Accounting for the adolescent social context in school mental health interventions

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Mental health interventions in secondary schools aim to reduce or prevent mental health problems in adolescents. These usually involve psychoeducation and practical exercises and are typically delivered in groups, either to all adolescents regardless of need (*universal* interventions) or to smaller groups considered to be at risk (*targeted* or *indicated* interventions). Meta-analyses indicate that these group-based interventions have, on average, small positive effects[1]. However, sometimes these interventions are ineffective and sometimes they can have negative effects, in at least some subgroups. As rates of adolescent mental health problems continue to rise, important questions must be asked about why the effectiveness of these group interventions is limited.

There are a number of possible contributing factors. First, adolescents often do not use the techniques they are taught in interventions, because they think they are boring or irrelevant, which may mean there is limited opportunity for them to develop the knowledge and skills required to improve their mental health[2,3]. Second, for adolescents with more severe mental health problems or significant life stress, the generic information shared in group interventions might be inadequate; qualitative research again indicates that this is the case[4–6]. Third, it could be that interventions don't address the socioeconomic context that may be contributing to adolescents' mental health problems[7]. Other possibilities include that school staff do not have the time or resources required to deliver the intervention optimally[8].

In this article, we focus on one additional explanation as to why these group-based interventions have limited effectiveness: that such interventions do not sufficiently take into account the unique social context of adolescence. That is, the extensive social cognitive development that occurs in adolescence and the distinct social environment in which adolescents are embedded (i.e. secondary school, with many hours spent with the same group of peers). Group school-based interventions are delivered not to individuals but to adolescents together, and they receive the intervention in an established social environment. Understanding the unique social context at this age is thus vital for understanding why these interventions do not currently work well and how they might work better.

Adolescence is a period of heightened sensitivity to social evaluation

Relative to adults, adolescents are especially attuned to, and affected by, feedback from their peers. For example, when given information that peers do not like them, adolescents are more likely to subsequently feel worse about themselves compared to adults[9]. When adolescents are socially rejected by peers in a computer game, they experience a greater decrease in mood and a greater increase in anxiety than adults[10]. Lastly, if adolescents believe they are being watched by peers, they are more likely to report feeling self-conscious than adults do[11]. Unsurprisingly, then, adolescents consider it highly risky to deviate from what their peers considered to be socially acceptable or desirable. Relative to adults, adolescents are particularly concerned about engaging in behaviours or expressing opinions that make them different to their peers[12].

This hypersensitivity to social evaluation suggests that peers' attitudes towards a school mental health intervention will likely affect each adolescent's engagement with the intervention. This was highlighted in a qualitative evaluation of a school yoga intervention designed to improve a number of aspects of mental health and wellbeing[13]. In interviews, the 14- to 16-year-old participants reported a number of benefits, but some highlighted concerns that their peers disapproved. Specifically, some said that although they had enjoyed the intervention, their peers mocked them for this and this made them concerned about subsequently engaging with the programme[13]. Other research has found that some adolescents are reluctant to participate in targeted or indicated interventions in schools because their peers disapprove, leading to stigma, again indicating that peer attitudes might affect adolescents' engagement in school-based interventions.

Adolescence is a period of heightened sensitivity to social influence

Related to the above, adolescents are especially susceptible to peer influence. Compared to adults, adolescents are more likely to adjust their behaviour and attitudes to be in line with that of their peers[14]. This is because conformity promotes a sense of similarity with peers, which is turn promotes affiliation and bonding, at a time when group belonging is so important and desirable. In line with this, adolescents are especially likely to conform to peers that have high social status[15]. Again, this indicates that if some adolescents deem a school mental health intervention to be uncool or unacceptable, this attitude could 'spread'

to other adolescents in the class, making it less likely that students across the group will engage with the intervention. This may be especially relevant for adolescents who have low social status, for example those who are victimised or bullied by their peers.

Adolescents can feel unsafe at school

Secondary schools are complex social ecosystems made up of individuals and friendship groups organised into a strict social hierarchy. Bullying and other forms of violence are common, and around 20% of adolescents report feeling unsafe at school[16]. This has significant implications for understanding how effective group school-based mental health interventions can be. When mental health interventions are delivered to groups, inevitably some participants will be taught alongside their aggressor or other peers that make them feel unsafe. There is evidence that this is the case. One ethnographic study found that some adolescents did not want to shut their eyes during a school mindfulness practice because they did not feel safe doing so in front of their classmates[5]. A qualitative evaluation of a CBT-based universal intervention for depression highlights how self-disclosure activities – a common component of school interventions – can be difficult because they require participants to trust their peers, which often is not the case[17]. When participants are asked to explore personal thoughts and feelings in a group setting, those who feel unsafe will face the choice of either avoiding disclosure, lying about their thoughts and feelings, or being honest and risking the possibility of social judgement and ostracism. It is possible that interventions that involve group self-disclosure or other practical exercises might have limited effectiveness, especially for adolescents who feel vulnerable in front of their peers.

Suggestions for future work

The development of future school-based mental health interventions should draw on the comprehensive body of literature examining social cognitive development in adolescents, including social evaluation concerns and social influence. For example, future interventions could consider which activities or approaches might make adolescents feel self-conscious or vulnerable in front of their peers and implement alternatives (e.g. writing exercises instead of group discussions; small group activities with friends instead of those involving the whole class). To identify what these alternatives might be, future interventions should be co-designed with adolescents themselves. By asking adolescents for input, researchers give

adolescents autonomy, choice and respect, which in itself may improve intervention effectiveness, but such coproduction can also reveal how adolescents might feel, for example, about doing practical exercises or learning about mental health in front of their peers. This information can then be used to adapt components of the intervention if necessary (for example, completing a writing exercise instead of a group discussion activity).

In addition to using coproduction in the early stages of the intervention design, it may be necessary and beneficial for intervention developers to work with adolescents within each individual school to make adjustments based on the school's specific social context. This would be akin to a precision medicine approach, and is important because each school and class has its own unique social networks, dynamics and needs. For example, it might be useful to identify which adolescents within a specific school have higher social status, and ask them to help ensure acceptability of the design and then lead peer-led interventions. There is evidence that an antibullying intervention was more effective when it was led by well-connected adolescents (i.e. those whom many other students reported wanting to spend time with) compared to less well-connected adolescents[18]. This is an example of how adolescents' susceptibility to social influence can be harnessed to improve the effectiveness of school-based interventions. However adolescent input is sought and implemented, the key point is that adolescents' heightened sensitivity to social evaluations and heightened susceptibility to social influence at this age can be harnessed in a productive way. If researchers can design interventions that win the approval of adolescents, particularly adolescents with high social status, then this approval could spread across school networks and improve engagement and effectiveness.

Conclusion

Adolescence is a period of substantive social cognitive development, in which individuals become increasingly concerned about fitting in with their peer group and avoiding social ostracism. These social cognitive changes take place while adolescents are in the distinctive social environment of secondary school: they spend every day with the same group of peers, organised into a strict social hierarchy, and it is relatively common for individuals to feel unsafe. We argue here that, to date, this social context has not been sufficiently taken

into account when designing and implementing group school mental health interventions, even though these are delivered to adolescents embedded in existing social networks. Ultimately, it may be the case that group school interventions will always have limited effectiveness, because what adolescents really need is adjustments to external stressors and/or one-to-one therapeutic support. But designing these interventions with adolescent social development at their heart will allow researchers to evaluate interventions that adolescents engage in, more comprehensively addressing the question of whether group interventions are worth implementing in schools.

Competing interests

The authors declare no competing interests.

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