Clinical Psychologist	5-10 years	CAMHS

Note. CAMHS = Child and Adolescent Mental Health Services

Ethics

Ethical approval was granted by the University of East Anglia Faculty of Medicine and Health Science Research Ethics Subcommittee (FMH S- REC; reference: ETH2425-0448; Appendix H) prior to the study commencing. All participants were provided with a Participant Information Sheet and written consent forms. Participants were informed of their right to withdraw from the study at any time. All data were anonymised and identifying information was removed prior to analysis and were stored securely on a password-protected university OneDrive, participant recordings were deleted once transcription had been completed and transcripts had been checked for accuracy. Following the interview, participants were given a debriefing sheet (Appendix I), which included contact details for the researcher and supervisory team should any concerns arise following participation. No concerns were reported.

Although participants were clinicians rather than service users, the interviews involved discussion of risk, service pressures and ethical dilemmas, which could be emotionally challenging. All participants were reminded that they could pause or stop the interview at any time, and interviews were conducted in a flexible and participant led way. No participants terminated the interview early.

Procedure

Participants were recruited through posting a poster (Appendix J) on social media platforms, including X and LinkedIn, as well as through professional networks associated with the clinical psychology training programme. They were not recruited directly through NHS services. Clinicians who expressed interest were contacted

directly by the researcher and provided with the PIS and consent form via email. Participants were given the opportunity to ask questions before providing written informed consent. Semi-structured interviews were conducted online via Microsoft Teams. Interviews lasted approximately one hour and were audio recorded with participants' consent. Following the interview, participants were compensated with a £10 amazon voucher as a thank you.

Interviews

Interviews were conducted between May 2025 and November 2025, with interviews carried out by JG, a female Trainee Clinical Psychologist studying for a doctorate in clinical psychology. Interviews lasted between 42 and 59 minutes. The interview schedule was developed jointly by JG, the supervisory team (SA, KM), and two PPI members. Topics included clinicians' experiences of identifying and interpreting early or uncertain indicators of bipolar disorder in young people, navigating mental health service pathways, views on the use of the term 'at risk bipolar' and communicating potential risk with young people and their families.

Analysis

Data was analysed using reflexive thematic analysis, following Braun et al. (2022) six phase approach (Table 2). This method was chosen as the study aimed to explore patterns of meaning across clinician's accounts of how they recognised, interpreted and responded to possible bipolar risk in young people. Reflexive thematic analysis allowed patterns of shared meaning to be developed across different clinicians and service contexts, whilst also allowing flexibility to explore differences in how clinicians made sense of uncertainty in practice. This approach

was considered more appropriate than other qualitative methods, such as grounded theory, as the aim was not to develop a new theory, but to explore the clinician's experiences and understanding of recognising risk in clinical practice. An IPA approach was also not selected as the focus was on understanding patterns across clinicians' accounts, rather than providing an in-depth exploration of an individual clinician's experience. The six phase approach was used as a flexible guide rather than as a linear procedure (Braun et al., 2022). Interview data was initially transcribed using the Microsoft Teams built in transcription function and then manually checked for accuracy by JG. To support data familiarisation, all transcripts were read in full both during transcription and after transcription before coding began. Nvivo qualitative data analysis software was used to support data management and organisation (Appendix K). Initial codes (Table 3) were then generated inductively from the data and coded in relation to the research aims, no preexisting codes used. Analysis was an iterative process, with movement between phases as codes as themes were developed and refined. Codes were then examined for patterns of shared meaning and were grouped into candidate themes. Themes were then defined and named to capture the core meaning of each theme and its relevance to the research aims. The final phase of producing the report, was considered an active part of the analysis, as writing provided further opportunity to reflect on and refine the overall analytic narrative (Braun et al., 2022).

Table 2. *Six Phases of Reflexive Thematic Analysis*

Analysis stage	Procedure
Familiarising yourself with the data	Microsoft Teams built in transcription software. Transcripts manually checked for accuracy. Reading and re-reading the transcripts. Making notes of interest
Generating initial codes	Transcripts annotated with initial codes on NVivo. Checking to ensure codes address research question.
Searching for themes	Putting codes together to start to identify themes
Reviewing potential themes	Reviewing themes to make sure that they capture meaningful patterns within the data which addresses the research aims. Considering the narrative of each theme, in addition to how they form together to tell the narrative of clinicians' experiences.
Defining and naming themes	Definitions of themes are written to capture the core concepts. Names are assigned to themes.
Producing the report	Findings written up

Sourced from Braun et al. (2022).

Table 3. *Examples of initial coding from interview data*

Participant	Data extract	Initial Code
C5	*'I guess thinking of what comes to mind, I guess is that kind of low mood and then that kind of more high-energy kind of phases and, yeah, kind of extremes'*	Identifies mood extremes as potential indicators of bipolar risk
C8	*'But then who? Who do you get them to see? How how do you do that? And I guess if you had the, you know, but even you have the school saying the same thing as well. It's it's actually trying'*	Uncertainty about appropriate referral destination for complex risk
C9	*'With ADHD signs are normally from a lot younger, whereas with bipolar I'd be assuming there would be a precipitating event that really started things off'*	ADHD seen as early onset, bipolar seen as triggered later

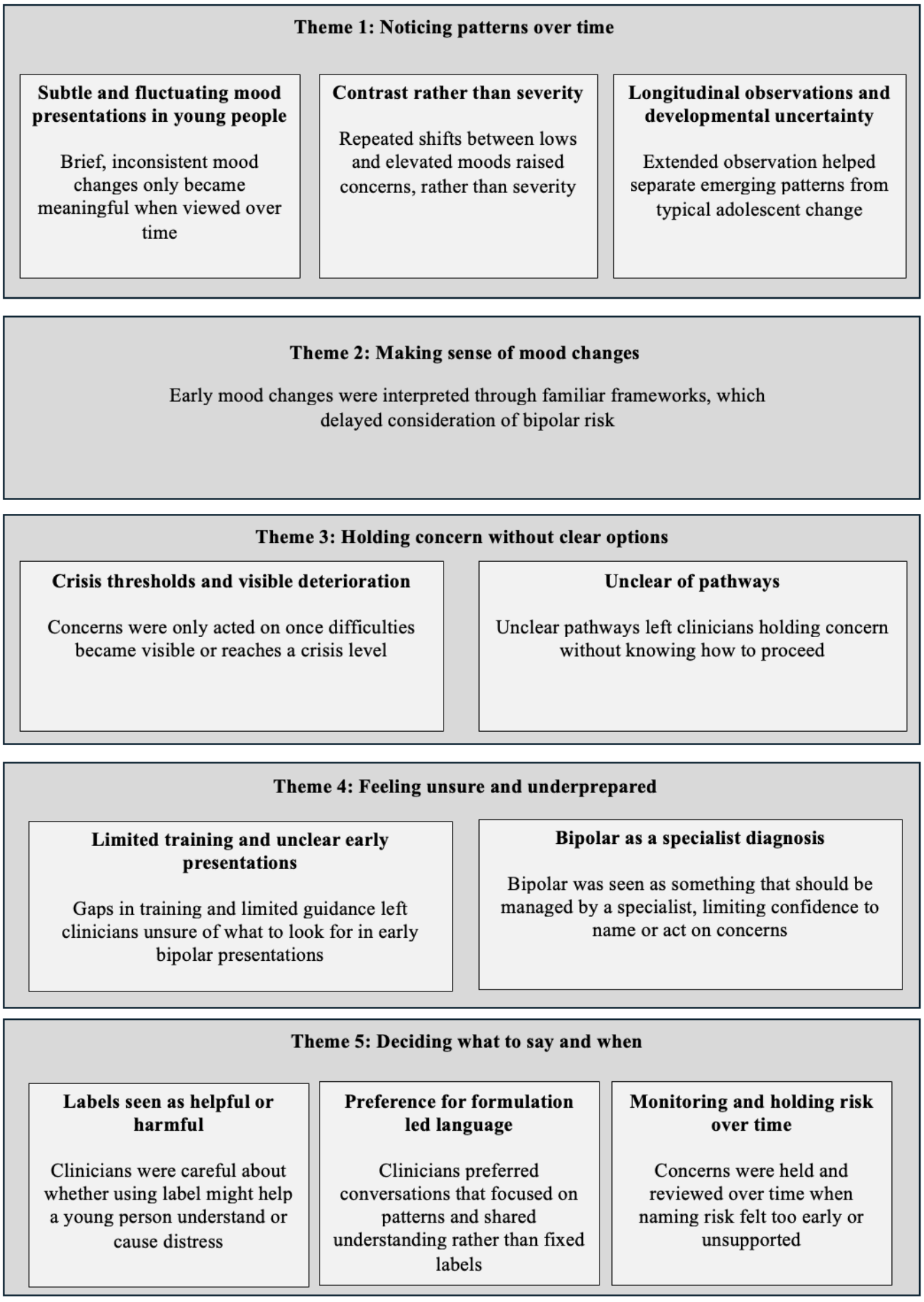
Reflexivity

In line with Braun et al.'s (2022) approach to reflexive thematic analysis, throughout the research process, JG maintained a reflexive journal (Appendix L). This was used to reflect on potential assumptions and influences at each stage of the research process. Where relevant, reflections from the reflexive journal were discussed in research supervision.

Results

Nine interviews were conducted to explore clinicians' reflections and experiences on recognising and responding to early indicators of bipolar disorder in young people. The clinicians described the challenges of noticing possible bipolar risk, how they made sense of mood changes over time and how they might respond in their service. The themes identified through the thematic analysis are presented below (figure 1).

Figure 1. *Overview of themes and subthemes developed through reflexive thematic analysis*



Theme 1: Noticing patterns over time

This theme describes how clinicians first became concerned around possible 'at risk' bipolar disorder in young people. Rather than a single, clear diagnostic moment, recognising young people at risk was a gradual emergence for many clinicians. This involved noticing patterns of mood changes over time. Most clinicians shared a similar approach where bipolar disorder was not their focus and instead, they would look at changes to mood in relation to developmental norms or other complex diagnostic presentations. Clinicians were not necessarily responding to the severity of symptoms, but the changes in how young people presented over time.

Subtheme 1.1 Subtle and fluctuating mood presentations in young people

Clinicians described early presentations of bipolar disorder in young people as noticeably different from the adult population, specifically in terms of mania. Rather than overt or sustained manic episodes, they spoke about mood changes that were brief and inconsistent, and shared that they would only notice or become concerned when a young person presented this over a longer period of time. One clinician described focusing on contrasts between mood states rather than any specific symptoms:

'So because of bipolar I'd be looking into kind of stark contrasting states in them. So I'd be looking to see if they have kind of…if they're described with two distinct presentations, or really…umm… they're very low and they withdraw and they can't do anything for themselves and they feel very suicidal and they're really struggling…to then they're…they're so happy and they're upbeat and they're life and soul and they're whizzing about.' (C9, Clinical Psychologist)

The absence of typical adult markers of mania was described as making recognition more difficult. Symptoms and behaviours commonly used to identify mania in adults were often described as not applicable to younger people, requiring the clinicians to rely on more subtle indicators:

'…and that's very typical, but I think in a child with like less ability to do kind of adult traditional manic symptoms, like gambling or sexual behaviour, or spending loads of money, I think just a stark contrast in how they are over set periods would be enough to just think about it, not necessarily diagnose.' (C9, Clinical Psychologist)

Across accounts, clinicians suggested that early concern was brought on by an unease of fluctuating or contrasting states of mood.

Subtheme 1.2 Contrast rather than severity

Clinicians explained that their concerns for at risk bipolar disorder came not from a severe set of symptoms at one time, but by comparing their contrast in mood over longer periods of time, the pattern often being long periods of low mood, followed by short burst of excessive energy or activity:

'But we had people who were starting to exhibit cycles of really, really prolonged period of like, low, low, low, low mood…and then, like, a really small burst of, they were…everything was great. They'd come to session, they'd be telling you things

they've done and you'd be thinking, oh, that is insane, like how have you.. you need to slow down.' (C1, Clinical Psychologist)

These elevated periods were often interpreted as recovery or baseline functioning rather than as a part of a broader pattern. One clinician reflected:

'…this child will come in with like repeated episodes of low mood, perhaps had some kind of therapeutic intervention in the past…umm…but then their mania, or the happier child, or the more energy full child that you see, it taken as their normal, their happy…rather than as the offshoot the other way.' (C9, Clinical Psychologist)

These accounts highlight that examining contrast in mood over time, rather than the severity in mood, was central to how clinicians would reconsider their initial formulations. Bipolar risk was often only considered in later course, once these contrast in mood were difficult to explain using existing formulations.

Subtheme 1.3 longitudinal observations and developmental uncertainty

Because of the fluctuating nature of presentations, clinicians often spoke about the importance of having repeated contacts and extended assessments in order to interpret mood patterns within the context of adolescent development.

'It's really difficult to separate the symptoms, what they're experiencing from in the short one hour assessment, I think it needs to be longer' (C7, CBT therapist)

'We mapped out cycles and cycles and cycles of through these different parts of her life where she'd be up, they'd be down, they'd be up, they'd be down.' (C1, Clinical Psychologist)

Clinicians described adolescence as a time when emotions change a lot, young people can act more impulsively and there are relationship shifts, which can make it harder to interpret emerging patterns and differentiate between early signs of bipolar and typical adolescent development:

'…we're so used to in adolescence, like major mood swings, hormonally or dysregulation wise, impulsivity, lots of family conflicts and an increase in risk behaviour anyway, that it probably is really hard of young people themselves and for families to pick it up' (C6, Clinical Psychologist)

Because of this, cyclical mood changes were described as often being overlooked or minimised:

'I think them being missed or dismissed because it's cyclical and it's not like…this is what's going on all the time so we can address this.' (C9, Clinical Psychologist)

Overall, these narratives suggest that early bipolar risk would most often be recognised through prolonged unease about patterns that did not sit comfortably within developmental explanations. Over time, longitudinal observations would help clinicians make sense of what they were seeing. This would make it more possible

to revisit developmental explanations as patterns of mood fluctuation continued, rather than because there were clear or obvious symptoms.

Theme 2: Making sense of mood changes

The second theme pictures how clinicians initially interpret early mood changes in young people before 'at risk' of bipolar disorder was even considered. To interpret presentations, clinicians would often rely on familiar developmental, behavioural, and diagnostic frameworks. This theme captures the uncertainty involved in understanding ambiguous mood presentations, particularly when symptoms overlapped with other explanations such as adolescence, neurodevelopmental differences or emotional dysregulation. Clinicians used these frameworks to make sense of what they were observing and to organise complex presentations where there was not a clear explanation for changes in mood.

Early mood changes were often described as being understood through the behavioural or developmental lenses, and impulsivity and risk taking were seen as responses to contextual stressors or as just features of adolescence. One clinician reflected on how behaviours that might later be reconsidered, were understood initially as appropriate for the young person's age or situation, meaning that recurring mood changes were rarely treated as the main clinical concern:

'The, like, risky, manic behaviours would be very different to what we're…not very necessarily different, but they were often seen as like rebellious teenage angst or something that could be explained away by them being angry at the system, or them being young and naive.' (C1, Clinical Psychologist)

Bipolar disorder seemed to be rarely a part of the clinicians' initial diagnostic frameworks. They reflected on how they were more likely to focus on presentations that were familiar to them, and that they encountered more in their services:

'...I'm frequently thinking and talking about ADHD, I'm frequently thinking and talking about ways of supporting behaviour, frequently thinking and talking about emotional regulation. I'm not frequently thinking and talking about bipolar.' (C4, Clinical Psychologist)

Throughout the interviews, clinicians described how early bipolar presentations were frequently understood through alternative diagnostic frameworks that were more commonly used within their services. ADHD, ASD, emotional dysregulation and trauma related difficulties were most frequently mentioned:

'I'm just thinking about ADHD actually, and how this seems to be some, perhaps some similarities in, in the physical presentation of what you might hear and see.' (C3, Nurse)

And once a framework had been established clinicians described difficulty revisiting or shifting these early formulations, even when presentation became more complex over time:

'...once you're on this pathway, it's like nothing else matters to them' (C1, Clinical Psychologist)

Ultimately clinicians described bipolar risk as something that was often recognised later, rather than being actively considered during early presentations or initial assessments. This reflects how clinicians would revert to familiar frameworks to help make sense of ambiguous presentations early on, but also how these initial understandings could delay the consideration of bipolar disorder.

Theme 3: Holding concern without clear options

The next theme captures the experiences around what happens once concern about possible bipolar risk has emerged. Building on earlier themes, clinicians described reaching a point where patterns over time no longer sat comfortably within existing formulations. However, they often lacked clear pathways for escalation, assessment or intervention.

Subtheme 3.1 Crisis thresholds and visible deterioration

This subtheme captures how, throughout the interviews the clinicians would talk about how services had unrealistic thresholds, which they felt would require a young person to be in visible deterioration or crisis before being accepted. Even when clinicians brought forward concerns, they were rarely sufficient to trigger assessment or intervention, especially without the presence of observable mania, effectively making bipolar risk inactionable until it had escalated. One clinician described the difficulty of accessing mental health services even when risk was high:

'Our mental health services are so unbelievably atrocious…you know, I can't even…when I think about when I've…I very seldom…you know, the majority of low grade mental health stuff I manage. In fact, the last time…it was a few years ago,

that I saw someone who I thought was bipolar, and trying to get them seen by a mental health service was impossible. Literally…you'd say I've got a depressed person who's got a gun and rope and left a note, and they'd say…well, we might see them next week or something.' (C8, GP)

They emphasised how bipolar disorder was unlikely to be considered unless there were clear manic symptoms:

'They won't accept a bipolar diagnosis unless they've seen mania. They need to see the mania.' (C1, Clinical Psychologist)

These thresholds meant that concerns about bipolar disorder were not acted on until things became more obvious or serious, rather than being explored earlier.

'I think sometimes people act on risk rather than discussing risk.'(C7, CBT Therapist)

Subtheme 3.2 Unclear of pathways

Across the interviews there was also a great deal of uncertainty about what to do when at risk bipolar was suspected. Unlike psychosis, where clinicians collectively felt that early intervention pathways were familiar, they were unclear of the equivalent route for bipolar presentations:

'*Clearly there's the first psychosis service…but I'm not aware of there being anything similar to…bipolar.'* (C8, GP)

In this absence of clear pathways, bipolar was described as implicitly positioned as the psychiatrist's domain, and not to be named by other members of the mental health team:

'I remember hearing that like, oh, well, liaise with the psychiatrist because they know all about bipolar…we don't know about bipolar, be careful about the bipolar, don't talk about the bipolar, it feels like its, like this hidden thing.' (C1, Clinical Psychologist)

As a result, clinicians described holding concern without a clear next step:

'Who do you get them to see? How do you do that?' (C8, GP)

Taken together, this theme shows how clinicians often found themselves holding concern about possible bipolar, without having a clear way to act on it. Whilst risk was recognised, high crisis thresholds and a lack of clear pathways meant that concern was often deferred rather than addressed. This left the clinicians feeling like they were in an ethically challenging position, where awareness of risk was not matched by services' capacity to respond.

Theme 4: Feeling unsure and underprepared

The fourth theme illustrates clinicians' experiences of uncertainty and limited confidence when thinking about 'at risk' bipolar disorder in young people. Whilst earlier themes focused on how clinicians recognised and made sense of emerging

mood changes, this theme captures whether clinicians felt equipped to respond when bipolar risk was considered. A shared view across accounts was that uncertainty was not an individual failing but reflected the wider issues within services and professional support. They spoke on how guidance and training was limited, their view on how bipolar disorder is seen as a specialist diagnosis, and that clinicians and services should be receiving specific bipolar training. These gaps in training and role expectations exacerbated their uncertainty in recognising and responding to possible bipolar risk in clinical practice.

Subtheme 4.1 Limited training and unclear early presentations

Often spoken about was the gaps in training around how bipolar disorder presents in young people, particularly when considering early or subthreshold forms. Clinicians described uncertainty about what signs to look for and a lack of confidence in identifying bipolar risk:

'I don't feel super confident with what it would be that I'd be looking out for' (C6, Clinical Psychologist)

'I really don't know what to look out for. I think that's a big hole in my knowledge.' (C2, Clinical Psychologist)

Similarly, a GP described that identifying bipolar risk was not routinely done:

'But in terms of identifying people who are at risk, I don't think I actively do that to be honest.' (C8, GP)

Rather than looking at it as an individual's failing, clinicians described this lack of confidence and uncertainty as reflecting wider gaps in awareness and training across different systems. They spoke about the need for increased education not only within specialist mental health services, but across healthcare and educational systems too:

'There needs to be more awareness raised at all different levels, socio, politically, socially, I think, you know, in that it, I don't know, maybe there's some stats in terms of who it generally impacts or effects, whether that would be really helpful to kind of in terms of raising that awareness, people not being, you know, aware generally.' (C3, Nurse)

Alongside these calls for broader training and awareness, clinicians would often speak about how bipolar identification and treatment was seen as something that was managed outside their role. This meant that uncertainty about early bipolar presentations became normalised within clinicians' work. Limited training not only reduced confidence but also affected how prepared clinicians felt in recognising and responding to possible bipolar risk.

Subtheme 4.2 Bipolar as a specialist diagnosis

Building on this uncertainty, bipolar was frequently described as something that required specialist or psychiatric involvement. This perception appeared to shape clinicians' responses to uncertainty, with concerns often being brought to others who to them would appear more competent in their understanding.

'feel like I'd want to look to my colleagues in psychiatry probably, for something like this' (C5, Clinical Psychologist)

Others reflected that bipolar disorder felt increasingly removed from general mental health teams, with knowledge held within a small group of specialists:

'Yeah, I think… I do feel like bipolar does become quite niche. Again, it's the problem that it's removed from other teams, so I think then learning about it all stays within quite a niche pool of people and it doesn't kind of trickle down.' (C6, Clinical Psychologist)

Overall, clinicians explained that they would often revert to psychiatry when they suspected at risk bipolar disorder. Even though at times clinicians recognised potential risk, often they felt unable to diagnose or support the condition themselves, contributing to delays in formal recognition and treatment. This reflects both the clinicians' lack of confidence and training when met with bipolar risk, and how bipolar disorder is considered a specialist area.

Theme 5: Deciding what to say and when

The final theme focuses on the ethical and relational work involved in deciding whether or not, and how and when to talk about 'at risk' bipolar disorder with young people and their families. Building on the earlier themes, communicating 'at risk' was described as an ongoing process, that happened over time, rather than a single point of disclosure. This process was influenced by uncertainty about

diagnosis, awareness of the young person's developmental stage, limited pathways for support, and worries about the impact of naming bipolar risk too early. Clinicians described feeling responsible for how these conversations were handled with young people and their families. They also expressed concern about the potential for harm if bipolar risk was named without clear support in place.

Subtheme 5.1 Labels seen as helpful or harmful

Clinicians described mixed feeling about using diagnostic labels. Across accounts, they discussed both positives and negatives to using an 'at risk' label.

When considering the benefits of using the label, clinicians described how it could provide an explanation or sense of validation for young people and their families:

'Yeah, I think when people are quite invested in getting a diagnosis, because I think that sort of gives them an explanation for why they're feeling the way they're feeling.' (C7, CBT Therapist)

At the same time, clinicians were also cautious about the possible risks of giving a label of 'at risk' bipolar. They expressed concern about how such a label might be understood or taken on by the young person, especially if it was given without adequate explanation or support. For some, this included worries about the emotional impact of receiving an 'at risk' label:

'and again, it's that thing of when, once you've said it, once you've said the word some people, because, because they don't know, they might be, well, bipolar, I've got this.' (C1, Clinical Psychologist)

Across accounts, clinicians spoke about how they would make careful case-by-case judgements on whether or how they would use an 'at risk' label. They weighed the potential benefits of using an 'at risk' label to support understanding and access to appropriate support against the possibility of causing distress or harm to the young person. This ambivalence reflected uncertainty about early presentations, as well as worries about what might happen if a label was used without a clear support plan in place.

Subtheme 5.2 Preference for formulation led language

Rather than explicitly naming 'at risk' bipolar, majority of clinicians admitted favouring formulation-based conversations when working with young people, as formulation allowed them to hold onto uncertainty whilst collaboratively working with a young person to understand emerging concerns.

'I think I probably, from my background, probably do sit more on the side of understanding the presentation in a formulative way rather than a diagnostic way.' (C5, Clinical Psychologist)

Clinicians also described formulation led conversations as more collaborative, especially when discussing uncertainty with young people, rather than imposing a fixed label:

'Again, it's never about me putting a label on a person but just opening up the conversation with them about what this is or what this could be and let's explore it together.' (C1, Clinical Psychologist)

Overall, formulation led conversations were described as a way of balancing openness with caution, allowing the clinicians to acknowledge possible 'at risk' bipolar disorder whilst also avoiding premature diagnostic labelling. Rather than naming a diagnosis explicitly, clinicians preferred to talk about patterns of experience, using language that reflected ongoing sense making rather than certainty. Therefore, formulation led language reflected both ethical considerations and a practical way of communicating risk when there was uncertainty.

Subtheme 5.3 Monitoring and holding risk over time

The final subtheme captures clinicians' concerns about naming 'at risk' bipolar in the absence of ongoing support or containment. Clinicians described uncertainty about the usefulness of applying an 'at risk' label when there were limited options for continued monitoring or intervention:

'I don't know how helpful that is for kids given the diagnosis aren't getting the support they need, let alone people with an 'at risk' label. What does that mean?' (C9, Clinical Psychologist)

Rather than labelling 'at risk', some clinicians would prefer continuous contact and review to monitor their concerns over time. They described this as an

opportunity to review any change in presentation without subjecting the young person to a label which they felt they could adequately support.

'Oh, I would do it I'd ask the young person what they'd like I think whether they want it on record, whether they want to me to explain it with them or with their families, and we we would keep talking about it over time, keep checking in.' (C7, CBT Therapist)

Multiple clinicians described the communication around bipolar risk as a continuous and collaborative process rather than a single point of disclosure. This process was shaped by uncertainty, ethical concerns, and the availability of support, with clinicians prioritising their relationships and developmental considerations over diagnostic certainty. Ongoing monitoring and formulation led language was used to acknowledge possible risk while avoiding giving a label too early. This helped clinicians manage concerns about potential harm or stigma and maintain trust with young people and their families when clear pathways for intervention were not available.

Discussion

By exploring the perspectives and experiences of nine clinicians working across various UK health services, this study aimed to understand how early 'at risk' indicators of bipolar disorder in young people are understood and responded to.

A key feature of the first theme, 'noticing patterns over time', revealed how clinicians relied on observing contrasts in mood or mood fluctuating patterns across time, rather than observing severity of symptoms at any one point. It was evident in

the transcripts that clinicians shared the opinion that any concerns of possible bipolar disorder were prompted by noticing a shift or contrast in mood, energy, sleep and functioning. This aligns with the existing literature that suggests that early bipolar presentations in young people rarely resembles what is presented in classic adult mania and that young people's symptoms are more likely to involve episodic and fluctuating changes (Martini et al., 2021). This helps explain clinician's emphasis on continuity of care, as without sustained involvement it is difficult to recognise and retain an understanding of recurring mood patterns. Consistent with previous research, clinicians also spoke about how in their experiences bipolar disorder often has a prolonged and nonspecific prodromal phase, during which symptoms can overlap with other disorders such as depression, anxiety, ADHD and emotional regulation difficulties (Conroy et al., 2018).

Understanding how early mood changes were initially understood through developmental and behavioural frameworks was described in the second theme, 'making sense of mood changes'. Clinicians explained how often fluctuations could be interpreted as a response to psychological and social stressors or typical adolescent characteristics. This mimics the same difficulties found in previous literature, suggesting that impulsivity or mood instability in young people may be normalised or linked to their current situation, potentially delaying the identification or consideration of bipolar disorder (Yatham et al., 2018). In this way, rather than frameworks simply being used to describe presentations, they actively shape what is observed, examined and pursued further. Clinicians described that once an initial formulation was established, it often shaped subsequent thinking and was difficult to reconsider. Even after later patterns raised concern, alternative explanations such as trauma or ADHD related difficulties were defined as shaping care pathways and

limited how new symptoms were understood. These accounts relate to the broader concerns about early assessment and diagnostic decision making in bipolar disorder, particularly given the varied and non specific nature of early presentations (Martini et al., 2021). Delays may therefore happen not only because of the ambiguity of early symptoms, but also because clinicians rely on more familiar frameworks that offer clearer pathways and treatment options.

Within the third theme, ‘holding concern without clear options’, clinicians described what happened once they did begin to consider bipolar risk. Consistently throughout interviews, clinicians held the concern that without observation of mania or visible deterioration of symptoms, young people would not be considered for specialist assessment. These accounts indicate a gap between what policy says should happen and what services are realistically able to do. The service thresholds described by clinicians reflect patterns reported in national surveys of children and young people’s mental health in the UK, which examine their experiences of service and support (NHS Digital, 2023). Participants also believed that an equal pathway to the ARMS service, for bipolar disorder was lacking. This reflects the wider literature which suggests that although early intervention approaches are well established within psychosis services, equivalent approaches for young people who may be at risk of bipolar disorder remain less developed (Shah et al., 2022; Yung et al., 2021). Without knowing where to escalate their concerns, they felt frustrated and uncomfortable having to manage risks without having a formal process in place for monitoring. This supports previous research highlighting how service level factors, including limited pathways and access to specialist support, may contribute to delays in recognising and responding to emerging bipolar presentations (Keramatian & Morton, 2023; Hoppe et al., 2025). Therefore, whilst early identification remains

important, the current findings suggest that recognition alone may not be sufficient without clear pathways that allow clinicians to respond to uncertainty in practice.

The fourth theme, ‘feeling unsure and underprepared’, captured how clinicians’ uncertainty was closely linked to limited confidence and training. Gaps within their knowledge and guidance around how bipolar disorder presents within young people was described by all participants, especially in relation to subthreshold forms. This is in line with the wider literature where most of the existing literature specifically focused on bipolar disorder in young people is limited (Saraf et al., 2021). Therefore, although clinicians could recognise concerning patterns and behaviours, they considered bipolar disorder and bipolar disorder risk, to be the responsibility of psychiatry, so may hesitate to communicate this risk. Professional boundaries, gaps in training and distinct roles are also factors which influence one’s ability to identify and discuss bipolar disorder. This suggests that difficulties recognising early bipolar risk may not only reflect individual clinician knowledge, but also the wider systems and structures in which clinical decisions are made.

Alongside these structural constraints, the final theme, ‘deciding what to say and when’, described the ethical and relational complexity in determining what to say and when. Uncertainty was expressed by participants about whether they could use the ‘at risk’ label and language. Contemplating whether it would bring benefits of validation or add stigma and anxiety alongside a lack of clear follow up pathways. These accounts align with previous literature that suggests that the use of diagnostic labels in youth mental health can be complex, particularly in contexts where diagnostic uncertainty and the risk of misdiagnosis is high (Yatham et al., 2018). The clinicians stressed the importance of working collaboratively with the young person,

favouring an open and clear communication style and staying attuned to what the young person wanted.

Overall, these findings suggest that recognising bipolar disorder in young people is not immediately intuitive. Clinicians described a mixture of uncertainty in clinical presentation, complexities of adolescence and wider service limitations. This study gives insight on the difficulties in practice when determining or acting on early symptoms of bipolar disorder risk. It is not a result of symptoms being invisible or ignored, but within the current systems clinicians have limited ways of holding and responding to uncertainties before crises emerge.

Limitations

Whilst this study has many strengths, such as its qualitative exploration of clinicians' understanding and current knowledge of bipolar disorder in young people, there are also several limitations. Participants were self-selecting and therefore may represent clinicians who are more reflective or more interested in bipolar disorder, which could provide a partial perspective on experiences of 'at risk' bipolar. Additionally, whilst efforts were made to recruit across different roles and service contexts, the professional diversity originally sought was not achieved. The majority of the participants were clinical psychologists, which might have biased the nature of the accounts and experiences. It should also be noted that all participants were based within UK services, meaning that findings should be interpreted within UK service contexts.

The second limitation relates to recruitment, with only nine clinicians recruited to this study. Although reflexive thematic analysis favours depth and richness of analysis over breadth (Braun et al., 2022), the sample was smaller than

initially anticipated. However, as the analysis developed, later interviews did not appear to change the overall patterns being identified but helped to deepen and clarify existing themes. This suggested that the dataset was sufficient to address the research aims, while recognising that other perspectives may exist beyond those captured in this study (Braun et al., 2022).

Furthermore, this study exclusively focused on clinical perspectives without equal views from young people or their families, therefore has limited understanding of how uncertainties, monitoring or clinical caution are experienced by those receiving the care.

Finally, whilst efforts were made by the researcher to reflect on and manage any pre-existing assumptions and experiences, these nonetheless would have had some influence on the study design and analysis.

Clinical and Research Implications

It is recommended to clinicians when working with young people who may be at risk of bipolar disorder, that they attend to patterns and contrasts in mood over time, rather than relying on adult orientated presentations, especially in regard to mania. They should remain mindful that presentations are likely to be characterised by subtle and fluctuating mood changes, that could represent normative adolescent experiences or other alternative diagnoses.

The findings also highlight that services would benefit from clearer pathways and consultation structures to help support clinicians manage bipolar risk when diagnostic certainty is lacking. This could include improved access to specialist advice, regular supervision, and opportunities for clinicians to discuss young

people's difficulties with other professionals. These additional supports may help clinicians feel more confident in raising concerns about possible bipolar risk.

Further research in the NHS context with larger and more diverse samples would be beneficial to explore how young people and their families experience services and pathways as those receiving the care. Bringing together the views of clinicians with the experiences of young people, may help us to understand whether these approaches feel supportive or dismissive and invalidating. In addition, further research that includes psychiatrists and service commissioners may also help to explore how organisational culture and commissioning decisions influence early bipolar identification. Research that examines the service pathways may also help to identify where young people with early bipolar presentations are more likely to fall between service thresholds, and how decisions regarding monitoring and escalation are made in practice.

Conclusion

This study offers insight into how clinicians make sense of possible early indicators of bipolar disorder in young people within routine UK services. From clinicians' accounts, bipolar risk was understood to gradually emerge through uncertainty, clinical judgement and observation of behaviours over time, opposed to being identified in a single assessment or clear diagnostic markers. The findings highlighted how clinicians often recognise concerns but feel constrained by professional boundaries, service structures and a lack of clear pathways for action.

Overall, the study suggests that difficulties in responding to early bipolar risk are not only due to a lack of awareness, but also due to limited ways of working with uncertainty before crisis thresholds are reached. Improving earlier intervention for

bipolar disorder therefore requires not only greater opportunity in clinical settings to recognise early presentations through improved service models, but also the ability to share decision making when diagnostic uncertainty is high.

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Chapter Five: Discussion and critical evaluation

Word count: 2130

Discussion and Critical Evaluation

This chapter presents the findings from both the systematic review and the empirical study, offering a critical evaluation of the results and highlights the strengths and limitations of the studies.

Summary of findings

The systematic review examined ten studies on help seeking in young people with or at risk of mood and bipolar disorders. Amongst the varying methods and definitions used within these studies, there was a theme established that young people would rarely seek professional help early on, often delaying intervention until symptoms were more severe or caused unignorable disruption to daily life. This was consistent with earlier research suggesting that young people may feel uncertain about whether their experiences warrant professional support and may prefer to manage difficulties themselves rather than seeking help (Baldofski et al., 2024). Another common theme in this review showed that often, it was the intervention of either parents, teachers or trusted adults that would start the help seeking process, rather than the individuals themselves accessing care independently (O'Neill et al., 2023)

Adding to existing knowledge, findings from the empirical study propose that delays in early intervention are not only due to young people's behaviour around seeking help, but also the structural constraints within health settings. Clinicians reported that rather than a single diagnostic moment for bipolar risk, they needed to observe how patterns of mood developed over time. This uncertainty of symptoms is similarly described by Martini and colleagues (2021) and Youngstrom and colleagues (2009) underlining the long and often unclear early phase of bipolar disorder. However, even when clinicians noticed early signs of risk, they were

apprehensive to act as referral pathways were often unclear or they were concerned they could be labelling a young person with bipolar disorder prematurely.

Findings from both the systematic review and empirical study suggests that there is a disconnect between recognition of early risk and the time in which appropriate response was taken. Observation of early mood difficulties and potential bipolar risks were widely documented amongst parents, peer and clinicians, but timely and appropriate intervention was reported lacking. This suggests that delay in care could be a result of individual uncertainty, professional error, or restraints at a service level, opposed to just one single point of failure. Assessing the studies collectively, the findings contest that early identification and intervention occur as a simple process of diagnosis and treatment. Instead, it appears to be an approach of long-term monitoring with repetitive steps, within a system in which services are unclear.

Implications

Clinical Implications

Findings from this research have important implications for clinic practice, especially within mental health services for how early and possible mood problems and possible bipolar risk are identified. Typically, mood difficulties develop slowly and unevenly making it difficult to know when and how to intervene (Scott et al., 2022). Similarly, earlier research suggests that for young people early signs of mental health difficulties may be unclear or uncertain (Youngstrom et al., 2009), and that help-seeking often depends on how problems are recognised and interpreted (Rickwood et al., 2005).

Findings from the empirical study indicated that longer periods of monitoring can reveal concerning mood patterns. However, without diagnostic certainty,

clinicians lack confidence and clear guidance regarding how to respond or which service to involve. Corresponding with earlier work, this suggests that clinicians may adopt a more cautious approach when assessing early bipolar presentations, especially with their concerns of the potential harm from misdiagnosis or premature labelling (Keramatian & Morton, 2023). While the clinical caution is understandable, this hesitancy could have a negative impact on those not meeting service thresholds, if clinicians are missing the opportunity for early support through monitoring and formulation.

Overall, the findings support the approach of long-term formulation to assessment, allowing clinicians to track mood, functioning and stress overtime rather than trying to observe specific symptoms. Fitting with developmental perspectives of bipolar disorder this approach considers how mental health conditions can change and develop within the early stages (Youngstrom et al., 2009). By using these models in practise, clinicians can still take on early concerns seriously but be flexible in managing risk and avoid premature diagnoses.

The findings also showed the need to support clinicians with managing uncertainty, with some clinicians in the empirical paper describing anxiety around doing too little or too much. Previous research has found that clinician's confidence depends on their training and access to specialist advice (Hoppe et al., 2025). These clinician accounts indicate the requirement for clinical supervision, shared decision making and the ability for reflection in services. By improving support structures, this could encourage clinicians to intervene with young people earlier and appropriately communicate risk even when it is unclear.

As with earlier research, clinicians stated there was uncertainty around pathways for young people with possible bipolar disorder, this meant that they would

often monitor a young person without support or guidance. The clinicians accounts raise the question as to how youth mental health systems handle early or unclear cases that do not meet criteria for specialist care. A logical concern is that systems which use thresholds to manage resources, will inadvertently result in young people who need support to be not receiving it because they do not fit a clear diagnosis. The research suggests that these thresholds are a main contributing factor to delays in early intervention. Other studies have found similar results, showing that barriers within primary care can limit young people's access to appropriate support (Farr et al., 2021). As a result, clinicians' only options are often to monitor with no clear guidance, placing the burden of risk on individuals rather than the service.

These findings suggest that bipolar risk cannot always be identified at one point in time and that mental health services need flexible pathways that can reduce delays over time. Suggestions for improving services include needs-based, non-stigmatising support, regular monitoring, and shared care between primary and specialist services to support young people with attenuated or early symptoms (Yung et al., 2021). Changing these approaches to routine services could encourage early support and reduce symptoms worsening from delayed intervention.

Research Implications

The findings from this thesis also highlight several directions for future research. There is a need for more longitudinal work exploring how early mood changes unfold over time, particularly given the prolonged and often unclear early phase of bipolar disorder described in previous studies (Conroy et al., 2018; Martini et al., 2021). Following young people over longer periods of time may help clarify which early patterns are more likely to develop into bipolar disorder and which reflect typical developmental variations.

There is also a need for research that includes the perspectives of young people and families. Much of the existing literature has focused on risk markers and clinical features (Saraf et al., 2021), with less research focused on how monitoring, diagnostic uncertainty and cautious conversations about risk are experienced by those receiving the care.

Finally, further research into service models may be helpful, particularly considering ongoing pressures, high referral thresholds and challenges within UK services (Hoppe et al., 2025). Understanding how more flexible or staged approaches could support young people earlier may help address the gap between recognising concerns and being able to act on them.

Theoretical Implications

The findings from this thesis challenges the current approach to how early bipolar risk is understood in youth mental health services and early intervention frameworks. Although policy and theoretical models stress the importance of early identification and prevention, health services don't always appear to be sufficiently equipped in identifying emerging and complex symptoms making it difficult to provide effective care (Cosma et al., 2025). In contrast, the findings from both studies found that early mood related behaviours are ambiguous and evolving, making recognition challenging using the current frameworks. Early intervention approaches aim to identify early symptoms that can be clearly separated from normal development, making referrals to appropriate services fast (Vieta et al., 2018), but clinicians in this study found that early signs of bipolar risk rarely matched these assumptions. Instead, they saw mood changes as patterns that gradually developed over time, rather than typical symptoms of illness. This compares with

developmental views that see mental health behaviours as changing over time and requiring ongoing assessment (Youngstrom et al., 2009), which challenges theories that focus on early classification instead of continual assessment and review.

These findings encourage moving towards models that focus on long term process and relationships and away from threshold driven ideas of risk. Factors such as family, relationships, environment and service limitations shape how early signs of difficulties are noticed and managed, suggesting that risk cannot be fully understood outside these contexts. Gaining insight into how uncertainty is handled in practice and how risk is shaped by interactions between people and systems may give a better understanding of early intervention in youth mental health services. These approaches would better reflect real clinic work and offer a way to respond to early concerns of risk before becoming more severe.

Strengths and Limitations

This thesis has several methodological strengths including the portfolio design, systematic review integration with a qualitative empirical study, and combined diverse perspectives of a shared research focus. This approach allowed current evidence to be measured alongside detailed first-hand accounts, supporting a more comprehensive understanding, than either method alone. Such integration is consistent with the value of qualitative research in exploring meaning, experience and contextual influences that may not be fully captured through quantitative designs (Braun et al., 2022).

The qualitative design of the empirical study was well suited to exploring how clinicians understood early mood symptoms and dealing with uncertainty. Reflective thematic analysis helped identify shared patterns while recognising the researcher's

role in interpretation (Braun et al., 2022). Using a critical realist perspective helped demonstrate the limits within current services, but also how the ideas of risk are shaped by social and professional interpretations (Fletcher, 2017). Reflexive practices, such as keeping a reflective journal, support reflexive openness and methodological coherence within the analysis (Braun et al., 2022).

However, there are also several limitations to note. Studies included within the systematic review used varying designs and definitions of help seeking, making direct comparison difficult and reduced confidence in the combined conclusions (Popay et al., 2006). Although the MMAT allowed for appraisal across study types, it relies on subjective judgement and does not have strict cut-offs (Hong et al., 2018). Limiting the review to English language studies may also reduce how well the findings apply to other cultures.

The empirical study was limited by a small sample, mostly from clinical psychology backgrounds, which is likely to have influenced their perspectives. Although reflexive thematic analysis values depth over representativeness (Braun et al., 2022), results may differ in services with different diagnostic practices. Self-selection bias is also possible, and the UK-based service context limits how well the findings apply to other healthcare systems.

Dissemination

Different steps have been taken to disseminate the findings. A summary of the empirical paper results was sent by email to all participants that opted to receive a copy as indicated on their consent form. The PPI clinicians also received a summary to close the feedback loop, and they will be given the opportunity to read the

completed thesis if they would like to. There are plans to submit both the systematic review and the empirical paper for publication in peer-reviewed journals.

Overall Conclusion

Both the systematic review and the empirical study support the conclusion that young people's opportunity to early access to support is influenced by uncertainty from both young people, clinicians and current service structures. This thesis provides insight into how early mood difficulties and potential bipolar risk are recognised, interpreted and managed within structures. Symptoms of bipolar risk at an early stage are ambiguous, requiring longer periods of observation which is challenging for clinicians to work within the current diagnostic procedures and service pathways. The findings propose that delays in intervention are not the result of individual-level factors but arise from the interaction between young people's help seeking behaviour, clinician's experience of uncertainty and structural constraints within services. The thesis extends on existing literature of early intervention, by examining the disparity between early recognition of 'at risk' behaviours and the ability to appropriately respond when diagnostic certainty is unclear.

In conclusion, this thesis supports the suggestion that services need to manage signs of 'at risk' symptoms and monitor changes over time, rather than defaulting to premature labelling as referral options are limited with diagnosis. It is encouraged for future research to explore the long term and flexible methods to identify early risk, as well as new service approaches that allow for monitoring and support prior to a clear diagnostic is made. Addressing these gaps may improve opportunities for early intervention, allowing young people to access appropriate support before symptoms worsen.

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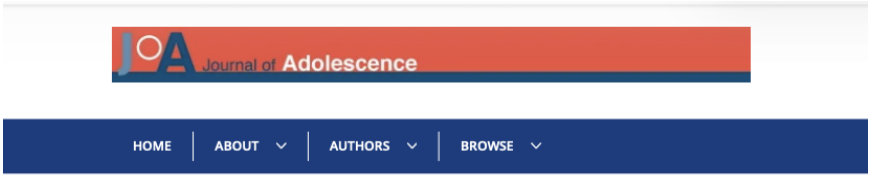
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Appendices

Appendix A. *Author Guidelines for Journal of Adolescence*



Author Guidelines

The *Journal of Adolescence* is an international, broad based, cross-disciplinary journal that addresses issues of professional and academic importance concerning development between puberty and the attainment of adult status within society. Our focus is specifically on adolescent *development:* change over time or negotiating age specific issues and life transitions. The aim of the journal is to encourage research and foster good practice through publishing empirical studies, integrative reviews and theoretical and methodological advances. The *Journal of Adolescence* is essential reading for adolescent researchers, social workers, psychiatrists, psychologists, and youth workers in practice, and for university and college faculty in the fields of psychology, sociology, education, criminal justice, and social work.

Research Areas Encompassed:

- Adolescent development with particular emphasis on social, cognitive, and emotional functioning
- Resilience, positive development, and effective coping within the context of adolescent development
- Disturbances and disorders of adolescence, approached from a developmental perspective
- Public health approaches and interventions designed to reduce risk or support positive development

JoA actively seeks papers that are strongly grounded in theory and have a clear developmental focus. We are particularly interested in research focusing on less studied populations or that examine contextual variation in developmental processes. In addition to empirical research articles, JoA also publishes systematic Review Articles and papers that focus on areas of methodological import.

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Sections

1. Submission and Peer Review Process
2. Article Types
3. After Acceptance

1. Submission and Peer Review Process

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Journal of Adolescence follows APA form for final publications (see format exceptions below). However, we will accept **Free Format submission** for a simplified and streamlined submission process.

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The main text file should be in Word and include:

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    - Abstracts should have four headers, each comprising a short separate paragraph: Introduction, Methods, Results & Conclusions.
    - Abstracts should be 200-250 words long, concise and factual.
    - Abstracts must be able to stand alone, and are often presented separately from the article
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    - All abstracts must include basic information about the sample, including country of data collection, year of data collection, sample size, and relevant demographics. Numerical age and gender of participants are required.
    - Method of data collection should be indicated (e.g., qualitative analysis of interview material, surveys administered to parents and adolescents) and whether the study is cross-sectional or longitudinal
- Maximum of six keywords, listed immediately after the abstract. Avoid general and plural terms and multiple concepts (avoid, for example, 'and', 'of'). Only abbreviations firmly established in the field may be eligible. Keywords will be used for indexing purposes.
- Main body: formatted as introduction, materials & methods, results, discussion, conclusion. Please consult the APA Style Manual for publication guidelines.
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    - Discussion and Conclusion: Discussion of the results should clearly reflect back on the literature cited in the introduction, draw a clear conclusion, and suggest future areas of research. Limitations of the current work should be clearly and succinctly described.
- References;
- Tables (each table complete with title and footnotes);
- Figure legends: Legends should be supplied as a complete list in the text. Figures should be uploaded as separate files (see below).

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Figures and Supporting Information

Figures, supporting information, and appendices may be submitted separately in the Free Format submission or may be supplied as separate files. You should review the **basic figure requirements** for manuscripts for peer review, as well as the more detailed post-acceptance figure requirements. View **Wiley's FAQs** on supporting information.

Peer Review

This journal operates under a double-blind **peer review model**. Papers will only be sent to review if initial review by the Editor-in-Chief and/or Associate Editors determines that the paper meets the appropriate quality and relevance requirements.

In-house submissions, i.e. papers authored by Editors or Editorial Board members of the title, will be sent to Editors unaffiliated with the author or institution and monitored carefully to ensure there is no peer review bias.

Wiley's policy on the confidentiality of the review process is **available here**.

Refer and Transfer Program

Wiley believes that no valuable research should go unshared. This journal participates in Wiley's **Refer & Transfer program**. If your manuscript is not accepted, you may receive a recommendation to transfer your manuscript to another suitable Wiley journal, either through a referral from the journal's editor or through our Transfer Desk Assistant.

Guidelines on Publishing and Research Ethics in Journal Articles

The journal requires that you include IRB approvals, ethical treatment of human and animal research participants, and gathering of informed consent in the manuscript, as appropriate. You will be expected to declare all conflicts of interest, or none, on submission. Please review Wiley's policies surrounding **human studies, animal studies, clinical trial registration, biosecurity, and research reporting guidelines**.

This journal follows the core practices of the **Committee on Publication Ethics (COPE)** and handles cases of research and publication misconduct accordingly (**https://publicationethics.org/core-practices**).

This journal uses iThenticate's CrossCheck software to detect instances of overlapping and similar text in submitted manuscripts. Read **Wiley's Top 10 Publishing Ethics Tips for Authors** and **Wiley's Publication Ethics Guidelines**.

2. Article Types

Article Type	Description	Word Limit	Abstract / Structure	Other Requirements
Research article	Report of new research findings, including evaluations of interventions. Articles should clearly make a new contribution to the existing literature and advance our understanding of adolescent development.	Up to 5,000 words excluding abstract, references, tables, figures or appendices. Qualitative research papers may require additional words in lieu of tables. Please consult with the editor.	250 word structured abstract.	Data availability statement.
Review article	Critical review of the literature in the field of adolescence, including systematic review and meta-analysis. The journal is not prescriptive about how reviews should be undertaken, but the methods used should be clear. We also encourage reviews of and practical guidelines for developmental methodology .	Up to 8,000 words excluding abstract, references, tables, figures or appendices	250 word unstructured abstract.	If authors would like to discuss their plans for a review or methodology article, please contact the Editor through the journal mailbox **joa.office@wiley.com**.
Brief report	A report of research findings that are strongly data based and require only a brief literature review to provide context. These might include findings from the early stages of a program of research, registered replications (including failures to replicate) previously reported findings in novel contexts, or extentions of previously published work.	Up to 3,000 words excluding abstract, references, tables, figures or appendices	250 word structured abstract.	
International Research Note	A very brief report of research replications from developing countries and places with a less well supported adolescence research field, where it may be difficult to find international publication outlets and bring the work to the attention of a wider audience.	Up to 1000 words excluding abstract, references, tables, figures or appendices	250 word structured abstract.	

3. After Acceptance

First Look

After your paper is accepted, your files will be assessed by the editorial office to ensure they are ready for production. You may be contacted if any updates or final files are required. Otherwise, your paper will be sent to the production team.

Wiley Author Services

When an accepted article is received by Wiley's production team, the corresponding author will receive an email asking them to login or register with **Wiley Author Services**. You will be asked to sign a publication license at this point as well as pay for any applicable APCs.

Copyright & Licensing

You may choose to publish under the terms of the journal's standard copyright agreement, or Open Access under the terms of a Creative Commons License.

Standard **re-use and licensing rights** vary by journal. Note that **certain funders** mandate a particular type of CC license be used.

Self-Archiving Definitions and Policies: Note that the journal's standard copyright agreement allows for **self-archiving** of different versions of the article under specific conditions.

Proofs

Authors will receive an e-mail notification with a link and instructions for accessing HTML page proofs online. Authors should also make sure that any renumbered tables, figures, or references match text citations and that figure legends correspond with text citations and actual figures. Proofs must be returned within 48 hours of receipt of the email.

Article Promotion Support

Wiley Editing Services offers professional video, design, and writing services to create shareable video abstracts, infographics, conference posters, lay summaries, and research news stories for your research – so you can help your research get the attention it deserves.

Author Name Change Policy

In cases where authors wish to change their name following publication, Wiley will update and republish the paper and redeliver the updated metadata to indexing services. Our editorial and production teams will use discretion in recognizing that name changes may be of a sensitive and private nature for various reasons including (but not limited to) alignment with gender identity, or as a result of marriage, divorce, or religious conversion. Accordingly, to protect the author's privacy, we will not publish a correction notice to the paper, and we will not notify co-authors of the change. Authors should contact the journal's Editorial Office with their name change request.

Correction to authorship

In accordance with Wiley's **Best Practice Guidelines on Research Integrity and Publishing Ethics** and the **Committee on Publication Ethics'** guidance, the Journal of Adolescence will allow authors to correct authorship on a submitted, accepted, or published article if a valid reason exists to do so. All authors – including those to be added or removed – must agree to any proposed change. To request a change to the author list, please complete the **Request for Changes to a Journal Article Author List Form** and contact either the journal's editorial or production office, depending on the status of the article. Authorship changes will not be considered without a fully completed Author Change form. Correcting the authorship is different from changing an author's name; the relevant policy for that can be found in **Wiley's Best Practice Guidelines** under "Author name changes after publication."

Appendix B. *PRISMA Checklist*

PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	

PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	
Study characteristics	17	Cite each included study and present its characteristics.	
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	
	23b	Discuss any limitations of the evidence included in the review.	
	23c	Discuss any limitations of the review processes used.	
	23d	Discuss implications of the results for practice, policy, and future research.	
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	
Competing interests	26	Declare any competing interests of review authors.	
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71. This work is licensed under CC BY 4.0. To view a copy of this license, visit https://creativecommons.org/licenses/by/4.0/

Appendix C. *Mixed Method Appraisal Tool (MMAT)*

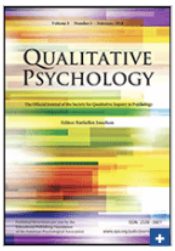
Part I: Mixed Methods Appraisal Tool (MMAT), version 2018

Category of study designs	**Methodological quality criteria**	**Responses**			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?				
	S2. Do the collected data allow to address the research questions?				
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?				
	1.2. Are the qualitative data collection methods adequate to address the research question?				
	1.3. Are the findings adequately derived from the data?				
	1.4. Is the interpretation of results sufficiently substantiated by data?				
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?				
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5 Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

Appendix D. *Author Guidelines for Qualitative Psychology*

Home > Publications & Databases > Journals >

Qualitative Psychology



Outgoing Editor: Heidi M. Levitt
Incoming Editor: Gabriel Velez
ISSN: 2326-3601
eISSN: 2326-3598
Published: three times a year, beginning in February
Impact Factor: 14.3
Psychology - Multidisciplinary: 5 of 221
5-Year Impact Factor: 8.9
This journal is a publication of The Society for Qualitative Inquiry in Psychology (a Section of APA Division 5)

Journal scope statement

The mission of the journal *Qualitative Psychology*® is to provide a forum for innovative methodological, theoretical, and empirical work that advances qualitative inquiry in psychology. The journal publishes articles that underscore the distinctive contributions that qualitative research can make to the advancement of psychological knowledge. Studies published in this Journal often focus on substantive topics, while also highlighting issues of epistemology, the philosophy of science, methodological criteria, or other matters bearing upon the formulation, execution, and interpretation of qualitative research.

Qualitative Psychology publishes studies that represent a wide variety of methodological approaches including narrative, discourse analysis, life history, phenomenology, ethnography, action research, and case study. The journal is further concerned with discussions of teaching qualitative research and training of qualitative researchers.

Subscribe to the RSS feed for *Qualitative Psychology*

Equity, diversity, and inclusion

Qualitative Psychology supports equity, diversity, and inclusion (EDI) in its practices. More information on these initiatives, including our journal EDI statement, is available under EDI Efforts.

Call for papers

- General call for papers

Editor's Choice

One article from each issue of *Qualitative Psychology* will be highlighted as an "Editor's Choice" article. Selection is based on the recommendations of the associate editors, the paper's potential impact to the field, the distinction of expanding the contributors to, or the focus of, the science, or its discussion of an important future direction for science. Editor's Choice articles are featured alongside articles from other APA published journals in a weekly newsletter and are temporarily made freely available to newsletter subscribers.

Author and editor spotlights

Explore journal highlights: free article summaries, editor interviews and editorials, journal awards, mentorship opportunities, and more.

COLLAPSE ALL

Submission Guidelines

Prior to submission, please carefully read and follow the submission guidelines detailed below. Manuscripts that do not conform to the submission guidelines may be returned without review.

Submissions are handled only through our Editorial Manager platform, and the only official journal website is through APA. If you believe you interacted with a fraudulent website for this journal, please email APA Journals. Review our resource for authors for more information on identifying predatory journals.

Submission

Qualitative Psychology is now using a software system to screen submitted content for similarity with other published content. The system compares each submitted manuscript against a database of 25+ million scholarly publications, as well as content appearing on the open web.

This allows APA to check submissions for potential overlap with material previously published in scholarly journals (e.g., lifted or republished material). A similarity report will be generated by the system and provided to the *Qualitative Psychology* Editorial office for review immediately upon submission.

To submit to the editorial office of Heidi Levitt, please submit manuscripts electronically through the Manuscript Submission Portal in Microsoft Word or Open Office format.

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* using the 7th edition and in compliance with the Journal Article Reporting Standards – Qualitative (PDF, 163KB). Manuscripts should be copyedited for bias-free language (see Chapter 5 of the *Publication Manual*). APA Style and Grammar Guidelines for the 7th edition are available, and please see the Journal Article Reporting Standards for Race, Ethnicity, and Culture (PDF, 232KB).

You can read the editor's guidance for submitting to *Qualitative Psychology* in their editorial on PsycNet. Authors interested in learning more about our journal can also see a special section focused on the first decade of *Qualitative Psychology* in Volume 10, Issue 3.

SUBMIT MANUSCRIPT

Qualitative inquiry is relatively unbounded and affords a great deal of opportunity for creativity and originality. Thus, the editorship of the journal is going to specify general rather than rigid criteria for evaluation of submissions and will endeavor to stay open to novel approaches.

Nevertheless, there are some criteria that we'd like to outline in order to ensure that the articles published in *Qualitative Psychology* are meritorious and of the highest quality. Articles will be evaluated according to the below criteria.

Manuscript preparation

Review APA's Journal Manuscript Preparation Guidelines before submitting your article.

Theoretical or methodological articles criteria

- Does the article advance our understanding of qualitative inquiry in terms of conceptualization or approach?
- Does the article position itself within approaches to the philosophy of science, interpretation theory, or epistemology?
- Does the article lay out postulates or hypotheses that lend themselves to further investigation through qualitative inquiry and/or additional theoretical analysis?
- Does the article adequately engage with existing literature?

Articles reporting results of original research criteria

- Is the topic meaningful? Is the presentation persuasive and illuminating? Will readers be enlightened on the topic by this article? Does the work advance psychological understanding?
- Is there adequate conceptualization (as opposed to simple description or reporting of themes)? Are there larger psychological questions addressed beyond reporting thematic description of a particular group of people?
- Has relevant other literature been joined? Is the relationship between this study and previous studies explicit?
- Has the mode of inquiry been explicated in detail so the reader can judge whether it was adequate and appropriate for the issues in question? This includes some discussion of the procedures of the work, and the processes of analysis and interpretation, and of how ethical challenges were met.
- Has the researcher taken into reflexive account his or her own role in the inquiry? Are assumptions and biases recognized?
- Does this work engage with methodological questions or debates? For some studies, the researcher might explicitly argue for the value of using a methodology that is different from the methods typically used to study this topic. In other cases, the researcher might explain how his or her study's design or findings further develop (or even challenge) some aspect of the qualitative approach it employs.
- Are interpretations well-grounded in presentation of data?
- Is there evidence that the researcher was tolerant of ambiguity, searched for alternative explanations, and considered negative instances? Is broader relevance considered?
- Is the contribution substantial in offering a sophisticated understanding of some aspect of human experience? Is this understanding deeply grounded in some stated perspective?
- Is the article well-written, thoughtfully shaped, sufficiently complex and engaging? Does the presentation invite further discussion?

As *Qualitative Psychology* will be published online as well as in print format, we strongly encourage the use of voice and video files (used with appropriate disguise and permission) to document your study.

Journal Article Reporting Standards

Authors should review the APA Style Journal Article Reporting Standards (JARS) for quantitative, qualitative, and mixed methods. The standards offer ways to improve transparency in reporting to ensure that readers have the information necessary to evaluate the quality of the research and to facilitate collaboration and replication.

For quantitative manuscripts

JARS-Quant offers guidance to researchers using quantitative methods that may be used in research designs such as descriptive analyses, correlational analyses, quasi-experimental analyses, and experimental analyses. These JARS:

- recommend the division of hypotheses, analyses, and conclusions into primary, secondary, and exploratory groupings to allow for a full understanding of quantitative analyses presented in a manuscript and to enhance reproducibility;
- offer modules for authors reporting on replications, clinical trials, longitudinal studies, and observational studies, as well as the analytic methods of structural equation modeling and Bayesian analysis; and
- include guidelines on reporting on of study preregistration (including making protocols public); participant characteristics (including demographic characteristics; inclusion and exclusion criteria) psychometric characteristics of outcome measures and other variables, and planned data diagnostics and analytic strategy.

For qualitative manuscripts

JARS-Qual offers guidance to researchers using qualitative methods that may be used in research designs such as narrative data, grounded theory, phenomenological, critical, discursive, performative, ethnographic, consensual qualitative, case study, psychobiography, and thematic analysis approaches. These JARS:

- guide researchers to include a description of the researchers' backgrounds and perspectives in approaching the study and how their prior understandings of the phenomenon were managed;
- provide guidance to support a description of all recruitment and data selection processes as well as data collection and data-analytic strategies used; and
- encourage a discussion of the ways that procedures used enhanced or compromised the methodological integrity of the findings.

The guidelines focus on transparency in methods reporting, recommending descriptions of how the researchers' own perspectives affected the study, as well as the contexts in which the research and analysis took place.

For mixed methods manuscripts

JARS-Mixed offers guidance to researchers using both quantitative and qualitative methods within a study. These JARS:

- guide authors to follow the set of JARS that is appropriate for each component of the study; and
- guide authors to explicitly discuss the value of using a mixed method approach through the reporting of study aims, methods, findings, and discussion.

For all manuscripts

Authors should also review the new Journal Article Reporting Standards for Race, Ethnicity, and Culture (JARS–REC). Meant for all authors, regardless of research topic, JARS–REC include standards for all stages of research and manuscript writing, on, for example:

- Using the title, abstract, and keywords to identify race and ethnicity of participants without signaling Whiteness as default;
- Discussing the applicability of the theoretical approach to populations for which it was not developed;
- Addressing limits on generality, recognizing that generalizability is always constrained and is not the primary purpose of every study; and
- Considering whether findings could be misused to cause harm to members of historically excluded groups.
- For more, see the Guidance for Authors sections of the table (PDF, 184KB).

Special sections

Please see the special section and issue proposal guidelines for detailed information on proposing special sections.

Formatting

Double-space all copy. If specific participants are discussed in the article, please refer to them with names rather than initials.

Use pseudonyms unless there is some reason to use actual names and you have written permission to do so.

Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the APA Style website.

Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

Academic writing and English language editing services

Authors who feel that their manuscript may benefit from additional academic writing or language editing support prior to submission are encouraged to seek out such services at their host institutions, engage with colleagues and subject matter experts, and/or consider several vendors that offer discounts to APA authors.

Please note that APA does not endorse or take responsibility for the service providers listed. It is strictly a referral service.

Use of such service is not mandatory for publication in an APA journal. Use of one or more of these services does not guarantee selection for peer review, manuscript acceptance, or preference for publication in any APA journal.

Submitting supplemental materials

APA can place supplemental materials online, available via the published article in the APA PsycArticles® database. Please see Supplementing Your Article With Online Material for more details.

Abstract and keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

Journal article

McCauley, S. M., & Christiansen, M. H. (2019). Language learning as language use: A cross-linguistic model of child language development. *Psychological Review*, *126*(1), 1–51. https://doi.org/10.1037/rev0000126

Authored book

Brown, L. S. (2018). *Feminist therapy* (2nd ed.). American Psychological Association. https://doi.org/10.1037/0000092-000

Chapter in an edited book

Balsam, K. F., Martell, C. R., Jones. K. P., & Safren, S. A. (2019). Affirmative cognitive behavior therapy with sexual and gender minority people. In G. Y. Iwamasa & P. A. Hays (Eds.), *Culturally responsive cognitive behavior therapy: Practice and supervision* (2nd ed., pp. 287–314). American Psychological Association. https://doi.org/10.1037/0000119-012

Figures

Preferred formats for graphics files are TIFF and JPG, and preferred format for vector-based files is EPS. Graphics downloaded or saved from web pages are not acceptable for publication. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file. When possible, please place symbol legends below the figure instead of to the side.

Resolution

- All color line art and halftones: 300 DPI
- Black and white line tone and gray halftone images: 600 DPI

Line weights

- Adobe Photoshop images
    a. Color (RGB, CMYK) images: 2 pixels
    b. Grayscale images: 4 pixels

- Adobe Illustrator Images
    a. Stroke weight: 0.5 points

APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.

The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., "the red (dark gray) bars represent") as needed.

For authors who prefer their figures to be published in color both in print and online, original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay:

- $900 for one figure
- An additional $600 for the second figure
- An additional $450 for each subsequent figure

Permissions

Authors of accepted papers must obtain and provide to the editor on final acceptance all necessary permissions to reproduce in print and electronic form any copyrighted work, including test materials (or portions thereof), photographs, and other graphic images (including those used as stimuli in experiments).

On advice of counsel, APA may decline to publish any image whose copyright status is unknown.

- Download Permissions Alert Form (PDF, 13KB)

Publication policies

For full details on publication policies, including use of Artificial Intelligence tools, please see APA Publishing Policies. Also refer to guidance from the *Qualitative Psychology* editorial board on usage of AI in qualitative research.

APA policy prohibits an author from submitting the same manuscript for concurrent consideration by two or more publications.

See also APA Journals® Internet Posting Guidelines.

APA requires authors to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test or procedure, funding by pharmaceutical companies for drug research).

- Download Full Disclosure of Interests Form (PDF, 41KB)

Ethical Principles

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).

In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14). This said, the sharing of qualitative data may violate other ethical standards held dear by psychologists, such as protecting confidentiality or our responsibility to protecting the decisions of participants in deciding with whom they would like to share their data. For instance, participants may decide deliberately to share data with an investigator who is anti-racist or LGBTQ+ affirming and this should not be taken to imply that they wish to share their data with any researchers who they have not vetted.

Also, sharing data may not advance either scientific or verification purposes with qualitative data. The act of de-identifying data can remove contextual factors that are critical for the interpretation of findings and lead them not to be interpretable. Many qualitative methods use epistemological approaches that recognize that the methodological expertise, engagement with participants, and content knowledge of the investigator is critical for interpretation. For these reasons, it may not be reasonable to expect a researcher to undergo the extensive process of de-identifying data in order to share them with another competent researcher outside of the study team.

In contrast, qualitative methods have other processes that can be used to verify findings. Manuscripts typically include many quotations from text or other data sources and illustrate the process of analysis for each of the main findings. In this way, the evaluation of rigor can be conducted directly from the manuscript being submitted by a competent qualitative researcher.

APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.

Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their participants, human or animal, or to describe the details of treatment. Authors must also state that they have permission to use any interview material, voice or video samples obtained from their participants and have sufficiently disguised material to assure anonymity (unless they have written permission not to do so).

- Download Certification of Compliance With APA Ethical Principles Form (PDF, 26KB)

- Download Certification of Compliance With APA Ethical Principles Form (PDF, 26KB)

The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conduct electronically on its website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.

In the 7th edition of the *Publication Manual of the American Psychological Association*, authors can find statements of cautions that indicate times when sharing data from qualitative projects may be both unethical and not useful in advancing science. Authors are encouraged to review these cautions to support them to make ethical decisions to share qualitative data.

Prior to the submission of a manuscript that is co-authored, all co-authors are expected to have agreed to have the manuscript submitted and to agree with the authorship order listed on the paper. It is the ethical responsibility of the first author to ensure this before submission.

Other information

See APA's Publishing Policies page for more information on publication policies, including information on author contributorship and responsibilities of authors, author name changes after publication, the use of generative artificial intelligence, funder information and conflict-of-interest disclosures, duplicate publication, data publication and reuse, and preprints.

Visit the Journals Publishing Resource Center for more resources for writing, reviewing, and editing articles for publishing in APA journals.

Editorial Board

Appendix E. *Interview Schedule*

University of East Anglia

Interview Schedule – Version 1 (14.01.2024)

Semi-structured interview (recorded through Microsoft Teams) – *approximately 1 hour.*

Clinicians' Perceptions of 'At-Risk Bipolar Disorder' in Young People: a Thematic Analysis

Interview:

Experience and Role

1. Can you tell me about your current role and experience working with young people in a mental health setting?

Identification Processes

1. How might you identify young people who could be at risk of developing bipolar disorder?

2. What types of behaviours or symptoms would you consider important to watch for it you were trying to identify young people at risk of developing bipolar disorder?

3. Can you describe a typical pathway you might follow, or can imagine following, from initial concern to potential diagnosis for young people at risk of bipolar disorder?

Barriers to Accessing Mental Health Services

Barriers and Challenges

1. What do you think could be the main barriers preventing young people at risk of developing bipolar disorder from accessing mental health services?

2. In your view, how might systemic issues affect the treatment and identification of youth at risk of bipolar disorder?

3. How do you think cultural or socioeconomic factors influence access to mental health services for young people at risk of bipolar disorder?

Stigma

1. How might the stigma around mental health and bipolar disorder affect young people's willingness to seek help?

2. What strategies might you use to help address these stigmas?

Navigating Barriers

1. How do you navigate, or how might you navigate, the barriers you have identified to provide care for youth at risk of bipolar disorder?

2. What role does collaboration with other professionals (e.g., educators, social workers) currently play, or could play, in navigating these barriers?

Perception of the 'At Risk Bipolar' Description

1. What are your thoughts on the clinical utility and relevance of the 'at risk bipolar' description, and how do you think it could be used in practice?

2. In your opinion, what could be the potential advantages or disadvantages of using the 'at risk bipolar' description?

3. Do you feel that current training and resources adequately prepare you to use the 'at risk bipolar' description in your practice?

4. How might you communicate the concept of being ‘at risk bipolar’ to young people and their families?

5. How do young people and their families typically respond, or how do you think they may respond, to being described as ‘at risk’ for bipolar disorder?

Other

1. Based on your experience, what improvements would you suggest for early identification and support for young people at risk of developing bipolar disorder?

2. Is there anything else you would like to share with me about this topic that we haven’t talked about already?

Post-Interview

- The participant will be thanked for their time, and the recording will be stopped.
- The participant will be given an opportunity to ask any questions about the interview.
- A full debrief will be offered, explaining the research aims.
- The participant will be informed that their identity will remain confidential in the research write-up, and they can withdraw their data within two weeks of the interview by contacting the lead researcher. The correct email address (UEA email address) will be confirmed with the participant.

The participant will be given the option to receive a £10 voucher.

Appendix F. *Participant Information Sheet*

Participant Information Sheet

Study Title: Clinicians' Perceptions of 'At Risk' Bipolar Disorder in Young People: a Thematic Analysis

You have been asked to take part in this study because you are a qualified mental health professional who has experience working in the NHS with people aged between 16-24. This Study is exploring how mental health professionals perceive and address the barriers for young people at risk of bipolar disorder. We will be interviewing clinicians with a diverse background in professional qualification (e.g., psychologist, nurse, psychiatrist etc.) and experiences. Participation is voluntary, and you will have the option to receive a £10 gift card to thank you for your time.

Confidentiality: Throughout the research process your identity will be kept entirely confidential. Only the lead researcher and their supervisors will have access to your data. Through the write up and publication of this research a pseudonym will be used instead of your name and any information that may be identifiable such as your specific place of work or any unique professional experiences will be removed. All your data will be stored on a secure University of East Anglia OneDrive server on a password-protected computer and accessed only by the research team.

What's Involved: Participation in this study will involve a one-hour interview via Microsoft teams. The interview will ask you a series of questions in which you are to

provide your honest views and opinions on the subject matter. You may also share any additional information you feel comfortable to which is relevant to your experience.

Purpose of the Research: This study aims to explore the views and strategies of mental health professionals that have experience with young people at risk of developing bipolar disorder accessing mental health services. Early intervention for this population is crucial in improving long term health outcomes, but there are significant barriers for accessing diagnosis and treatment. We hope to identify ways to improve the services and support available for young people at risk of this condition, by understanding the challenges and strategies that mental health professionals are faced with.

Advantages of Participating: As a token of our appreciation for your time you will be offered a £10 gift card. Insights provided from your views and experience will contribute to research that is aimed at improving access to mental health services for young people at risk of developing bipolar disorder.

Disadvantages of Participating: Discussing topics related to mental health may bring up sensitive experiences. You can stop or pause the interview at any time if the content becomes too distressing. If you require it, an additional debriefing session with the lead researcher and/or supervisor will be offered.

Withdrawal: You may withdraw from the study at any time without providing a reason and with no consequences. If you wish to withdraw your data from the study, you may do so up to the point that transcription is complete. Please note that due to a limited availability, the £10 gift card will only be given upon full completion of the interview.

Contact Information: For further information, please contact:

Lead Researcher: Josephine Goodman – Josephine.goodman@uea.ac.uk

Supervisor: Dr Sophie Allan - S.allan@uea.ac.uk

Course Director: Prof Sian Coker – S.coker@uea.ac.uk

If you have any problems or complaints, please contact the lead researcher (Josephine Goodman) or research supervisor (Dr Sophie Allan), or if you would like to talk to someone independent from the research team you can contact the programme director Sian Coker, the course director.

Appendix G. *Consent form Version 2 (04.03.2025)*

University of East Anglia

Title of Project: Clinicians' Perceptions of 'At Risk' Bipolar Disorder in Young People: a Thematic Analysis

Name of Lead Researcher: Josephine Goodman

Please tick box

1. I confirm that I have read the information sheet dated 04/03/2025 for the above study. I have had the opportunity to review the information, ask questions, and have received satisfactory answers. ☐
2. I understand that my participation is voluntary, and I am free to withdraw my consent at any time without providing a reason and with no consequences. I acknowledge that I can withdraw my interview audio and data from the study up until the point of transcription. After this, my audio recording will be deleted, and my data will be anonymised, meaning it can no longer be withdrawn. ☐
3. I agree to take part in the above study and give consent for my statements to be included in the report. Any personal details or identifying information will be anonymised or removed prior to the report. I acknowledge that the supervisory team will have access to the recordings and transcripts solely for the purpose of this specific research. ☐
4. I consent to be interviewed via Microsoft Teams and to provide my email address for the interview. ☐
5. I understand that my participation will be recorded in audio and video, and that only the audio transcript will be stored. I also understand that the original recordings will be deleted once transcription is complete, and that the anonymised transcript will be securely stored for the purpose of the research. ☐
6. I understand that my personal contact details will be securely retained for the purpose of receiving the outcome of the research and will be permanently deleted once this has been communicated. ☐
7. I understand that my personal contact details will be securely retained for the purpose of receiving the gift voucher and will be permanently deleted once the voucher has been sent. ☐

My email address is: .....

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

Appendix H. *UEA Ethics Approval*

University of East Anglia
Norwich Research Park
Norwich. NR4 7TJ

Email: ethicsmonitor@uea.ac.uk
Web: www.uea.ac.uk

Study title: Clinicians' Perceptions of "At-Risk Bipolar Disorder" in Young People: a Thematic Analysis

Application ID: ETH2425-0448

Dear Josie,

Your application was considered on 12th March 2025 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved**.

You are therefore able to start your project subject to any other necessary approvals being given.

This approval will expire on **30th September 2027**.

Please note that your project is granted ethics approval only for the length of time identified above. Any extension to a project must obtain ethics approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) before continuing.

It is a requirement of this ethics approval that you should report any adverse events which occur during your project to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) as soon as possible. An adverse event is one which was not anticipated in the research design, and which could potentially cause risk or harm to the participants or the researcher, or which reveals potential risks in the treatment under evaluation. For research involving animals, it may be the unintended death of an animal after trapping or carrying out a procedure.

Any amendments to your submitted project in terms of design, sample, data collection, focus etc. should be notified to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) in advance to ensure ethical compliance. If the amendments are substantial a new application may be required.

Approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) should not be taken as evidence that your study is compliant with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. If you need guidance on how to make your study UK GDPR compliant, please contact the UEA Data Protection Officer (dataprotection@uea.ac.uk).

Please can you send your report once your project is completed to the FMH S-REC (fmh.ethics@uea.ac.uk).

I would like to wish you every success with your project.

On behalf of the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee)

Yours sincerely,

Dr Paul Linsley

Appendix I. *Debriefing form*

University of East Anglia

Research Debrief form
Clinicians' Perceptions of 'At Risk' Bipolar Disorder in Young People: a Thematic Analysis

This research was conducted to gain insight into the barriers for young people at risk of developing bipolar disorder accessing mental health services from the perception of mental health professionals and their views on the challenges involved. There is limited research on young people at risk of bipolar disorder, with most research heavily based on the adult population. There is acceptance amongst the research that although early diagnosis of the condition is key for improved health outcomes, there is admittance of a timely gap between diagnosis and treatment. Understanding how mental health professionals identify young individuals at risk of the condition, the barriers clinicians encounter and their views on the 'at risk' bipolar description, will help with developing better access to care for those at risk.

The research team will conduct interviews with 10-15 mental health clinicians that are currently working with or have experience working with young people with mental health conditions. To ensure anonymity of the participants, any identifiable information that is revealed during the interview (such as your name or place of work) will be removed. Following the interviewing stage, all information will be interpreted and examined to identify themes and patterns.

Please provide the researcher with your email address if you would like to read the outcomes of this research.

You may withdraw your information from this research within two weeks of completion of your interview, during which time you can request a copy of your transcript. If you no longer wish to participate in the study, please contact the research lead using the contact details below.

Please direct any complaints or concerns to the primary supervisor of the research, Sophie Allan, in the first instance. You may also contact the course director, Prof. Sian Coker, if you would prefer to speak to someone who is independent from the project. Their contact information can be found at the end of this form.

Contact details

Lead Researcher – Josephine Goodman – Josephine.goodman@uea.ac.uk
Dr Sophie Allan – Primary supervisor – S.allan@uea.ac.uk
Prof Sian Coker – Course Director – S.coker@uea.ac.uk

Appendix J. *Recruitment Poster*

PARTICIPANTS NEEDED!

University of East Anglia

Are you an NHS mental health professional who has experience working with clients aged 16-24? Join our study and contribute to vital research on Youth at risk of bipolar disorder.

Overview

We are conducting research to help understand how mental health professionals identify young people at risk of developing bipolar disorder and the challenges they face. We are looking for **Mental Health Clinicians who have experience working in the NHS with clients aged between 16-24.**

How you can help:

By taking part in a 60-minute interview via Microsoft Teams that will focus on your views and experiences working with young people in a NHS setting. As compensation for your time all completed interviewees will have the option to be sent a **£10 gift voucher.**

SIGN UP HERE

Or EMAIL: JOSEPHINE.GOODMAN @UEA.AC.UK

Please do not distribute via NHS channels.

I am interested:

If you are interested, please scan QR code or email the lead researcher on Josephine.goodman@uea.ac.uk

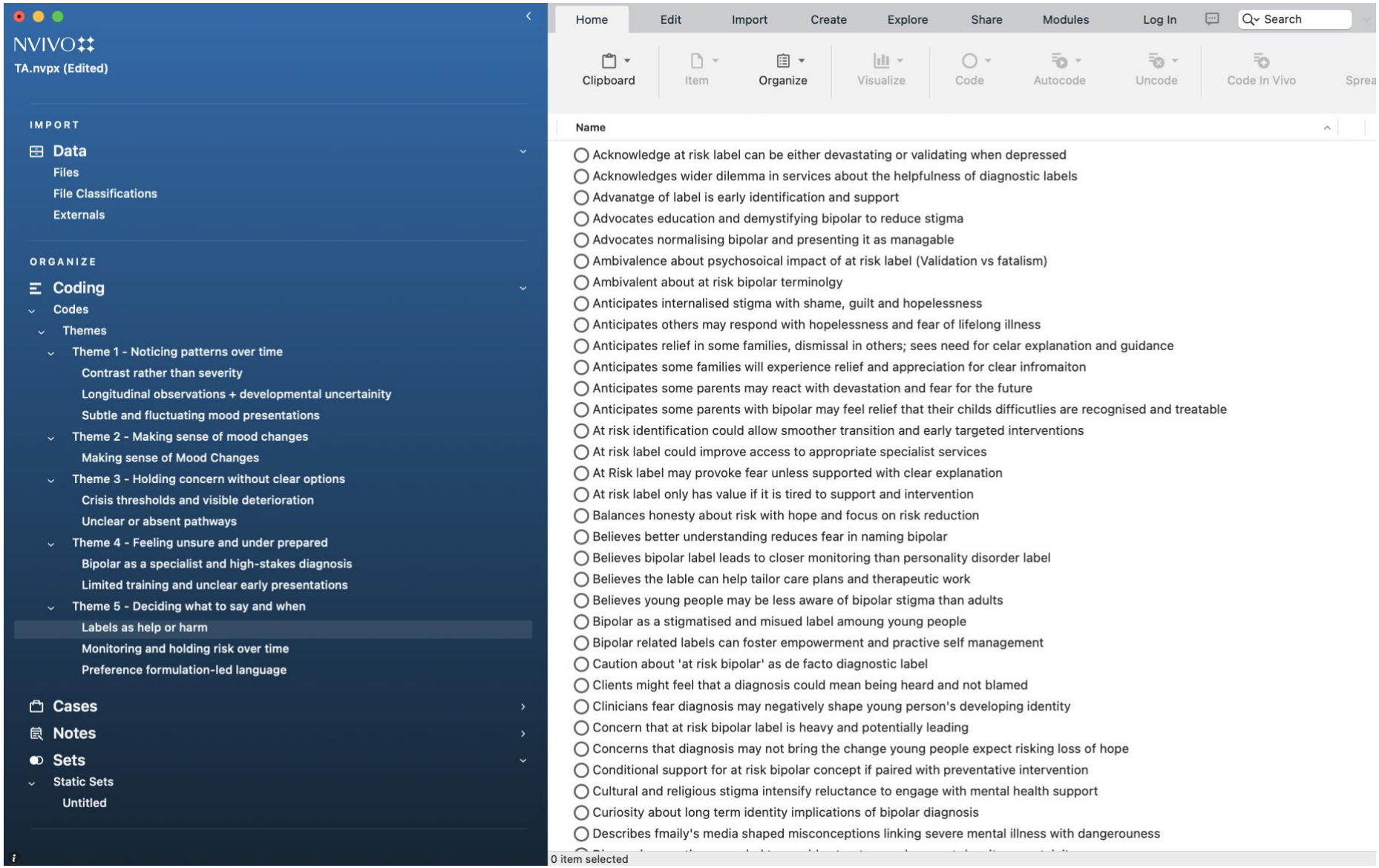


**Please note, not all applicants may be selected for participation.

University of East Anglia

This project is supervised by Dr Sophie Allan of the University of East Anglia.
Email: S.Allan@uea.ac.uk

Appendix K. *Snapshot of NVivo Codebook during Stage three of Analysis*



Appendix L. *Example Extracts from Reflexive Journal*

Stage of research	Selected reflexive extract
After interview 1	*'The interview went well, but I feel quite on edge. They spoke so confidently and I noticed myself worrying about whether I sound like I know enough. When they asked me question, I felt really uncomfortable not having some of the answers and became quite aware of myself and what I was saying. I need to remind myself going forward that I do not have to know all the answers that's why I am doing this. I need to slow down.'*
After interview 8	*'This was strangely harder than the other interviews, I felt way more anxious and aware of the interviewee being a GP. For some reason that made me feel like I had in earlier interviews where I felt so scared to not know something and definitely felt the power imbalance of me being a trainee. But they gave such good insight and a slightly different perspective that others who work mainly in mental health which was really interesting.'*
During initial coding	*'Initial coding feels hard and overwhelming. I have only coded 3 transcripts and I have way more codes than I thought I would have. Its really hard to not notice patterns, I know I shouldn't be doing that right now. When I code next, I need to let it be messy and stay close to the data.'*
Defining and naming themes	*'It's hard to add to the codes to themes at times, I find myself quite worried that I am putting things in the wrong place, or trying to fit a code into a theme, I have ended up having to leave some initial codes, which again makes it feel like it looks messy. I have also noticed though that going back and forth and re-reading the codes and the data has helped me even more with understanding the data more clearly, which has helped make me a lot more confident that the themes are actually grounded in what they were saying.'*