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A “Good Start in Life” can underpin lifelong mental wellbeing. The first JPMH issue of 2019 will be a special issue, “With children in mind: current research and policy developments on mental health and young people”, edited by Helen Donovan and Gill Coverdale (31 July 2018 is the deadline to submit a manuscript for this). In the hope of inspiring readers to make expert, international contributions to the special issue, I am focusing this editorial on some examples of current research and policy, in this country.

In this journal, the nature and promotion of resilience has been a frequent theme (e.g. Caan, 2016). I am indebted to the Association for Young People’s Health (2016) for their youth perspectives on resilience. This year, mental health promotion figured in several contributions to the 10th Anniversary Conference of the Association for Young People’s Health in London on 21 February 2018. Research presentations on the StreetGames national sport pilots and the Redthread violence intervention by youth workers were especially impressive. This inter-disciplinary meeting took place against the current policy background of a “green paper” for England on Transforming Children and Young People’s Mental Health Provision (Department of Health and Department for Education, 2017). A consultation on this cross-departmental policy is still underway as I write this, but will finish shortly (Hunt, 2018).

Readers from many countries will relate to current problems in England, around under-funding of care for the population with mental illness (Royal College of Psychiatrists, 2018). Here, increased demand for clinical care is predicted to rise by about a million persons per decade (Caan, 2017). Only widespread social policy interventions to address the determinants of mental health can prevent such a tide of misery (and prevent services being overwhelmed). One possible area for policy innovation was shown by a book launch on 8 February 2018 in Parliament. This book was a comprehensive report on Addressing Adversity (Bush, 2018). Adversity can take many forms, but cumulative childhood adversity becomes a strong predictor of developing mental illness. Bush (2018) identifies eight personal, structural and environmental factors that protect against mental problems, for example “access to a wider, supportive and understanding community”. For school age children, their school “community” is a good starting point for prevention. In theory, mental wellbeing should be covered in schools during personal, social, health and economic education (PSHE) sessions. However, in most English schools the educational “reforms” have fractured the system and currently PSHE is neither mandatory nor quality assured.

I am most grateful to the Westminster Education Forum, for their seminar held on 8 February 2018 in London: “Preparing for implementing compulsory relationships and sex education in schools”. In particular I liked the expression of one speaker, the Teacher Laura Foley, that staff need to be trained for “purposeful PSHE”. Overall, there was a consensus that thriving in childhood was built on a variety of positive relationships. Effective PSHE needed to link with safeguarding duties (protecting vulnerable children) and school nursing (healthcare) roles. This made co-ordinated workforce planning necessary, across both education and health sectors (see Merrifield, 2018). There was a need to recognise both current adversity (like bullying) and also that some children had previously experienced traumatic events. To develop better community practice would, of course, require the inclusion of young people and parents!

For some adults including parents, it is difficult to see with a young person’s perspective, but at present in the UK, many adolescents report being victimized over their appearance (Siddique, 2018). In our era of mass communication and online bullying, social policy needs to address problems around body image (and vulnerable self-esteem) across the young population.

In addressing adversity, resilience refers to patterns of positive adaptation in the context of significant risk or adversity (Ungar, 2018). It seems that the local context can influence the elements that build up resilience. This week I took part in a training event for improved community resilience, around the
county of Essex. We learned lessons about young people who experienced a massacre at a pop concert, and other young people who witnessed an appalling fire with multiple casualties. Crucially, the response by services needs to be prompt, local and respectful to young people. Professional responders, volunteers and mutual aid groups can all bring something valuable to the community affected. Chaos or competition can develop when very different groups work under pressure with a small, unfamiliar community, but future Public Health training should include skills to develop harmony between such responders. Recent re-organisation of the Department of Health and Social Care offers a unique opportunity. With a “Public Health” understanding of population health and of changing behaviour, the urgent appeal of NHS England (2018) to harmonise care from the National Health Service and from Local Government, could be realised—one community at a time.

Sometimes early adversity is not as visible as the blazing fire in which 72 neighbours were seen to perish. In Parliament on 13 February 2018 another meeting looked at the consequences of children growing up with an alcoholic parent (Parliamentary Office of Science & Technology, 2018). Left unrecognised and unsupported, that sort of invisible childhood adversity can cast a long shadow on adult health. However, the consensus of the meeting was that a culture of openness, backed up by research evidence, was starting to guide the development of new policies. Not only was a new light being shone on previously unrecognised children—the benefits of improved support, now, might extend to future generations.

**Adversity avalanche**

Too much, too soon,
Problems can overflow:
Too little, too late,
Services come to know.
Search high, search low,
Before lives sink, in snow.
Hear cries, clear paths,
And young minds, still, may grow.

**References**

Association for Young People’s Health (2016), *A Public Health Approach to Promoting Young People’s Resilience*, Association for Young People’s Health, London.
Evaluation of a novel approach to preventing railway suicides: the community stations project

Anna Ross, Nicola Reavley, Lay San Too and Jane Pirkis

Abstract
Purpose – The purpose of this paper is to describe an evaluation of the Community Stations Project. The Community Stations Project was designed to address railway suicides in two ways: by improving the station environment in a manner that might improve community members’ feelings of wellbeing; and raising community members’ awareness of poor mental health and likelihood of reaching out to at-risk individuals. It involved four types of interventions (arts and culture, music, food and coffee, and “special events”) delivered at four stations in Victoria.

Design/methodology/approach – A short anonymous survey was administered to community members on iPads at the four participating railway stations during the implementation of the interventions (between October and December 2016). The survey included questions about respondents’ demographics, their awareness of the intervention(s), their views of the station, their attitudes towards people with poor mental health and their emotional wellbeing.

Findings – A total of 1,309 people took part in the survey. Of these, 48 per cent of community members surveyed reporting noticing an intervention at their station. Noticing the events was associated with positive views of the station, improved understanding of poor mental health, and a greater likelihood of reaching out to someone who might be at risk of poor mental health. Awareness of intervention events was not associated with respondents’ own emotional wellbeing.

Practical implications – Continuing to focus efforts on mental health awareness activities may further strengthen the impact of the Community Stations Project interventions and ultimately prevent suicides at railway stations.

Originality/value – This paper evaluates a novel approach to improving wellbeing and understanding of poor mental health in the train station environment.

Keywords Suicide prevention, Mental health, Emotional wellbeing, Community intervention, Rail suicide, Train station

Introduction

In Victoria, suicide accounts for the majority of deaths on railway networks, with 17 per cent of Victorian railway suicides occurring at stations (Too et al., 2015). This equates to five suicides per year occurring in the station environment. These suicides have significant traumatic impacts for those who witness them, including train drivers, other railway staff and passengers and may result in diagnoses of acute or post-traumatic stress disorders (Bardon and Mishara, 2015; Limosin et al., 2006; Mishara, 2007; Clarner et al., 2015). They also cause economic losses through disruptions of train services, driver absenteeism and counselling required for affected railway staff (Mehnert et al., 2012). Rail suicides that occur in the station environment may also have more witnesses, which carries the potential for traumatic impact on larger numbers of people.

The World Health Organisation (2014) has argued for the essential role of the community in preventing suicide, with the importance of this role emphasised through inclusion of community-wide
prevention in national suicide prevention strategies (Australian Government Department of Health and Ageing, 2007; UK House of Commons Health Committee, 2017). However, difficulties in measuring the efficacy of community-level interventions at reducing suicide have also been recognised, limiting the conclusions that can be drawn from evaluation studies (Turecki, 2016; Zalsman et al., 2016). With railway tracks identified as a “suicide hotspot”, it is recognised that there are four main intervention approaches to reduce suicide at hotspots: restricting access to means (through installation of physical barriers); encouraging help-seeking; increasing likelihood of intervention by a third party; and encouraging responsible media reporting of suicide (Cox et al., 2013; Pirkis et al., 2015). While the evidence for restricting access to means by installing physical barriers along railway tracks to reduce access to these is strong (Pirkis et al., 2013; Cox et al., 2013), the cost of this intervention can make it unfeasible. Alternatively, implementing interventions that encourage help-seeking and increase the likelihood of intervention by a third party may be more financially feasible to implement, with evidence suggesting that these are promising approaches (Pirkis et al., 2015).

A possible approach to reducing railway suicides utilises these approaches, involving community-based interventions that aim to improve community members’ understanding of poor mental health, their likelihood of reaching out to at-risk individuals, and their emotional wellbeing. A proposed programme logic matrix that may underpin these interventions is outlined in Figure 1. The hierarchy suggests that higher-level outcomes like decreasing suicide and suicide attempts are dependent upon lower-level impacts, and if lower-level outcomes can be achieved then the higher-level outcomes are likely to follow, even if they cannot be measured in an evaluation.

![Figure 1: Proposed hierarchy of objectives for decreasing suicide in a community station context](https://example.com/figure1.png)
Essentially, the hierarchy of objectives has two arms: one relating to improving community members’ knowledge, beliefs and attitudes towards people with poor mental health; and encouraging reaching out to others who may be at-risk of poor mental health. The other arm involves increasing wellbeing and social connectedness by altering the ambiance of stations and through the community nature of events.

To achieve the objectives of the hierarchy and to ultimately decrease suicide, a package of community-level interventions to improve understanding of poor mental health, likelihood of reaching out to at-risk individuals and wellbeing of community members was developed. These interventions included special mental health awareness-raising events, arts and cultural events, music events, as well as the provision of free food and coffee. Interventions related to the first arm involved special mental health awareness-raising events, aiming to improve community members’ understanding of mental health and reaching out to others who might be at-risk of poor mental health. These events involved promotions by local health services and mental health organisations, including Lifeline and community education units, as well as Australian Rotary Health’s Lift the Lid on Mental Illness (a national mental health fundraising and awareness day) and R U OK? Day (an Australian national day of action that encourages people to connect with and support those around them who may be struggling) (Mok et al., 2016) campaigns. In relation to the second arm, interventions aiming to improve social connectedness and wellbeing were implemented by the train networks and involved participation in arts and cultural events, and providing free food and drinks. Examples of these events include taking part in making murals and gratitude montages, watching drama performances, musical performances by buskers, community bands and singing groups, a playable piano, and providing free tea/coffee, cupcakes and sausage sizzles to community members. Intervention events took place at each station during either morning or afternoon peak times on weekdays, and during the day on some weekends, on most days over the intervention period.

As a community events approach to prevent railway suicides is a novel initiative, to the best of our knowledge, there is no evidence regarding the effectiveness of these interventions on suicide reduction. However, similar interventions have been applied in different settings, which provide some indication of the impact these interventions might be expected to have on mental health and wellbeing in a community context.

**Events aiming to improve understanding of mental health and suicide**

The research literature investigating the impact of interventions and campaigns that aim to improve the public’s awareness of poor mental health and knowledge of available supports is rapidly building. This improved awareness is increasing utilisation of effective self-help coping strategies and help-seeking for mental health concerns. Improved understanding of poor mental health has been found to be associated with decreased stigmatising attitudes, as well as increased recognition of mental health problems, help-seeking intentions and support offered to others (Jorm, 2000, 2012; Jorm et al., 2006; Kelly et al., 2007). Community-based depression-awareness campaigns have also been found to modestly improve community knowledge of and attitudes towards depression and suicide; however, the durability of these attitude changes is unknown (Dumesnil and Verger, 2009). Based on these findings, an intervention that acts to increase mental health awareness and knowledge in the community can be ultimately expected to increase self-help behaviours, increase support offered to others and increase appropriate help-seeking.

**Events aiming to improve wellbeing**

Active participation in community arts and cultural events, such as film and photography exhibitions, dance, film making, storytelling, mural creation, as well as other arts and crafts workshops, has been found to increase social connectedness and community engagement (Chung et al., 2009; Mohatt et al., 2013; Philipp et al., 2014). Studies have also shown that exposure to music that is self-selected or relatively gentle in tempo and tone, such as classical music, has been found to significantly reduce negative emotional states (including reduction in anxiety, depression and anger), enhance mood and sense of wellbeing (Labbé et al., 2007;
Furthermore, research findings also show that certain foods and drinks can have immediate psychological benefits and promote a sense of wellbeing. Dairy products, particular vegetables and particular bakery products have been linked to reported immediate improvements in mood (Geier et al., 2012), as well as described by respondents as “good for wellbeing” and to “make me feel good” (Ares et al., 2016). These findings suggest that conducting similar events in a community setting could be expected to bring about increases in community members’ perceived social connectedness and wellbeing.

The Community Stations Project

Concern about railway suicides led Public Transport Victoria, Metro Trains Melbourne and TrackSAFE Foundation to instigate a pilot project known as the Community Stations Project. Four stations across Melbourne, Australia, participated in the Community Stations Project. Working alongside the local councils and volunteer organisations, these stations implemented various interventions designed to improve wellbeing, understanding of poor mental health and help-seeking, aiming to ultimately decrease suicides at railway stations.

Aims of the evaluation

Overall, this study aimed to evaluate the impact of the Community Stations Project. The three specific aims were to investigate if the interventions:

1. Improved people’s views about the stations.
2. Improved people’s attitudes towards those with poor mental health.
3. Improved people’s self-rated emotional wellbeing.

Methodology

Survey design

A short anonymous survey was designed to be administered to community members (aged 18 and over) at the railway stations that were participating in the Community Stations Project. The survey, which took approximately two to three minutes to complete on an iPad, included questions about respondents’ demographics (gender, age group and how often they came to the station), and whether they had noticed any of the following public events at the stations: arts and culture, music, food and coffee, and awareness-raising events (special events). Those who had noticed the events were then asked to rate whether the events had affected their views about the station on a scale of 1–10 (1 = very negative, 10 = very positive). Those who noticed the “special events” were asked if these had improved their understanding of people with poor mental health or made them more likely to reach out to someone whom they thought might be at risk of poor mental health. All respondents were then asked to rate their own emotional wellbeing on a scale of 1–10 (1 = very poor, 10 = very good).

To encourage respondents to seek support for their emotional wellbeing if they rated their emotional wellbeing as low or if it was something they were concerned about, the following text was presented below the final question about wellbeing: “If you feel you want to talk to someone about your response to this question, please call Lifeline: 13 11 14 (toll-free).

Participants and data collection

Surveys were conducted at the four stations involved in the Community Stations Project over a six-week period, from mid-October to early December 2016. Two researchers visited each station for an average of two to four hours during the daylight hours of one weekday each week. Researchers aimed to conduct surveys at times that coincided with intervention activities being conducted at the station, and aimed to survey a minimum of 40 respondents per station visit.

Each researcher had an iPad with the survey questionnaire loaded onto it. Researchers randomly approached community members as they entered the station or as they were waiting on the
platform, offering some brief information about the survey and asking if they would be interested in participating. Community members who requested further information about the survey were provided with a copy of the project’s Plain Language Statement.

Community members who were interested in taking part were handed an iPad to provide their responses to the survey. Consent to participate in the project evaluation was sought at the beginning of the survey, and only those providing consent went on to view the survey questions. Researchers stood at a reasonable distance from participants to allow participants space to enter their responses confidentially. Those who reported being uncomfortable using an iPad were offered the option of having the researcher read the survey questions to them and enter responses for them.

**Data analysis**

Descriptive statistics were used to report the characteristics of respondents in terms of sex, age group and travel frequency, as well as the proportion of those who noticed an event and their view about the stations. A proportion test was utilised to evaluate the effect of “special events” on understating of poor mental health and reaching out to someone who might be at risk of poor mental health. Linear regression was used to assess the links between respondents’ exposure to the interventions and their own wellbeing.

**Ethics approval**

The evaluation was approved by The University of Melbourne’s Human Research Ethics Committee (HREC 1647684.1).

**Results**

Overall, 1,376 people indicated that they were interested in participating in the evaluation and were given the iPad to complete the questionnaire. Subsequently, 1,309 (95.1 per cent) consented to participate in the survey. Data from 51 respondents who did not provide complete responses were removed. Thus, surveys from a total of 1,258 respondents were included in the analysis.

Characteristics of respondents are presented in Table I. The gender distribution of respondents was evenly spread between males and females. Over half of respondents were aged below

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>605</td>
<td>48.1</td>
</tr>
<tr>
<td>Female</td>
<td>649</td>
<td>51.6</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>0.2</td>
</tr>
<tr>
<td>Rather not say</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td><strong>Age group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 25</td>
<td>380</td>
<td>30.2</td>
</tr>
<tr>
<td>25–34</td>
<td>332</td>
<td>26.4</td>
</tr>
<tr>
<td>35–44</td>
<td>206</td>
<td>16.4</td>
</tr>
<tr>
<td>45–54</td>
<td>139</td>
<td>11.1</td>
</tr>
<tr>
<td>55–64</td>
<td>120</td>
<td>9.5</td>
</tr>
<tr>
<td>⩾65</td>
<td>81</td>
<td>6.4</td>
</tr>
<tr>
<td><strong>Travel frequency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Every day</td>
<td>287</td>
<td>22.8</td>
</tr>
<tr>
<td>Monday to Friday</td>
<td>547</td>
<td>43.5</td>
</tr>
<tr>
<td>Once a week</td>
<td>139</td>
<td>11.1</td>
</tr>
<tr>
<td>Once a fortnight</td>
<td>47</td>
<td>3.7</td>
</tr>
<tr>
<td>Once a month</td>
<td>66</td>
<td>5.3</td>
</tr>
<tr>
<td>Once every few months</td>
<td>172</td>
<td>13.7</td>
</tr>
</tbody>
</table>
34 (56.6 per cent). Most respondents were frequent commuters, with 66.3 per cent of respondents travelling from the given station between five and seven days a week. The surveys were administered at four selected stations in a fairly similar proportion.

The proportion of respondents who noticed an event at the respective station, for each event type, is reported in Table II. About half of the community members surveyed reported to have noticed an event at their station, with coffee/food carts being the most noticed events at each station. Respondents who indicated that they had noticed an event at the station were then asked if the event influenced their view of the particular station. These findings are also presented in Table II. Overall respondents indicated that the events had a moderately positive impact on their view of the station.

Noticing a “special event” (including mental health awareness events) at the station was significantly associated with an improved understanding of people with poor mental health \( (p = 0.009) \) and an increased likelihood of reaching out to someone that participants thought might be at risk of poor mental health \( (p < 0.001) \). Table III presents these data.

Univariate regression analyses showed that noticing the events was not significantly associated with the self-rated wellbeing of respondents (coffee/food, \( p = 0.999 \); arts/cultural, \( p = 0.764 \); music, \( p = 0.739 \); special event, \( p = 0.525 \)).

### Discussion

This study aimed to assess the impact of the Community Stations Project interventions on community members’ views of the stations, their understanding of people with poor mental health, and their own emotional wellbeing. The findings indicate that the interventions increased positive views about the stations and improved understanding of people with poor mental health. However, the interventions were not found to have a direct impact on emotional wellbeing.

**Impact on views about the station**

Almost half of the community members surveyed reported noticing the interventions at the stations, and these people generally indicated that the interventions influenced them to view the station more positively. According to the programme logic matrix of the Community Stations Project, viewing the station more positively can be expected to improve social connectedness and emotional wellbeing, thus potentially acting to decrease risk of poor mental health and

<table>
<thead>
<tr>
<th>Event</th>
<th>n</th>
<th>Noticed event (%)</th>
<th>View influenced by event M(SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coffee/food</td>
<td>474</td>
<td>37.7</td>
<td>6.80 (2.19)</td>
</tr>
<tr>
<td>Arts/cultural</td>
<td>129</td>
<td>10.3</td>
<td>7.29 (2.13)</td>
</tr>
<tr>
<td>Music</td>
<td>242</td>
<td>19.2</td>
<td>6.98 (2.15)</td>
</tr>
<tr>
<td>Special event</td>
<td>65</td>
<td>5.2</td>
<td>6.85 (2.37)</td>
</tr>
<tr>
<td>None of the events</td>
<td>615</td>
<td>48.9</td>
<td>na</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes n (%)</td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td>The event improved your understanding of people with poor mental health</td>
</tr>
<tr>
<td>The event made you more likely to reach out to someone who you thought might be at risk of poor mental health</td>
</tr>
</tbody>
</table>
ultimately decrease suicide. Whether or not community members noticed the interventions may have been influenced by numerous factors, including the placement of the activities within the station. Most of the stations included in the project had numerous entrances, and therefore not all community members would have necessarily passed the intervention activities upon entering the station. For the events to have any impact on wellbeing or understanding poor mental health, it is important that these are noticeable to community members. Increased awareness may have been achieved through adequate signage, PA announcements and positioning events in high-foot traffic areas.

Impact on knowledge about and attitudes towards poor mental health

Community members reported improved understanding of poor mental health after being exposed to a “special event” at the station. They also reported being more likely to reach out to someone who they thought might be at risk of poor mental health following exposure to these interventions. This suggests that providing community members with further information on mental health problems, and advice on assisting someone they are concerned about, improves awareness and understanding of these problems and may prompt the offering of support to others and thus protect against suicide. This finding is consistent with extensive research by Jorm et al. (2000, 2006, 2012) showing that improving understanding and attitudes towards poor mental health promotes help-seeking and reaching out to others who might be at risk of poor mental health or suicide. These findings are also consistent with Dumesnil and Verger (2009) who found mental health awareness campaigns improve community knowledge of and attitudes towards people with poor mental health. As these awareness-raising events act to improve understanding of poor mental health, they may also further act to decrease suicide through increased help-seeking and support offered to others who might be experiencing poor mental health and may be at increased risk of suicide, and thus ultimately decreasing suicides.

Impact on emotional wellbeing

None of the different categories of interventions conducted at each of the four stations were found to have a direct impact on community members’ emotional wellbeing. As wellbeing is a complex concept that is influenced by a wide range of life domains, including social, economic, environmental, psychological, physical and spiritual (Felce and Perry, 1995), the interventions may not have had a sufficiently large effect on these domains to significantly impact wellbeing in this context. In order for these interventions to decrease suicide, based on the programme logic matrix, a positive impact on wellbeing was expected. Therefore, these findings were not consistent with the proposed programme logic.

Music and cultural/arts interventions described in past research that have been found to be successful at improving wellbeing have described participants’ exposure to the interventions, ranging from spending from 20 to 30 minutes listening to music, to participating in numerous exposures to intervention activities over a few hours (Labbé et al., 2007; Chan et al., 2009; Teo et al., 2015; Pearce and Lillyman, 2015). It is possible that limited exposure to the interventions in this project may have reduced their potential impact on wellbeing. Particularly during peak times at the stations, where trains arrive and depart at an increased frequency, community members spend minimal time at the station and thus limiting their exposure to events. It is also possible that the attention of community members may have been focussed elsewhere while at the station (i.e. planning their train journey, looking at mobile phones) and may not be sufficiently focussed on activities occurring in the station environment. The research evidence describes that active participation in cultural and arts activities is what contributes to a sense of wellbeing and increased social connectedness (Chung et al., 2009; Mohatt et al., 2013; Philipp et al., 2014). The nature of participation in interventions in this project may have been too passive in nature, and not sufficiently engaging or sufficiently socially interactive to have a significant impact on wellbeing and social connectedness to ultimately decrease suicide at train stations. The train station environment, while being a community hub, may also be the type of transitional environment that is not conducive for interventions targeting wellbeing and social connectedness in this manner.
Strengths and limitations

This evaluation investigated the impact of a pilot intervention that aimed to increase social connectedness (by improving views about participating stations) and improve understanding of poor mental health and, in turn encourage help-seeking and improve emotional wellbeing, and ultimately prevent suicides in railway station setting. The researchers aimed, as much as possible, to conduct surveys at times when intervention activities were scheduled to run. Thus, the evaluation optimised the likelihood that those who were surveyed had been exposed to intervention events, facilitating the best possible opportunity to determine the impact of the interventions.

Some limitations of the evaluation must be acknowledged. First, as with all self-report surveys, the impact of social desirability needs to be considered. However, as the surveys were mostly completed on an iPad, researchers could not see any responses, and therefore limiting the influence of responding in a socially desirable pattern. Those who choose to verbalise their thoughts to the researcher while responding to the survey may have been the respondents most likely to have been influenced by social desirability. Second, a number of respondents asked about the meaning of “wellbeing” in the context of the study and varied ways of interpreting this concept may have influenced survey responses, possibly contributing to the insignificant impact of the interventions on emotional wellbeing. Third, with only 65 participants in this study noticing the special events, the sample size to evaluate the impact of these events was relatively small.

Additionally, the surveys were conducted at the beginning of the Community Stations Project, with the interventions starting only two to three weeks prior to the beginning of survey data collection, potentially reducing opportunities for exposure prior to being surveyed. Ideally, rather than a cross-sectional study design, a pre- and post-intervention design would have maximised exposure opportunities and have allowed a more thorough evaluation of the impact of the interventions. Due to the difficult nature of assessing the direct impact of the intervention on suicide, no outcome measure for suicide was utilised in this study which thereby limits conclusions regarding the ultimate effectiveness of the intervention at decreasing suicide in these communities. Also, including school-aged young people, who were outside the age range to participate in this evaluation and were often observed by the researchers to notice and interact with the interventions, may increase overall awareness.

Implications

Given the important role of the community in suicide prevention initiatives and the large number of people who visit train stations, more research is required to explore the effectiveness of such interventions in a train station environment. Investigation into specific suicide prevention messaging and the most effective delivery formats for this would guide future intervention efforts. Based on the current findings, engaging and concise messaging seems it would be most efficacious. Further, providing training to railway staff on assisting someone who may be at risk of poor mental health or suicide (such as Mental Health First Aid suicide prevention training) should be trialled and evaluated as an additional intervention avenue.

Conclusions

Evaluation findings suggest that the efforts being made to improve the station environments through the Community Stations Project are appreciated and valued by commuters who noticed the events. There is also some evidence to suggest that the mental health awareness events at train stations were effective at increasing awareness of poor mental health and increasing intentions to help someone who may be at risk of poor mental health. Combining mental health awareness events with other event categories, such as food or arts events, may also help to add interest and increase participation in these events and thus increase their positive impact to decrease rail suicides.
References


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Financial difficulties and psychosis risk in British undergraduate students: a longitudinal analysis

Thomas Richardson, Mma Yeebo, Megan Jansen, Peter Elliott and Ron Roberts

Abstract
Purpose – The purpose of this paper is to examine whether financial variables impact psychosis risk over time in students.
Design/methodology/approach – In total, 408 first-year British undergraduate students completed measures assessing psychosis risk and finances at three time points.
Findings – Greater financial difficulties increased psychosis risk cross-sectionally both in terms of symptoms and distress. Other financial variables such as student loan amount were not significant. In longitudinal analysis financial difficulties increase psychotic symptoms and distress over time, but there was no impact of psychotic symptoms on later financial difficulties.
Research limitations/implications – The study used a relatively small and heavily female sample. Future research is needed to confirm the findings.
Practical implications – Whilst amount of debt does not appear to impact psychotic symptoms in students, greater financial difficulties appear to increase the risk of psychosis over time. Professionals working with students should be aware of this potential link.
Originality/value – This is the first time a longitudinal study has examined the effect of finances on psychosis symptoms.
Keywords Student, Psychosis, Debt, Financial, Psychotic
Paper type Research paper

Introduction
Psychosis is a significant public health issue, costing £11.8 billion a year to the UK economy (Schizophrenia Commission, 2012). Incidence rates for schizophrenia peak between the ages of 20-24 for men and 25-29 for women (Kirkbride et al., 2006) with prevalence estimates in the UK ranging from 32 to 50 per 100,000 in rural areas (Cheng et al., 2011) to 74 per 100,000 in South London (Kirkbride et al., 2012). Epidemiological research has shown a number of risk factors implicated in the onset of psychosis. These include urbanity (Krabbendam and Van Os, 2005), gender (Kirkbride et al., 2006), ethnicity (Pinto et al., 2008) and low socio-economic status (SES) (Harrison et al., 2001; Werner et al., 2007). Studies have shown that those with the lowest SES have eight times the relative risk of developing schizophrenia, compared to those in the highest social class (Holzer et al., 1986). Birth studies and longitudinal research have found that individuals with schizophrenia are more likely to reside in areas with higher social deprivation and occupy positions of lower SES (Holzer et al., 1986; Harrison et al., 2001; Werner et al., 2007).

A recent meta-analysis by Richardson et al. (2013) found that a significant relationship between mental health and debt existed. However, it also elucidated that only two previous studies (Jenkins et al., 2008, 2009) had been conducted examining the relationship between debt and psychosis, both of which were cross-sectional in nature limiting the ability to ascertain the temporality of the relationship.
The age of onset of mental health disorders including schizophrenia frequently co-occurs with the start of university, indicating a high risk time for many students (Reavley et al., 2012; Royal College of Psychiatrists, 2011). Factors such as poor sleep may also be relevant to the risk of psychosis in this population: CBT for insomnia reduces paranoia in students (Freeman et al., 2007).

One factor that seems to contribute to poorer mental health in students is financial difficulties (Jessop et al., 2005; Carney et al., 2005; Cooke et al., 2004; Andrew and Wilding, 2004; Roberts et al., 2000; Roberts et al., 1999). One recent survey showed that 84 per cent of British students worry about having enough money to pay the bills, 72 per cent believe they will never pay off their student loan and 50 per cent believe their financial difficulties impact their mental health (Save the Students, 2018). The average British student is more than £25k in debt (MAT, 2016).

A number of studies in students have shown a relationship between debt and financial difficulties and symptoms of depression, anxiety, alcohol dependency and eating disorder risk (Richardson et al., 2013, 2015, 2017). However, no study to the best of the author’s knowledge has examined the impact that financial difficulties and debt has on psychosis risk in students. This study therefore aimed to use a longitudinal design to examine the relationship between financial difficulties and psychosis in British undergraduate students.

Methods
Design and procedure
A longitudinal design using data from a cohort study was used (Richardson et al., 2015). A national sample of British first-year undergraduate students was recruited through student unions. International students were excluded as the original study was about tuition fees increases for British students. Every student union in the country was contacted and invited to advertise the survey as a “Student Mental Health Survey” looking at whether variables such as “finances, demographics and alcohol use” were related to mental health. Participants completed an online survey at baseline and at least at one other follow-up point at time 2 (3-4 months) and/or time 3 (6-8 months). Those who did not complete multiple time points were excluded as they could not be included in any longitudinal analysis. Ethical approval was obtained by the University Of Southampton School Of Psychology Ethics Committee.

Standardised measures
The Prodromal Questionnaire-Brief Version (PQB) (Loewy et al., 2011), measures psychosis risk using 21 questions answered Yes/No such as “Do you feel that other people are watching you or talking about you?” and “Have you seen things that other people can’t see or don’t seem to see?” producing a total for positive symptoms. Participants are also asked to rate how distressing these experiences were (When this happens, I feel frightened, concerned, or it causes problems for me: strongly disagree, disagree, neutral, agree, strongly agree), which leads to a distress scale. In the current sample $\alpha$ was 0.82 for positive symptoms and 0.82 for distress. This was completed at all time points.

The Family Affluence Scale (FAS) (Currie et al., 1997) measures SES of the home environment of adolescents using questions such as “During the past 12 months, how many times did you travel away on holiday with your family?” (Not at all, once, twice, more than twice) and “Does your family own a car, van or truck?” (No, Yes one or Yes two or more). This was completed only at the start of the study.

The Index of Financial Stress (IFS) (Siahpush and Carlin, 2006) measures financial difficulties over the past six months using questions such as “Was unable to heat home” and “Went without meals” answered “Yes” or “No” $\alpha = 0.72$. This was completed at all time points.

Questions were developed to ask about age, gender and ethnicity. The following questions were also developed to ask about financial variables:

- Approximately how much do you currently owe overall for your student loan? (Entered as a free text number and then converted into categorical based on the median).
- Approximately how much money do you owe apart from student loan, i.e. overdraft, credit card, other loans, borrowing from friends, etc? (Entered as a free text number and then converted into categorical based on the median).
- How stressed do you feel about your level of debt? (Not stressed, a little stressed, quite stressed, very stressed).
- Have you seriously considered abandoning your course because of financial difficulties (For example talking to your tutor about doing so, looking into career options, etc.) (Yes/No).

**Statistical analyses**
Hierarchical multiple linear regression was used to see whether IFS, FAS, demographic and financial variables predicted PQB scores at baseline. Significant financial variables were then entered into a regression to see whether these variables remained significant predictors of PQB scores over time.

Variables were considered outside of normal distribution if skewness and kurtosis were outside of \([-2/\pm2\). The FAS and PQB positive symptoms were normally distributed. The PQB Distress scale had high kurtosis (3.96) though skewness was in normal range (1.78). The IFS similarly had normal skewness (1.4) but kurtosis just outside of the normal range (2.1). Data of high kurtosis cannot be transformed, the data can be transformed into categorical variables, however logistic regression should not be used to examine the same participant (Field, 2009, p. 273), and both the IFS and PQB symptoms were required to be continuous variables as they were dependent variables. Thus they were kept as a continuous variable both as a DV and an IV, acknowledging the limitations of doing a linear regression analysis with non-normally distributed data.

**Results**
*Participant characteristics*
A total of 408 participants took part in the study; Figure 1 shows a flow diagram of their participation in the study. The larger cohort study from which this data are drawn only introduced the PQB as a measure after its initial time point, as this measure had not yet been published: hence the sample size here is smaller than for the larger study (Richardson et al., 2015). Table I displays the demographic characteristics of the sample.

![Flow diagram of participant inclusion in study](image)
Baseline predictors

Table II displays the baseline linear regressions at baseline for PQB positive symptoms and distress total. The only variable which was a significant predictor on its own was scores on the IFS scale: higher scores on this predicted higher score on both PQB distress and PQB positive symptoms after controlling for demographic variables.

Baseline finances predicting later psychotic symptoms

As IFS was the only significant predictor at baseline this was entered along with baseline PQB scores and demographic variables of age, gender and ethnicity, to see whether baseline financial stress predicted time 2 psychotic symptoms after controlling for baseline psychotic symptoms. Higher IFS scores at baseline significantly predicted higher scores on PQB positive symptoms: $\beta = 0.10, p < 0.05$ and PQB distress $\beta = 0.12, p < 0.05$ at time 2.

The IFS was then entered into a regression along with demographic variables to see whether this predicted time 3 psychotic symptoms. Higher IFS scores at time 2 did not significantly predict time 3 psychotic symptoms.

### Table I  Participant characteristics

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>% (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>78.1 (318)</td>
</tr>
<tr>
<td>Male</td>
<td>21.9 (89)</td>
</tr>
<tr>
<td>Age (years)</td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>19.9 (4.68)</td>
</tr>
<tr>
<td>Range</td>
<td>17-57</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>White British or white other</td>
<td>90.4 (268)</td>
</tr>
<tr>
<td>Asian/Asian British</td>
<td>1.5 (6)</td>
</tr>
<tr>
<td>Black British/Black other</td>
<td>1.2 (5)</td>
</tr>
<tr>
<td>Mixed ethnicity</td>
<td>5.4 (22)</td>
</tr>
<tr>
<td>Other ethnicity</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Do not state</td>
<td>0.5 (2)</td>
</tr>
<tr>
<td>Self-report disability</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>9.8 (40)</td>
</tr>
<tr>
<td>No</td>
<td>90.2 (367)</td>
</tr>
<tr>
<td>Mature student</td>
<td></td>
</tr>
<tr>
<td>Mature student</td>
<td>11.1 (45)</td>
</tr>
<tr>
<td>Not a mature student</td>
<td>88.9 (362)</td>
</tr>
<tr>
<td>Park of UK live in prior to university</td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>73.5 (299)</td>
</tr>
<tr>
<td>Wales</td>
<td>2.9 (12)</td>
</tr>
<tr>
<td>Scotland</td>
<td>21.6 (88)</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>2 (8)</td>
</tr>
<tr>
<td>Area of degree</td>
<td></td>
</tr>
<tr>
<td>Business or Law</td>
<td>7.1 (29)</td>
</tr>
<tr>
<td>Humanities</td>
<td>24.8 (101)</td>
</tr>
<tr>
<td>Medicine</td>
<td>4.4 (18)</td>
</tr>
<tr>
<td>Nursing</td>
<td>1.5 (6)</td>
</tr>
<tr>
<td>Other health professions</td>
<td>1.7 (7)</td>
</tr>
<tr>
<td>Maths/Economics</td>
<td>5.9 (24)</td>
</tr>
<tr>
<td>Sciences</td>
<td>17.4 (71)</td>
</tr>
<tr>
<td>Human/Social sciences</td>
<td>22.9 (93)</td>
</tr>
<tr>
<td>Engineering</td>
<td>3.7 (15)</td>
</tr>
<tr>
<td>Other</td>
<td>10.6 (43)</td>
</tr>
</tbody>
</table>

**Note:** Please note not all numbers will add up to 408 as data were missing for a small number of participants.
predict higher scores on PQB positive symptoms at time 3: $\beta = 0.10, p > 0.05$. However, higher IFS scores at time 2 did significantly predict higher scores on PQB distress at time 3 $\beta = 0.13, p < 0.05$.

Baseline psychotic symptoms predicting later finances

In order to examine whether baseline psychotic symptoms increased the risk of later financial difficulties, baseline PQB scores were entered into a model with demographics and baseline IFS to predict time 2 IFS scores. Higher IFS at baseline were significantly predicted by IFS at baseline: $\beta = 0.67, p < 0.001$, but not by baseline PQB positive symptoms ($\beta = 0.15, p > 0.05$) or distress total ($\beta = 0.02, p > 0.05$).

A regression was conducted to see whether time 3 IFS was predicted by demographics, time 2 PQB scores and time 2 IFS. Higher IFS at time 3 was significantly predicted by being aged 19 or older compared to those aged 17/18: $\beta = 0.19, p < 0.05$, non-white ethnicity: $\beta = 0.14, p < 0.01$ and time 3 IFS score: $\beta = 0.47, p < 0.001$. There was no impact of time 2 PQB positive symptoms ($\beta = −0.07, p > 0.05$) or distress total ($\beta = 0.22, p > 0.05$).

Discussion

This paper examined whether financial difficulties exacerbated psychosis risk in British undergraduate students. Lower family affluence did not appear to have an impact, against previous findings on greater likelihood of low SES in psychosis (Werner et al., 2007). There was also no impact of student loan amount or amount of other debt. This is surprising as previous studies have shown higher total debt is related to poor mental health in students (Richardson et al., 2013), however this is the first study to examine the impact on psychosis.

How stressed individuals were about debt and whether they had considered abandoning university due to financial reasons were also not related to psychosis risk. Previous research using this cohort found that considering dropping out for financial reasons increased depression (Richardson et al., 2017), and other studies have shown that worry and concern about debt impacts general mental health in students (Cooke et al., 2004). Broader stress has also been considered to increase the vulnerability to psychosis in those who are vulnerable (Corcoran et al., 2002). It may be that different financial variables impact different mental health issues in unique ways within this population,

Table II  Individual predictors from baseline regression models

<table>
<thead>
<tr>
<th>Overall model</th>
<th>PQB positive Symptoms</th>
<th>PQB distress Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>$n$</td>
<td>354</td>
<td>330</td>
</tr>
<tr>
<td>$F$</td>
<td>3.0*</td>
<td>4.0**</td>
</tr>
<tr>
<td>$df$</td>
<td>9,344</td>
<td>9,320</td>
</tr>
<tr>
<td>$R^2$</td>
<td>0.07</td>
<td>0.10</td>
</tr>
</tbody>
</table>

Individual predictors ($\beta$)

<table>
<thead>
<tr>
<th>Predictor</th>
<th>PQB positive Symptoms</th>
<th>PQB distress Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (female)</td>
<td>0.05</td>
<td>−0.20</td>
</tr>
<tr>
<td>Age (17/18 vs 19+)</td>
<td>−0.04</td>
<td>−0.02</td>
</tr>
<tr>
<td>Ethnicity: (white) vs BME</td>
<td>−0.04</td>
<td>−0.04</td>
</tr>
<tr>
<td>Family affluence scale</td>
<td>−0.06</td>
<td>−0.10</td>
</tr>
<tr>
<td>Index financial stress</td>
<td>0.26**</td>
<td>0.31**</td>
</tr>
<tr>
<td>(No non-student loan debt) vs Any non-student loan debt</td>
<td>0.01</td>
<td>−0.05</td>
</tr>
<tr>
<td>(Total student loan currently &lt; £7,500) vs Total student loan currently £7,500+</td>
<td>0.00</td>
<td>−0.02</td>
</tr>
<tr>
<td>(Have not considered abandoning university for financial reasons) vs Considered abandoning university for financial reasons</td>
<td>−0.02</td>
<td>−0.05</td>
</tr>
<tr>
<td>(Not stressed about debt) vs A little, quite or very stressed about debt</td>
<td>−0.02</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Notes: Dummy variables are shown in parenthesis. Where $\beta$ values are + the comparison variable predicts a higher score, where $\beta$ is −, the dummy variable predicts a higher score. Please also note the sample sizes are smaller than in the flow diagram as participants were excluded if they had any missing data. *p < 0.01; **p < 0.001
with financial stress not being linked to mental health as strongly as broader stress levels. However, it could be that the one item question about stress about finances used in the current study was not sensitive enough, and using a standardised measure such as the Perceived Financial Wellness Scale (Prawitz et al., 2006), might have shown an impact of about stress and worry about finances.

Greater financial difficulties such as being unable to pay the bills predicted greater positive symptoms and distress. This held after controlling for demographic variables and baseline psychotic symptoms suggesting that financial difficulties in students exacerbate the risk of psychosis over time. There was no evidence of reverse causality: demographic variables predicted worsening of finances over time but there was no impact of psychotic symptoms. Thus, it does not appear that those who are at higher risk for psychosis are poorer at financial management or less likely to earn to support themselves than other students.

Financial difficulties were a predictor of psychosis risk, in line with previous studies from this cohort showing that financial difficulties impacted eating disorder risk, anxiety, global mental health and alcohol problems over time (Richardson et al., 2017). The finding that financial difficulties are more important than amount of debt is in line with wider findings outside of student populations: Selenko and Batinic (2011) found that financial strain rather than amount of debt predicted worse global mental health. Surveys of students have also found that students are more likely to worry about short-term finances such as being able to pay bills than longer term finances such as student loan (NASMA, 2016).

**Limitations**

A number of limitations in this study need to be acknowledged. First the study is limited by a predominately white and female sample, which may not be representative of the UK student population as a whole. The longitudinal nature of the study could have resulted in a potential selection bias. This will be predominately due to attrition at each measure’s time point. The time period of follow-up is also relatively short so the longer term impact of finances on student’s mental health is not known. Next several regressions were run increasing the risk of developing a type I error, and some data are not normally distributed so not ideal for a linear regression. The IFS asks about the past six months thus there is a potential overlap between time points. There is a relatively low sample size for the follow-up analyses which may reduce statistical power. Lastly, these findings do not necessarily apply to those with established psychosis.

**Conclusions**

Financial difficulties appear to increase psychosis risk over time in a student population, with no evidence of psychosis risk worsening financial situation over time. Other financial variables previously shown to be important for other mental health issues such as amount of debt do not appear to be important for psychotic symptoms. Future research is needed to confirm this finding in light of the limitations stated above. In particular a larger sample size with a longer follow-up period is required. Health professionals as well as financial advisors working with students should be aware of the potential link between financial difficulties and psychosis risk. Budgeting interventions which help students live within their means might help reduce risk of psychosis in some students.

**References**


**Further reading**


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Looking into some of the risk factors of mental health: the mediating role of maladaptive schemas in mothers’ parenting style and child anxiety disorders

Narges Adibsereshki, Mahdi Abdollahzadeh Rafi, Maryam Hassanzadeh Aval and Hassan Tahan

Abstract
Purpose – Anxiety disorders have a high prevalence in children. Those children with anxious symptoms are more likely to experience significant disruption in their lives. This disruption can interrupt or even stop a child from participating in a variety of typical childhood experiences. It is understood that genetic and environmental factors may cause this disorder. The purpose of this paper is to focus on environmental factors, namely, the mediating role of maladaptive schemas in mothers’ child-rearing and childhood anxiety disorders.

Design/methodology/approach – This study used correlation-modeling to assess the analysis. The sample included 326 students (aged 9-12 years old) and their mothers. The parenting style (Baumrind, 1973), Early Maladaptive Schema (Rijkeboer and de Boo, 2010), and anxiety disorders (Munis et al., 2006) questionnaires were used in this study.

Findings – The results showed a relationship between parenting styles of mothers and childhood anxiety disorders, a significant correlation between childhood maladaptive schemas and childhood anxiety disorders, a relation between child-rearing styles and childhood maladaptive schemas, and finally a mediating role on childhood anxiety disorders and mothers’ child-rearing styles for some childhood maladaptive schemas.

Originality/value – This research contributes to the knowledge base of the importance of children’s mental health. The paper analyzes the relationship of mothers’ parenting styles and children’s anxiety. It also focuses on maladaptive schemas as a mediator and its relationship with childhood anxiety disorders.

Keywords Anxiety disorders, Early Maladaptive Schemas, Parenting styles (child-rearing)

Paper type Research paper

Introduction
The prevalence of anxiety disorders in children and adolescents is between 5 and 30 percent (Copeland et al., 2014), which in Iran is about 10 percent (Ghaamaari et al., 2009). These disorders are usually characterized by children or adolescents frequently experiencing anxiety symptoms, including intense negative emotions and fear (Mash and Wolf, 2010). Understandably, these disorders have a huge impact on patients’ daily lives (Antony et al., 1998). Anxiety disorders can also create undesirable consequences later in life, such as poor compatibility at work, poor family relationships and related problems, low life satisfaction, poor coping skills, chronic stress, alcohol and drug abuse, and anxiety in adulthood (Essau et al., 2014; Abdollahzadeh Rafi, 2014).

Hereditary and environmental factors have been linked to children’s anxiety disorders. Some studies have raised the issue of inheritance (Stein et al., 2002; Robinson et al., 1992). DiLalla et al. (1994) studied twins and revealed that the probability of developing anxiety disorders in the twins of one egg and in the twins of two eggs is similar, leading to the conclusion that environmental
influences may play a larger role in developing anxiety disorders than genetic ones. Even though genetic can have an impact on some individual’s characteristic (mood) which is related to anxiety (Fox et al., 2005), and congenital disorders such as hypothyroid diseases may lead to neuropsychiatric symptoms including anxiety and depression (Kurian and Jungbluth, 2014), about 30 percent of anxiety disorders are inheritable (Gregory and Eley, 2007). Among the environmental factors, family influences such as parents’ negative practices have been associated with childhood anxiety in children (Bögels and Brechman-Toussaint, 2006). By examining how parents interact with preschool children, Baumrind (1971) found that the level of control exhibited by parents with their children can be categorized along three parenting styles: authoritative, authoritarian, and permissive. Each style involves different limitations and rules, control of power, and emotional supports provided to children by parents. Using any of these approaches can have different effects on the physical and mental growth of children.

Based on the studies carried out by Baumrind (1991), children of authoritative parents grow better and have positive characteristics. They are responsible and competent and have high self-esteem, good self-control, and fewer problematic behaviors. They also experience fewer antisocial behaviors (Siegler et al., 2006) and more positive adjustment at school and are more vivacious and happy (Furnham and Cheng, 2000; Steinberg et al., 2006) and have fewer mental problems (Wolfradt et al., 2003; Xia and Qian, 2001).

The permissive parenting style is a peaceful but uninhibited style. Parents who use this method are very lenient, very sensitive, and responsive to the needs and demands of their children. They do not punish their children and are compliant with their impulses, behaviors, and demands (Baumrind, 1971). There is a positive relationship between the use of permissive parenting styles and internalized problems (e.g. anxiety disorders and mood disorders) in children (Tan et al., 2012).

Authoritarian parents are very restrictive, impose many rules on their children, and want them to obey unconditionally. They do not explain to their children the importance of making those rules. They try to limit their children’s freedom and, in fact, impose a lot of control over them (Baumrind, 1971). Punishment, threatening, and aggressive approaches are used to make children follow their rules, accept their words, and respect their experiences (Shaffer and Kipp, 2013). Studies about authoritarian parents have indicated that their children are afraid of being compared with others; have poor communication skills, lower inner spontaneity (Santrock, 2004), and lower self-esteem (Siegler et al., 2006); and suffer from more mental health problems, such as somatization, obsession, interpersonal sensitivity, anxiety, hostility, and phobia (Xia and Qian, 2001).

Lindhout et al.’s (2009) study about the effect of parenting styles (authoritative, authoritarian, and permissive) revealed that using some of these parenting styles could be the cause of child anxiety disorders. A study by Tergaonkar and Wadkar (2007) reported a significant negative correlation between anxiety and authoritative parents’ attitudes and acceptance and a significant positive correlation between anxiety and authoritarian and permissive parents’ attitudes.

Early research tended to focus on mothers being responsible for the adjustment of their children and adolescents. Recently, research has focused on both parents. These studies have considered fathers’ relationships with children and family (Marsiglio et al., 2004; Meuwissen and Carlson, 2015), the mothers’ parenting impact (Stright and Yeo, 2014) and both (McKinney and Renk, 2008; Bosco et al., 2003; Lungarini, 2015). McKinney and Reck’s (2008) study showed that a permissive father’s parenting style with an authoritarian mother is related to late adolescents’ emotional adjustment, and late adolescents who have one authoritative parent show better adjustment than those who do not have such a parent. In regard to mothers’ parenting style and their children, Bosco et al. (2003, p. 182) stated the following:

Children who perceived their mothers as using a discouraging parenting style may have a child with more behavior problems and less child social competence. Moreover, these children reported less scholastic and athletic ability, less confidence in physical appearance, low global self worth, and low social support from parents, teachers, and close friends (Scherer et al., 1996).

How parenting styles lead to anxiety in children is still controversial. Young et al. (2003) suggested that Early Maladaptive Schemas (EMSs) are associated with adverse childhood experiences and
that the severity of the experiences is associated with the severity of maladaptive schemas. Cognitive theory states that each type of emotional disturbance is related to a unique cognitive profile characterized by specific cognitive content (Beck, 1976). In depression, the predominant cognitive theme is assumed to be about negative self-evaluation, loss, and deprivation (Clark et al., 1999), and the primary beliefs in relation to anxiety are about physical or psychological threats (Beck et al., 1985). It is assumed that maladaptive schemas may come from four horrible childhood experiences (emotional deprivation/rejection, damages/victimization, too much support/interfering from the guardians, and giving lots of attention to others) which prevent the child reach the basic emotional needs (Young et al., 2003). He suggested that the most powerful schemas, such as indifference, instability, mistrust, abuse, emotional deprivation, failure, and shame, are formed in children because of early damages and scars in childhood. Young originally outlined 15 maladaptive schemas that differed in content, which can be grouped into five schema domains: disconnection/rejection, impaired autonomy/performance, impaired limits, directedness, and over-vigilance/inhibition. It seems that all schemas correlated significantly with internalizing and externalizing problem behavior. Nearly all schemas related significantly with symptoms of anxiety, depression, oppositional defiance, and conduct disorder (Van Vlierberghe et al., 2010).

Other studies have investigated the relationship between EMSs and parenting styles. Kooraneh and Amirsardari (2015) indicated that Baumrind’s parenting styles are significant predictors of EMSs. An authoritarian parenting style could positively predict EMSs in the area of rejection/disconnection and other-direction. Permissive parenting style did not predict EMSs. Baumrind’s authoritative maladaptive schemas parenting styles could negatively predict schemas in the area of rejection/disconnection.

Some research works have explained the mediating role of some schemas in the pathways of some psychological problems. One study (Lee, 2007) on the mediating effects of maladaptive cognitive schemas between socially prescribed perfectionism and depression or anxiety indicated that some schemas, such as fear of abandonment and failure to achieve, mediate the relationship between socially prescribed perfectionism and anxiety. Also, the vulnerability to harm schema indirectly influences the association through fear of abandonment. Young et al. (2003) described a situation in which a child is abused or victimized, and schemas such as mistrust/abuse, defectiveness/shame, or vulnerability to losses would be formed in his or her mind. Since each person judges his/her daily life experiences according to his/her mental schemas, a child who formed mistrust or abuse schemas expects others to harm, abuse, humiliate, and lie to him or her.

Given these facts the literature demonstrates that there is a relationship between parenting style and some anxiety disorders, and Young et al. (2003) has insisted on maladaptive schemas as the main reason behind psychological or mental disorders. This perspective and its assumptions should be investigated through research. Anxiety is a mental disorder which could have an immense impact on children’s health. For the development of good families, the mother plays a vital role. It would be very helpful to know if mother’s child-rearing can directly lead to this disorder or indirectly by maladaptive schemas. To our knowledge, there is not any research looking at the role of schemas in the relationships of mothers’ parenting style and child anxiety disorders. This study aims to highlight the impact of mothers’ parenting styles and practices on anxiety disorders of their children and whether maladaptive schemas could have a mediating role in the development of such disorders.

Method

This study used correlation-modeling to assess the analysis. In total, 326 students aged 9-12 and their mothers who had the required criteria (i.e. student’s age, mothers’ confidence, and ability to fill out the questionnaire) were chosen for this research. Of the three districts available in Tehran (north, center, and south), the sample was recruited from schools in the center district (all families are almost the same educationally, culturally, and economically). The students included 170 boys (52.1 percent) and 156 girls (47.9 percent). In terms of grades, 83 students (25.5 percent) were in 3rd, 85 (26.1 percent) in 4th, 78 (23.9 percent) in 5th, and 80 (24.5 percent) in 6th grade.
The mean and standard deviation for students’ age were 10.48 and 1.12 and their mothers’ age were 38.4 and 5.73. In all, 89 percent of mothers were housekeepers while 11 percent were employed. Their education level were such that 40 did not have high school diploma, 206 had a high school diploma, and 80 had attained an undergraduate degree or higher. All of them were married and lived with their husband.

This study was a correlation type and a scope or spectrum (not a specific level of severity) of anxiety disorders was considered to find the relationship between mothers’ parenting style and child anxiety (direct or indirect by maladaptive schemas). We invited mothers to the schools and explained our study to them. After receiving mothers and their children agreement, we asked mothers to fill out the parenting style questionnaire and their children fill out anxiety and maladaptive schemas questionnaires.

The parenting style questionnaire provided by Baumrind (1973) was used in the study. There are 30 questions about parenting style (authoritative, authoritarian, and permissive) and mothers filled it out by selecting the answers between five choices from completely agree to completely disagree. Leilabadi (1997) standardized this test and reported Cronbach’s α for the subscales; permissive (0.81), authoritarian (0.86), and authoritative (0.78). Cronbach’s α for the subscales in this study reported as: permissive (0.86), authoritarian (0.88), and authoritative (0.84).

The anxiety disorders questionnaire by Muris et al. (2006), which is designed for individuals 8-18 years old, was also used. There are 41 questions about physical phobia, generalized anxiety, separation anxiety, social, and school phobias which were answered by students choosing between three choices: never, sometimes, and often. Cronbach’s α was reported as 0.90. Khanjani et al. (2014) used the concurrent validity and found a significant relationship between Morris anxiety questionnaire and children anxiety scale. They used internal consistency and reported α = 0.90. For this study, α = 0.88 was reported.

The EMSs questionnaire, which is based on Young’s work and designed by Rijkeboer and de Boo (2010) for children aged 8-13, was used. There are 40 questions about childhood maladaptive schemas (loneliness, vulnerability to harm or illness, mistrust/abuse, defectiveness/shame, unrelenting standards, enmeshment, entitlement/grandiosity, insufficient control, failure, submission, and self-sacrifice) which were filled out by students. Cronbach’s α was between 0.53 and 0.79. Montezeri et al. (2012) used internal consistency and reported overall α = 0.95 and α for subscales between 0.85 and 0.90. In this study α = 0.84 and α for the subscales were between 0.80 and 0.86.

The Kolmogorov-Smirnov statistic was used to indicate normal distribution of data. Pearson’s correlation was used to show the relationships between variables and path analysis was used to investigate the role of schemas.

Results

Kolmogorov-Smirnov statistic indicated that the distribution of variables were normal (p > 0.05). Table I shows that there was not a significant correlation between mothers’ authoritative parenting style and the child anxiety disorder (p > 0.05). On the other hand, there was a positive

<table>
<thead>
<tr>
<th></th>
<th>Authoritative</th>
<th>Authoritarian</th>
<th>Permissive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical fear</td>
<td>−0.09</td>
<td>0.12*</td>
<td>0.03</td>
</tr>
<tr>
<td>Social phobia</td>
<td>−0.06</td>
<td>0.18*</td>
<td>0.04</td>
</tr>
<tr>
<td>Generalized anxiety</td>
<td>−0.07</td>
<td>0.13*</td>
<td>0.03</td>
</tr>
<tr>
<td>Separation anxiety</td>
<td>−0.06</td>
<td>0.17**</td>
<td>0.11*</td>
</tr>
<tr>
<td>School anxiety</td>
<td>−0.03</td>
<td>0.05</td>
<td>0.13*</td>
</tr>
<tr>
<td>Total</td>
<td>−0.06</td>
<td>0.16**</td>
<td>0.04</td>
</tr>
</tbody>
</table>

Notes: Authoritative: n = 305; authoritarian: n = 290; permissive: n = 300. *p < 0.05; **p < 0.001
correlation between mothers’ authoritarian parenting and child anxiety \((p < 0.05)\), except for school anxiety \((r = 0.05, p > 0.05)\). There was not a significant correlation between mother’s permissive style and child anxiety disorders except for separation anxiety \((r = 0.11, p < 0.05)\) and school anxiety \((r = 0.13, p < 0.05)\).

Table II indicates that there was not a significant correlation between mothers’ authoritative parenting style and child maladaptive schemas \((p > 0.05)\) except with vulnerability to harm \((r = -0.13, p < 0.05)\) and entitlement/grandiosity \((r = -0.18, p < 0.05)\). There was a positive correlation between mothers’ authoritative parenting and children’s maladaptive schemas \((p < 0.05)\) except vulnerability to harm \((r = 0.08, p > 0.05)\), mistrust/abuse \((r = 0.03, p > 0.05)\), and unrelenting standards \((r = 0.03, p > 0.05)\). There was a significant correlation between mothers’ permissive style and children’s maladaptive schemas \((p < 0.05)\) except with submission \((r = 0.10, p > 0.05)\), entitlement/grandiosity \((r = 0.02, p > 0.05)\), and self-sacrifice \((r = 0.03, p > 0.05)\).

Table III shows that there were significant correlations between children’s maladaptive schemas and anxiety disorders \((p < 0.001)\). Social phobia was related to entitlement/grandiosity \((r = 0.20, p < 0.05)\) and vulnerability \((r = 0.17, p < 0.05)\). For the incompetence schema and school anxiety, the correlation was not significant \((r = 0.09, p > 0.05)\).

For the path analysis, a model consisted of some schemas with significant relation to different parenting styles and anxiety disorders was examined. This model did not fit appropriately.

### Table II

<table>
<thead>
<tr>
<th></th>
<th>Authoritative</th>
<th>Authoritarian</th>
<th>Permissive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loneliness</td>
<td>-0.03</td>
<td>0.17**</td>
<td>0.21**</td>
</tr>
<tr>
<td>Vulnerability to harm</td>
<td>-0.16**</td>
<td>0.08</td>
<td>0.19**</td>
</tr>
<tr>
<td>Mistrust/Abuse</td>
<td>-0.09</td>
<td>0.03</td>
<td>0.14*</td>
</tr>
<tr>
<td>Defectiveness/Shame</td>
<td>-0.05</td>
<td>0.13*</td>
<td>0.16**</td>
</tr>
<tr>
<td>Submission</td>
<td>-0.01</td>
<td>0.12*</td>
<td>0.10</td>
</tr>
<tr>
<td>Enmeshment</td>
<td>-0.01</td>
<td>0.16**</td>
<td>0.13*</td>
</tr>
<tr>
<td>Entitlement/Grandiosity</td>
<td>-0.18**</td>
<td>0.11</td>
<td>0.02</td>
</tr>
<tr>
<td>Insufficient control</td>
<td>0.01</td>
<td>0.20**</td>
<td>0.15</td>
</tr>
<tr>
<td>Failure</td>
<td>-0.01</td>
<td>0.12*</td>
<td>0.16**</td>
</tr>
<tr>
<td>Unrelenting standards</td>
<td>0.07</td>
<td>0.03</td>
<td>0.14</td>
</tr>
<tr>
<td>Self-sacrifice</td>
<td>0.02</td>
<td>0.33**</td>
<td>0.03</td>
</tr>
</tbody>
</table>

**Notes:** Authoritative: \(n = 307\); authoritarian: \(n = 292\); permissive: \(n = 302\). *\(p < 0.05\); **\(p < 0.00\)

### Table III

<table>
<thead>
<tr>
<th></th>
<th>Physical harm fear</th>
<th>Social phobia</th>
<th>Generalized anxiety</th>
<th>Separation anxiety</th>
<th>School anxiety</th>
<th>Anxiety disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loneliness</td>
<td>0.29**</td>
<td>0.24**</td>
<td>0.31**</td>
<td>0.08</td>
<td>0.14*</td>
<td>0.30**</td>
</tr>
<tr>
<td>Vulnerability</td>
<td>0.33**</td>
<td>0.30**</td>
<td>0.31**</td>
<td>0.20**</td>
<td>0.18**</td>
<td>0.36**</td>
</tr>
<tr>
<td>Mistrust/Abuse</td>
<td>0.23**</td>
<td>0.16**</td>
<td>0.21**</td>
<td>0.08</td>
<td>0.18**</td>
<td>0.30**</td>
</tr>
<tr>
<td>Defectiveness</td>
<td>0.28**</td>
<td>0.18**</td>
<td>0.30**</td>
<td>0.07</td>
<td>0.21**</td>
<td>0.28**</td>
</tr>
<tr>
<td>Submission</td>
<td>0.39**</td>
<td>0.23**</td>
<td>0.41**</td>
<td>0.01</td>
<td>0.21**</td>
<td>0.34**</td>
</tr>
<tr>
<td>Enmeshment</td>
<td>0.29**</td>
<td>0.23**</td>
<td>0.36**</td>
<td>0.04</td>
<td>0.15**</td>
<td>0.29**</td>
</tr>
<tr>
<td>Entitlement/Grandiosity</td>
<td>0.32**</td>
<td>0.22**</td>
<td>0.25**</td>
<td>0.17**</td>
<td>0.14*</td>
<td>0.31**</td>
</tr>
<tr>
<td>Insufficient self-control</td>
<td>0.19**</td>
<td>0.11</td>
<td>0.27**</td>
<td>0.06</td>
<td>0.18**</td>
<td>0.21**</td>
</tr>
<tr>
<td>Failure</td>
<td>0.29**</td>
<td>0.19**</td>
<td>0.30**</td>
<td>0.06</td>
<td>0.14*</td>
<td>0.29**</td>
</tr>
<tr>
<td>Unrelenting standards</td>
<td>0.22**</td>
<td>0.19**</td>
<td>0.31**</td>
<td>0.03</td>
<td>0.09</td>
<td>0.23**</td>
</tr>
<tr>
<td>Self-sacrifice</td>
<td>0.23**</td>
<td>0.14*</td>
<td>0.27**</td>
<td>0.01</td>
<td>0.12*</td>
<td>0.21**</td>
</tr>
</tbody>
</table>

**Notes:** \(n = 324\). *\(p < 0.05\); **\(p < 0.001\)
With eliminating an insignificant path, the model was tested again and the new model was fitted properly. This model has answered the research question about the mediating role of maladaptive schemas in the relationships of mothers’ parenting style and child anxiety disorders. Considering the fit model, authoritative parenting did not have a direct impact on anxiety disorders but indirectly had an effect by impacting vulnerability to harm/illness ($\beta = -0.13$, $p < 0.05$). The permissive parenting also did not have a direct effect on anxiety disorders but indirectly by impacting vulnerability to harm ($\beta = 0.18$, $p < 0.05$). Also, defectiveness schemas had an impact on anxiety disorders ($\beta = 0.11$, $p < 0.05$) and authoritarian parenting had direct ($\beta = 0.22$, $p < 0.05$) and indirect (by affecting incompetence) impacts on anxiety disorders (Table IV and Figure 1).

**Discussion**

The findings of this study indicate that there is a relationship between a mother’s parenting style and child anxiety disorders. The results are consistent with Lindhout et al. (2009), Scherer et al. (1996), Phares and Renk (1998), Brown and Whiteside (2008), Tergaonkar, Wadkar (2007), and Wolfradt et al. (2003). Parental authority was positively correlated with adaptation activities and negatively correlated with anxiety in adolescents. For authoritarian and permissive parenting styles, the highest scores belonged to depression and anxiety, and the group with authoritative parenting style gained the highest scores in adaptation. Studies on perception of adolescents about their mothers’ mental health were significantly related to children’s psychological functioning (Scherer et al., 1996) and high levels of negative feelings toward parents were associated with greater levels of total behavior problems (Phares and Renk, 1998).

<table>
<thead>
<tr>
<th>Table IV</th>
<th>Direct and indirect pathways of mother’s parenting styles, schemas, and anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Standardized $\beta$</td>
</tr>
<tr>
<td>Authoritative</td>
<td>Vulnerable to harm and illness</td>
</tr>
<tr>
<td>Authoritarian</td>
<td>Anxiety disorders</td>
</tr>
<tr>
<td>Permissive</td>
<td>Incompetence</td>
</tr>
<tr>
<td>Vulnerable to harm and illness</td>
<td>Anxiety disorders</td>
</tr>
<tr>
<td>Defectiveness</td>
<td>Anxiety disorders</td>
</tr>
<tr>
<td>Incompetence</td>
<td>Anxiety disorders</td>
</tr>
</tbody>
</table>

**Figure 1** Model of fit indicators of mothers’ parenting style and anxiety disorder

Notes: $\chi^2 = 6.72; p = 0.666; GFI = 0.996; CFI = 0.998; RMSEA = 0.001; NFI = 0.985
The outcome of this study shows that permissive mothers’ parenting style is correlated with separation anxiety and school phobia in children. Permissive parents usually allow their children to behave inappropriately without monitoring them. Outside their home, these children cannot be satisfied fulfilling their needs, especially in school where many rules and expectations can be annoying to them. As a result, separation from their parents can be disturbing and moreover, the school environment can be daunting for them (Siegler et al., 2006). Also, by increasing the score of the authoritarian parenting style in mothers, anxiety disorders (except for school phobia) were increased in children. The reason why school phobia did not increase may be a result of schools providing an environment for the children to just stay away from the source of harassment and intimidation for some hours.

The findings of our study represent a significant positive relationship between a mother’s authoritarian parenting and maladaptive schemas such as loneliness/abandonment, defectiveness, submission, enmeshment, low self-control, and failure. Also, there was a significant relationship between permissive parenting and child maladaptive schemas such as loneliness, vulnerability, mistrust, defectiveness, unrelenting standards, insufficient control, and failure, but no significant correlation with submission, entitlement, and self-sacrifice schemas. These findings are consistent with Young et al. (2003). According to them, using permissive parenting practices leads to schemas of dependence/incompetence or entitlements/magnanimity. Permissive parents usually have excessive support for their children and as a result the kids may rely on them most of the time and will grow incompetent and dependent.

The positive correlation between maladaptive schemas and anxiety disorders in our results are consistent with Fard et al. (2014), Calvete et al. (2015), Pinto-Gouveia et al. (2006), Calvete et al. (2013), and Abdollahzadeh Rafi et al. (2017). Fard et al. (2014) found that child anxiety was mainly predicted by the child schemas of loneliness, submission, and vulnerability. Other analysis indicated a relationship between EMSs and anxiety, between schemas such as abandonment, rejection, lack of self-determination, and social anxiety of teenagers. The schemas of mistrust/abuse, emotional deprivation, and strict criteria can explain the variance of the anxiety too.

In regard to the question of whether maladaptive schemas of childhood have a mediating role in the relationship between mothers’ parenting style and child anxiety disorders, it seems that authoritative and permissive mothers parenting may affect children’s anxiety disorders through some maladaptive schemas while authoritarian parenting affects anxiety disorders directly and also through maladaptive schemas. Mothers’ authoritative parenting has a negative impact on vulnerability schema. When parents have authoritative style, vulnerability schema develops less in children, and as result, the rates of anxiety disorders decrease in them. Mothers’ permissive parenting has positive effect on vulnerability and defectiveness schemas and the impact of these schemas increases the anxiety disorders in children. Authoritarian parenting has a positive impact on the submission schema and this could lead to increase of anxiety disorders. This study also indicated that negative practices of child-rearing (permissive and authoritarian) could have an impact on the development of schemas such as submission, vulnerability and defectiveness, and as result, development of anxiety disorders. These findings are consistent with the predictions of the theory of Young schemas.

The limitation and suggestions

Parenting styles questionnaires were completed just by mothers who may be biased in filling out the form about their child-rearing. It is suggested that in a longitudinal study, observing the way both parents interact with their children and its relationship with maladaptive schemas of the child in teenage years be investigated. The findings of this study can be recommended and used by health professionals, specialists, and teachers who work with mothers, to inform them about the child-rearing approaches that can lead to their child anxiety. In a further study, the relationship between perceived parenting style and maladaptive schemas could be measured and compared. Even though the schools and samples were randomly selected, the roles of peers and teachers should not be ignored.
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Addressing funding issues for Danish mental health NGOs

Nawal Farhat Aguilar and Zaza Nadja Lee Hansen

Abstract

Purpose – Research has shown that non-governmental organizations (NGOs) often fail to appreciate that in their market, donors represent clients. Moreover, the unstable income characteristics of NGOs emphasize the importance of conducting market analysis specific to such organizations. The purpose of this paper is to identify key factors that influence fundraising success for mental health NGOs and determine the most advantageous fundraising approach based on a mixed-methods study that encompass a literature review, two surveys and a case study.

Design/methodology/approach – Based on a structured literature review, the most important factors affecting NGO fundraising are unified into a decision-making framework. This framework is tested using a triangulation approach by combining quantitative and qualitative methods. The former based on a general survey and the latter based on a case study.

Findings – The results highlight 15 key factors determining the optimal approach for mental health NGOs when fundraising in Denmark.

Practical implications – The decision-making framework can be used to assess the most advantageous fundraising approach based on a variety of internal and external circumstances.

Originality/value – While private firms develop exhaustive market analyses, NGOs often lack analyses to cope with fluctuating environments and changing customer needs. This paper addresses this gap by identifying key factors that determine an optimal fundraising approach and proposes a novel decision-making framework for practitioners.

Keywords Fundraising, Case study research, NGO, Stigma, Survey study, Mental health NGO

Paper type Research paper

Introduction

Market analysis studies enable non-governmental organizations (NGOs) to gain competitive advantages in their respective market. However, NGOs often forget that the sustainability mechanisms in their market are equivalent to those of private firms (Arora, 2016).

Some common challenges faced by NGOs include funding, inadequate management expertise, restricted institutional capacity, and low levels of sustainability (Bromideh, 2011). Among these issues, funding is most pressing, since NGOs are characterized by inconsistent revenue. This is exacerbated by stigma surrounding the illnesses with which these NGOs are associated, illnesses often prejudged by a society which can lack both knowledge and empathy, resulting in reduced support (Ma, 2017).

Although academics and private firms have increased their focus on development of market analyses since the 1960s, there are currently no studies focused on the determinants of a NGO’s fundraising capacity. Development of market analysis empowers NGOs to reach donors in order to raise funds and build and sustain networks that endure their growth (Berry, 2005). Given this gap, there is a strong need to identify which factors affect NGOs in order to develop the optimal approach for fundraising. This paper addresses this gap by investigating just this for mental health NGOs.

As such, this paper presents a decision-making framework for practitioners within mental health NGOs to use when formulating fundraising approaches, based on the NGOs internal and
external circumstances. In order to accomplish this, key factors affecting fundraising for NGOs are identified and unified into a decision-making framework derived from a literature review. The key factors are then quantitatively tested with a survey sent to the Danish public and another survey sent to Danish mental health NGOs. Moreover, they are further tested using a qualitative in-depth case study of a mental health NGO in Denmark. The result from these methods is combined in order to validate the proposed decision-making framework.

Literature review[1]

Contingency theory states that a firm needs to find the most profitable performance through an analysis of internal and external factors. Hence, the performance of an organization depends on the external environment and its internal work (Stewart and Luthans, 1977). This theory informs the categorization of fundraising factors shown below.

The literature review was conducted according to the guidelines described by Rowley and Stack (2004). The technique applied for revealing the key factors is the synthesis matrix; this matrix enabled sorting and categorizing the different arguments regarding the topic (Torraco, 2016). The procedure followed in order to fill out the synthesis matrix was citation pearl growing, i.e. retrieving documents through the references in analyzed sources and identifying the main authorities by investigating relevant articles (Rowley and Stack, 2004). This information was cyclically added to the matrix until no more relevant sources emerged.

Internal factors

Internal factors affecting NGO fundraising abilities, existing barriers, and potential solutions are summarized in Table I. NGOs can directly act on these without considering externalities. These factors within the organization influence the approach and success of the NGO’s operation.

External factors

External factors that influence a NGOs performance are summarized in Table II.

<table>
<thead>
<tr>
<th>Key factors</th>
<th>Description</th>
<th>Barriers</th>
<th>Proposed solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative</td>
<td>Expertise of NGO board members and administrative staff (Snow, 2011)</td>
<td>Limited time or expertise resulting in senior staff making decisions without support (Aruna and Thanasundari, 2015; Batti, 2014)</td>
<td>NGOs should select staff with expertise in the field to form a resource mobilization committee to be more likely to receive support from banks (Batti, 2014; WorldBank, 1995)</td>
</tr>
<tr>
<td>resources</td>
<td></td>
<td></td>
<td>Commitment and involvement across all organizational levels to gain advantages and intrinsic values (Grant, 2003; Greenley, 1986)</td>
</tr>
<tr>
<td>Strategic planning</td>
<td>Developing a vision, mission, setting objectives, crafting and implementing a strategy, and evaluating results (Players, 2015)</td>
<td>Limited managerial and organizational capabilities due to lack of technical tools and resources (Adera, 2014)</td>
<td>Commitment and involvement across all organizational levels to gain advantages and intrinsic values (Grant, 2003; Greenley, 1986)</td>
</tr>
<tr>
<td>Governance</td>
<td>Relationship between an organization’s management, board, and other stakeholders (Jordan, 2008)</td>
<td>NGOs have no obvious accountability structures (Lekorwe and Mpabanga, 2007)</td>
<td>Enhance governance and management, due to a growing emphasis on monitoring (Adera, 2014)</td>
</tr>
<tr>
<td>Marketing and</td>
<td>Transmitting a message to its desired market (Doyle, 2011)</td>
<td>Norms dictating styles of marketing communication imposed on NGOs (Sabre, 2011).</td>
<td>Use NGOs’ resources to attract attention (Sabre, 2011)</td>
</tr>
<tr>
<td>communication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human resources</td>
<td>Qualification and employee motivation (Bromideh, 2011)</td>
<td>High unemployment leading to unqualified job seekers, low salaries, and difficulty retaining highly skilled and qualified people (Sokkie, 2013)</td>
<td>Attract, develop, and retain qualified employees (Bromideh, 2011)</td>
</tr>
<tr>
<td>Capacity development</td>
<td>Obtaining, improving, and retaining the skills and knowledge needed, through training, knowledge exchange, etc. (Sorgenfrei, 2004)</td>
<td>Optimization of training cost and effort with foreseen benefits (Ulleberg, 2009)</td>
<td>Align efforts with objectives by focusing capacity development beyond the school, local communities and local NGOs (Ulleberg, 2009)</td>
</tr>
</tbody>
</table>
Decision-making framework for NGO fundraising approaches

A decision-making framework to allow mental health NGOs to analyze their internal performance and evaluate their external environment is illustrated in Figure 1. With this framework, NGOs are able to identify their respective strengths and weaknesses and subsequently develop an optimal fundraising approach.

Table II Description of external factors, barriers and proposed solutions affecting NGOs fundraising

<table>
<thead>
<tr>
<th>Key factors</th>
<th>Barriers</th>
<th>Proposed solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>NGO and private firm relations</td>
<td>Private firms’ conduct may harm a NGO’s reputation and legitimacy (Graf and Rothlauf, 2012)</td>
<td>Private firms and NGOs own dissimilar resources</td>
</tr>
<tr>
<td>Transparency</td>
<td>When NGOs are unaware of their relationship with donors, unclear expectations of credibility may emerge (Walker, 2015)</td>
<td>Donors must be aware of pertinent information (Burger and Owens, 2010)</td>
</tr>
<tr>
<td>NGO and donor relations</td>
<td>NGOs are not motivated by profit-maximization, hence limited temptation to commit illicit activities. Simultaneously, NGOs are averse to sharing information (Elkington, 2003; Farra and Jensen, 1983)</td>
<td>NGOs should enable access to information and establish open communication with stakeholders, increasing understanding of shareholder duties (Gálvez Rodríguez et al., 2012)</td>
</tr>
<tr>
<td>Seasonal aspects</td>
<td>Regional preferences and prejudices based on shared ethnicity, language, or culture can adversely affect potential donors (Tremblay-Boire and Prakash, 2016)</td>
<td>34% of donations take place in October, November and December (Mueller, 2014)</td>
</tr>
<tr>
<td>Philanthropy</td>
<td>Governments should expand explanation of where tax-revenue is directed, since donors might view taxes as charitable giving (Blackman, 2015)</td>
<td>Donors must be aware of pertinent information (Burger and Owens, 2010)</td>
</tr>
<tr>
<td>Taxes</td>
<td>Stigma surrounding mental-illness affects the attitudes and behaviors of the public and some social workers. This is felt in every stage of care, leading to an avoidance of psychiatric help (Melissa A. Hensley, 2006)</td>
<td>Individuals give more frequently to NGOs when they feel their actions are improving the welfare of others (Sargeant and Jay, 2010)</td>
</tr>
<tr>
<td>Social stigma</td>
<td>Since lower socio-economic backgrounds can create empathy for the welfare of others, pro-social behavior can also take place for this social class (Piff et al., 2010; Blascovich et al., 2001)</td>
<td>Societal ignorance is the root cause of this stigma. A shift in mind-set is needed by promoting a scientific understanding of mental-illness (Wig, 1997)</td>
</tr>
<tr>
<td>Donors’ gender</td>
<td>Women tend to be more charitable than men. However, there are strong variations in accordance with marital status (Piper and Schnepf, 2007)</td>
<td>Women tend to be more charitable than men. However, there are strong variations in accordance with marital status (Piper and Schnepf, 2007)</td>
</tr>
<tr>
<td>Socio-economic status</td>
<td>Since lower socio-economic backgrounds can create empathy for the welfare of others, pro-social behavior can also take place for this social class (Piff et al., 2010; Blascovich et al., 2001)</td>
<td>Donors’ gender</td>
</tr>
</tbody>
</table>

Figure 1 Decision-making framework: NGOs fundraising approach
Methods

As the topic is explorative in nature, an in-depth, single-case study approach and explorative surveys were selected as the most suitable research methods to validate the factors and test the framework (Yin, 2009). The case firm is a Danish mental health NGO called DMHNGO (pseudonym used for confidentiality), which works with people suffering from eating disorders and self-harm across eight locations in Denmark. DMHNGO was chosen because its size, structure, and processes are representative for mental health NGOs in Denmark.

All analyzed information originates from different sources, allowing for data triangulation and improves result reliability. Data from the case study was gathered using semi-structured interviews with DMHNGO employees regarding donors and funding, and internal data from DMHNGO (e.g. statistics from their Facebook page, website, and internal databases). The semi-structured interviews lasted around 30 minutes and all permanent staff members of the case firm where interviewed. The interviews followed an interview guide, were tape recorded, transcribed, coded and then analyzed. The interviews were followed up by shorter meetings to clarify points and to get validation of the transcribed interview.

To further validate the framework, two additional quantitative data sources were used in the form of explorative surveys. The survey design and target sample was conducted and chosen following the guidelines for explorative surveys (Bradburn et al., 2004; Dattalo, 2007; Isaac and Michael, 1995). A broad survey sent to the Danish public regarding mental health NGO donation, with extra focus on DMHNGO’s effects within eating disorders and self-harm, and a targeted survey sent out to all 14 Danish mental health NGOs regarding donation (this study contains responses from 12 of them). The first survey was carried out in Google form and consisted of 30 questions separated into seven categories. The survey was distributed by DMHNGO using all their online platforms (including Facebook and e-mail) and also distributed to all Danish municipalities and through the snow ball effect (i.e. sending the survey to one media, person or organization and having them distribute it further). The survey for the Danish mental health NGOs were sent directly to all 14 organizations and was also made in Google Form. It contained two questions and asked the respondents to rate the 15 factors based on importance and flexibility, on scales from 0 to 5.

All obtained data are analyzed following guidelines proposed by Saunders et al. (2009) to ensure proper techniques and procedures for data collection and analysis in order to evaluate the factors proposed in the framework both qualitatively and quantitatively.

The quantitative analysis in computed by using the equation given below:

\[
\text{Importance}_k = \frac{\text{(IF}_k \times \text{PI}_k)}{\sum_{k=1}^{15} (\text{IF}_k \times \text{PI}_k)100}
\]

where the importance of key factor \( k \), \( \text{Importance}_k \), illustrates how much of the total resources the NGO should employ to improve that key factor \( k \). The impact of key factor \( k \), \( \text{IF}_k \), depicts the influence of that factor \( k \) on a NGO’s fundraising approach (on a scale from 1 (lowest impact) to 5 (highest impact)). The potential improvement of key factor \( k \), \( \text{PI}_k \) shows what the gap for improvement of that key factor \( k \) is (on a scale from 1 (least likely to be improved) to 5 (most likely to be improved)).

Results[2]

The survey sent out to the Danish public regarding NGO funding confirmed the above mentioned 15 factors as the main factors influencing NGO donation. Both this survey and the targeted survey to all Danish NGOs confirmed the key barriers associated with these 15 factors.

After the factors in the framework had been validated, the framework itself was tested by using it on the case firm as described in the following section.
Qualitative findings from the case study

Table III depicts the key factors that influence the fundraising process for the case firm. Besides key findings for each factor, the table shows how DMHNGO performs in relation to each key factor and how much impact each factor has on DMHNGO. The scale used to evaluate performance ranges from “very poor” to “very good” in a 5-step scale. Impact is evaluated in a 3-step scale; low, average, and high. Performance and impact are rated based on insights derived from the case firm as described in the methods section. For example, for the factor administrative resources the case firm performs 3 out of 5, so average. However, the case firm evaluates this factor as having a high impact (3 out of 3) (see the first row in Table III).

The experts from DMHNGO assessed the importance as well as the potential improvement of the 15 key factors. Table IV shows each key factor’s importance calculated using Equation (1).

Quantitative findings from the case study

Broadly speaking, importance is equally distributed among all key factors, which implies all are relevant for the case company. Based on DMHNGO’s experts’ opinions, 37 percent of resources ought to be dedicated to improving internal management, while the remaining 63 percent should be employed to enhance the positive impact of external influences.

Considering the internal factors, the highest importance is manpower with 16.7 percent, i.e. administrative (KF1) and human resources (KF5). Furthermore, DMHNGO’s internal management is evaluated based on strategic planning (KF2), governance (KF3), and capacity development (KF6), which cover 20.3 percent of the required resources.

The analysis notably reveals a 3.1 percent importance concerning marketing and communications. DMHNGO is currently working effectively in terms of communication and marketing, and although the impact of this factor is relatively high, the performance is

<table>
<thead>
<tr>
<th>Table III</th>
<th>Findings for the 15 factors in the case firm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key factor</td>
<td>Findings</td>
</tr>
<tr>
<td>Administrative resources</td>
<td>15.55% are employees with suitable qualifications; the remaining 84.45% are volunteers</td>
</tr>
<tr>
<td>Strategic planning</td>
<td>There is a defined strategy, mission, and vision. Objectives are continually reviewed</td>
</tr>
<tr>
<td>Governance</td>
<td>Good communication between board members and General Secretary (weekly meetings). Budget system to be improved by better financial data management</td>
</tr>
<tr>
<td>Marketing and communication</td>
<td>High engagement on Facebook (likes, comments, etc.). Webpage to be enhanced, especially during peak visitor hours (Tuesdays). Active during different campaigns</td>
</tr>
<tr>
<td>Human resources</td>
<td>Scarce workforce, meaning high workload for salaried employees. No HR department</td>
</tr>
<tr>
<td>Capacity development</td>
<td>High part-time employee turnover, meaning wasted resources</td>
</tr>
<tr>
<td>NGO and private firm relations</td>
<td>External relationships with private firms must improve to obtain financial support. Visibility via these organizations already achieved</td>
</tr>
<tr>
<td>NGO and donor relations</td>
<td>Often personal contact with donors, who have doubled their donations in recent years</td>
</tr>
<tr>
<td>NGO’s transparency</td>
<td>Trustworthy organization. No scandals registered</td>
</tr>
<tr>
<td>Seasonal aspects</td>
<td>Clear seasonal trend. Highest donations in winter due to Christmas and yearly closure of accounts in most companies</td>
</tr>
<tr>
<td>Philanthropy</td>
<td>Limited social awareness of eating disorders and self-harm. However, data showed most donors have a relation to someone affected by these illnesses</td>
</tr>
<tr>
<td>Taxes</td>
<td>The general survey (38.1% of negative responses) indicated many Danes are unaware of tax deductions for charitable donations</td>
</tr>
<tr>
<td>Social stigma</td>
<td>The general survey showed approximately 70% of sampled Danes agreed that eating disorders and self-harm are real illnesses, showing greater awareness for these illnesses than literature in general reports</td>
</tr>
<tr>
<td>Gender of donors</td>
<td>Most donors and active people in DMHNGO are women. Awareness in men should be increased</td>
</tr>
<tr>
<td>Socio-economic status</td>
<td>There’s not a clear pattern in socio-economic status of the donors. Cultural factors should be studied</td>
</tr>
</tbody>
</table>
already satisfactory. The opposite case is shown with the human resources factor (KF5) where even though the factor has high potential improvement and impact to DMHNGO’s fundraising (as shown in Table IV), in this case, the current performance of DMHNGO is poor (as shown in Table III). This fact leads to increased resource requirement for future improvement.

External factors can be classified into three categories:

1. Relationship with stakeholders: relationship between NGO firms (KF7), relationship between NGO donors (KF8) and transparency (KF9).

2. Social aspects: philanthropy (KF11), social stigma (KF13), donor gender (KF14), and socio-economic status (KF15).

3. Other external factors: seasonal aspects (KF10) and taxes (KF12).

Social aspects illustrate a higher necessity for resources, meaning DMHNGO should focus on increasing public awareness.

This study suggested that donors are disproportionately women, implying women are effectively the customers that DMHNGO should focus on. Customer segmentation is recommended, first to promote female donations, and second foster male awareness for DMHNGO to increase financial support from this group. Additionally, findings point to eating disorders and self-harm as illnesses that don’t generate awareness in the general populace, only to those who have a close relationship with a person suffering from such conditions. This is likely due to social stigma, which should be taken into account in any approach a mental health NGO undertakes.

In Figure 2, suggested focus areas for DMHNGO are compared with the average key factor importance from the surveyed Danish mental health NGOs. Overall, all key factors show a deviation below 3.4 percent (seasonal aspect has the maximum deviation (KF10)). Due to similarity in responses between other mental health NGOs and DMHNGO, it can be suggested all mental health NGOs in Denmark should consider a similar fundraising approach to the one proposed to DMHNGO.

### Discussion

This paper provides practitioners with a decision-making framework to assess optimal fundraising approaches for a mental health NGO via the identification of 15 key factors. The framework offers a holistic view of NGO fundraising strategies, by means of a qualitative approach to assess their current approach as well as their optimal approach based on their specific context. Furthermore, the framework can aid practitioners with finding a

<table>
<thead>
<tr>
<th>Key factor</th>
<th>Impact factor (IF&lt;sub&gt;k&lt;/sub&gt;)</th>
<th>Potential improvement (PI&lt;sub&gt;k&lt;/sub&gt;)</th>
<th>Importance&lt;sub&gt;k&lt;/sub&gt; (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative resources</td>
<td>4</td>
<td>3</td>
<td>6.3</td>
</tr>
<tr>
<td>Strategic planning</td>
<td>4</td>
<td>3</td>
<td>6.3</td>
</tr>
<tr>
<td>Governance</td>
<td>4</td>
<td>4</td>
<td>7.9</td>
</tr>
<tr>
<td>Marketing and communication</td>
<td>3</td>
<td>2</td>
<td>3.1</td>
</tr>
<tr>
<td>Human resources</td>
<td>5</td>
<td>4</td>
<td>10.4</td>
</tr>
<tr>
<td>Capacity development</td>
<td>3</td>
<td>2</td>
<td>3.1</td>
</tr>
<tr>
<td>NGO and private firm relations</td>
<td>3</td>
<td>5</td>
<td>7.8</td>
</tr>
<tr>
<td>NGO and donor relations</td>
<td>4</td>
<td>2</td>
<td>4.7</td>
</tr>
<tr>
<td>NGO’s transparency</td>
<td>4</td>
<td>3</td>
<td>6.3</td>
</tr>
<tr>
<td>Seasonal aspects</td>
<td>5</td>
<td>3</td>
<td>9.4</td>
</tr>
<tr>
<td>Philanthropy</td>
<td>2</td>
<td>5</td>
<td>5.1</td>
</tr>
<tr>
<td>Taxes</td>
<td>4</td>
<td>4</td>
<td>8.3</td>
</tr>
<tr>
<td>Social stigma</td>
<td>4</td>
<td>4</td>
<td>8.3</td>
</tr>
<tr>
<td>Gender of donors</td>
<td>5</td>
<td>3</td>
<td>7.8</td>
</tr>
<tr>
<td>Socio-economic status</td>
<td>5</td>
<td>2</td>
<td>5.2</td>
</tr>
</tbody>
</table>
recommended percentage of resources to spend on different factors to ensure the best fundraising approach.

Use of both qualitative and quantitative methods has enabled development of an easy to use, novel and practical framework with which to analyze an NGO's market. The framework was tested in practice, ensuring its practical applicability. The application procedure for the framework can be seen in Figure 3; this procedure was validated with the case firm.

The procedure has five iterative process steps:

- **Step 1:** determine current fundraising approach – determine the percentage distribution of resources in an NGO. Once done, it must be regularly updated, i.e. every year.
- **Step 2:** determine optimal fundraising approach – assess the 15 key factors using internal and external data. First iteration requires involvement from all stakeholders to set and ensure the optimal fundraising approach. It is recommended external key factors be re-evaluated on a yearly basis, due to the dynamic environment.

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**Figure 2** Comparison of factors: case firm (lowest bar) vs Danish mental health NGOs (upper bar)

<table>
<thead>
<tr>
<th>Key Factor</th>
<th>Case Firm</th>
<th>Danish NGOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF1</td>
<td>6.3%</td>
<td>5.7%</td>
</tr>
<tr>
<td>KF2</td>
<td>5.7%</td>
<td>6.3%</td>
</tr>
<tr>
<td>KF3</td>
<td>6.3%</td>
<td>7.8%</td>
</tr>
<tr>
<td>KF4</td>
<td>3.1%</td>
<td>3.9%</td>
</tr>
<tr>
<td>KF5</td>
<td>10.4%</td>
<td>7.1%</td>
</tr>
<tr>
<td>KF6</td>
<td>3.1%</td>
<td>6.2%</td>
</tr>
<tr>
<td>KF7</td>
<td>7.8%</td>
<td>8%</td>
</tr>
<tr>
<td>KF8</td>
<td>4.7%</td>
<td>5.5%</td>
</tr>
<tr>
<td>KF9</td>
<td>6.3%</td>
<td>6.5%</td>
</tr>
<tr>
<td>KF10</td>
<td>9.4%</td>
<td>6%</td>
</tr>
<tr>
<td>KF11</td>
<td>5.1%</td>
<td>5.1%</td>
</tr>
<tr>
<td>KF12</td>
<td>8.3%</td>
<td>10%</td>
</tr>
<tr>
<td>KF13</td>
<td>10%</td>
<td>8.3%</td>
</tr>
<tr>
<td>KF14</td>
<td>7.1%</td>
<td>7.8%</td>
</tr>
<tr>
<td>KF15</td>
<td>8.2%</td>
<td>5.2%</td>
</tr>
</tbody>
</table>

**Figure 3** Framework application procedure

1. **Analysis of current strategy in regards of fundraising**
2. **Analysis of the optimal strategy in regards of fundraising**
3. **Development of improvement suggestions**
4. **Evaluation of proposed solutions**
5. **Implementation 1 or 4 year(s) check**
Step 3: development of improvement suggestions – if the optimal and current fundraising strategies match in Step 2, no actions should be taken until the following year. Otherwise, a proposal for optimizing present approach should be formulated.

Step 4: evaluation of proposed solutions – classify improvements into short and long term, then evaluate suggestions using cost-benefit analyses. Involvement from all key stakeholders is recommended to ensure both quantitative and qualitative benefits and costs.

Step 5: implementation – implement short-term solutions immediately. Drastic improvements will be considered long term, as they will need time to be implemented and accepted by employees and become part of organizational processes, procedures, and culture. It’s suggested that implementation be verified every four years.

Conclusions

Instabilities present in the revenue of NGOs create difficulties with regard to effective utilization of resources and fundraising. Additionally, NGOs rarely develop a market analysis, a key tool for any business, geared towards identification of strategically advantageous activities.

This paper addresses this research gap by identifying key factors determining the most advantageous fundraising approach, focusing on mental health NGOs. This study identifies 15 key factors (six internal and nine external factors) determining the most advantageous fundraising approach from a literature review and presents a decision-making framework based on these factors. The six internal factors are: administrative resources, board members’ lack of expertise and administrative skills, strategic planning, governance, marketing and communications, human resources and capacity development and the nine external factors are: R. NGO-Companies, R. NGO Donors, transparency, seasonal aspects, philanthropy, political interferences and taxes, social stigma, gender of donors, socio-economic status.

Data collection was triangulated from a case study of a Danish mental health NGO called DMHNGO and two surveys; one with the Danish public and one with Danish mental health NGOs in order to improve reliability of the results.

Testing the framework on the case firm the results showed that currently the case firm had a relatively equal distribution of resources between the internal and external factors. However, an optimal allocation would be 37 percent of resources spent on internal factors and 63 percent spent on external factors respectively. Governance and human resources were considered most important among the internal factors for the case firm while social stigma was the most important among the external factors. This allocation leads to the optimal fundraising approach for DMHNGO.

Due to similarities in rating of these 15 key factors between the case firm and the Danish mental health NGOs who responded to the survey, the developed fundraising approach for the case firm could also be useful for other mental health NGOs.

A limitation of the study is that the qualitative nature of the study means that the findings related to the perceived reality of fundraising. Furthermore, a limitation of the framework for mental health NGOs is the absence of current social trends regarding body image and self-esteem, and the increasing importance social media is gaining in the analysis process (Bucchianeri and Neumark-Sztainer, 2014).

Further research should investigate the robustness of the proposed framework by examining the identified key factors in-depth for other Danish mental health NGOs. Furthermore, similar studies in other countries with different approaches to mental health issues could be carried out in order to strengthen and further develop the framework, as well as compare results across NGOs. Also, studies with NGOs which have different structures and objectives should be carried out in order to further expand on and detail the framework and the application of it. Finally, longitudinal studies showing the effectiveness of using the framework and following the identified optimal fundraising approach could further strengthen the framework; a start could be to revisit the case firm in a few years as they are implementing the optimal fundraising approach presented in this paper.
Notes

1. Readers can request a more detailed version of this study from the authors which includes the full literature review sources.
2. Readers can request the full version of this study which includes all the specifications of all the data sources including survey questionnaires and relevant data.

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Further reading


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Reflections on happiness

Woody Caan

Abstract

Purpose – The purpose of this paper is to assess the twenty-first century reach and impact of “happiness” work by one individual (Professor Lord Richard Layard).

Design/methodology/approach – The author approaches his work as a public health case study, with the caveat that the author knew this “Case” personally, which could influence the author’s assessment.

Findings – During 2005-2018, Richard Layard stimulated discussion of “happiness” as a field of study. This field now has global relevance to mental health, although its relationship to practice for population health is still debated.

Originality/value – Layard’s ideas are behind many initiatives, such as Improving Access to Psychological Therapies.

Keywords Economics, Utility

Paper type Viewpoint

This week the sixth World Happiness Report was published (Helliwell et al., 2018). A driving force behind much research on “happiness” has been the Professor Lord Layard, an economist. Previously, Layard had been advising the UK Government about the impact of depression on the adult workforce (Centre for Economic Performance, 2006) which left a remarkable legacy in terms of new, psychological treatment services. In 2010, he went on to found the charity Action for Happiness (www.actionforhappiness.org/), whose patron is the Dalai Lama.

Layard’s consistent ambition, not only for improved mental health in Britain, but also around the world, has long gained my admiration. This opinion piece considers his happiness ideas as a case study of academic reach and impact.

When I searched the SCOPUS database (www.scopus.com/) for “Richard Layard” (2005-2017), there were 12 papers in three Languages (English, Spanish or French) in 11 different journals. One was a published interview (Pearce, 2005) which gives the foundation (from economics and policy-making) of Layard’s academic approach to happiness. Areas where Layard saw a clear overlap between public mental health and happiness included work, unemployment and parenting initiatives. Overall, the later papers identified flaws with the original economic or utility model of happiness, such as: a lack of community or societal dimensions, too narrow a view of an individual’s psychology or the absence of political or sociological frameworks in which to embed the expansion of treatment services. From my Editorial viewpoint, if Layard’s idea of “happiness” has stimulated over a decade of animated, international debate, that is a sign of powerful academic reach.

The immediate impact of the Penguin paperback Happiness (Layard, 2005) is illustrated by the multi-author, multi-disciplinary book The Science of Well-being that came out the same year (Huppert et al., 2005): four contributors cited Layard. By 2018, according to the ResearchGate data set of papers, Happiness has been cited 2,404 times. Layard’s (2013) personal impact on policy-makers was visible in Parliament when the Academy of Social Sciences launched its case for Mental Wellbeing there in 2013.

Professor Layard now works with an international partnership on global aspects of happiness, such as the impact of migration on wellbeing (What Works Centre for Wellbeing, 2018). One of key messages from that study is that:

• Happiness is not fixed.
In other words, creating an environment with trust, connectedness and co-operation enables even migrants from other (unhappy) societies to share a similar happiness to the resident population.

In terms of public health, there are still many aspects of happiness that are not well understood. Globalisation and proliferating online connections seem to increase the unhappiness of many children. For example, an increasing number of 9-16 year olds in the UK now worry about war and conflict (Morris, 2018). Girls are more likely to be distressed than boys.

At the age of 84, Layard continues to promote the field of happiness. For example, on 9 May 2018 in London he is going to address a conference for the Compassionate Mind Foundation (https://compassionatemind.co.uk/current-conferences/conferences/international-leadership-and-business-conference) on:

- Building and leading happier societies.

References


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In association with Mental Health Foundation

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