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How Chilean school communities understand and respond to adolescent mental health

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Research Article

Keywords: adolescent mental health, school mental health, social representations, school communities, Chile

Posted Date: August 20th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-10439090/v1

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Additional Declarations: No competing interests reported.

Abstract

Adolescent mental health has become a central concern for school communities, which must address distress, emotional crises, requests for support, and decisions about how to assist students. This study analyzes social representations of adolescent mental health in Chilean secondary school communities, focusing on meanings, explanatory frameworks, and responses. An interpretive qualitative study was conducted based on interviews with 124 participants, including students (n = 52), teachers (n = 43), and parents/caregivers n = 29) from different regions of Chile. The material was analyzed through reflexive thematic analysis to identify patterns of meaning, nuances, and tensions among participants.

The results indicate that adolescent mental health is represented both as emotional well-being and as problems, diagnoses, treatments, and specialized care. Younger generations are described as more open to recognizing and expressing distress, although adults often interpret this openness as greater fragility in the face of frustration and everyday demands. Adolescent mental health appears to be a widespread issue, although not necessarily a new one, as its increased visibility is also linked to cultural changes in the ways suffering is named, interpreted, and legitimized. Family relationships, school dynamics, and social media are identified as central contextual factors in how adolescents' mental health is represented. The responses deemed most legitimate tend to focus on individual intervention, professional referral, and specialized care. Overall, the study shows that school communities interpret adolescent mental health through a tension: they acknowledge social and relational conditions contributing to distress, yet they primarily rely on clinical, individual, and institutionally limited responses.

Clinical trial number: not applicable.

Introduction

Over the last few decades, mental health has become a source of widespread social concern in various regions of the world [1]. The notion of a "mental health crisis" has become firmly established in both public and academic discourse [2,3]. Several indicators support this concern: an increase in the proportion of individuals diagnosed with or receiving treatment for mental health issues; a marked rise in the demand for specialized mental health care; and a widespread perception of psychological distress [4]. These phenomena are observed across all age groups, but with particular intensity among adolescents, extending into youth and emerging adulthood, where sustained increases in indicators of psychological distress have been reported [5,6]. Although these trends predate the COVID-19 pandemic, the pandemic represents a significant milestone in the public visibility of mental health concerns [7,8], particularly following the challenges observed after students returned to in-person educational settings [9].

Within the academic field, there is debate regarding whether this increased attention to mental health and the growing demand for clinical services reflect a genuine rise in the frequency and magnitude of mental health problems. Part of the increase in consultations and diagnoses can be attributed to reduced stigma associated with seeking professional help, greater availability of services, and changes

in diagnostic practices toward greater inclusiveness [10,11]. However, studies examining trends in the general adolescent population consistently identify a substantial increase in the reporting of certain forms of psychological suffering, particularly emotional or “internalizing” distress [12,13]. According to these studies, adolescents in various regions of the world report experiences of anxiety, emotional distress, depressed mood, and suicidal ideation more frequently than in previous decades, a phenomenon that has become especially evident since the mid-2000s [14–16]. Increases in self-harming behaviors have also been observed [12].

One factor that complicates the interpretation of these findings is their dependence on sociocultural sensitivities, which may influence how distress is detected, expressed, and evaluated, both by individuals themselves and by those around them [17]. Several authors have described how the social expansion of the language and practices of psychology and psychiatry has fostered cultural transformations that contribute to a tendency to understand and manage diverse relational, social, educational, or biographical difficulties and experiences through the categories of these disciplines [18–20]. One potentially problematic consequence of this process is the tendency to decontextualize, individualize, and psychopathologize these situations, thereby affecting both how they are understood and how interventions are oriented [21–23].

From another perspective, the increase in mental health problems has been linked to broader socioeconomic and cultural transformations, as well as to the intensive use of social media, although there is no consensus regarding their relative contributions or the mechanisms through which they operate [24,25]. These explanations also circulate socially, influencing how contemporary adolescent experiences are interpreted.

Within this framework, social representations of adolescent mental health provide a valuable entry point for understanding how these debates are appropriated, translated, and discussed by different social actors. The ways in which students, teachers, and families define, explain, and evaluate adolescent difficulties and distress reflect not only expert knowledge but also broader representations of youth, emotions, family, school, social media, and individual or collective responsibility in relation to psychological suffering [26]. The study of these representations makes it possible to understand which experiences are recognized as mental health problems, what causes are attributed to them, and which responses are considered legitimate or feasible.

This context of growing concern and debate surrounding adolescent mental health is expressed with particular intensity in school settings. The educational system has become one of the main contexts in which these concerns are most visible, both due to the frequency with which teachers, students, and families report situations of distress and because of the everyday need to interpret and manage them institutionally. This has driven the development of policies, programs, and intervention strategies aimed at promoting, preventing, detecting, and referring mental health problems. However, different actors within the educational system often regard these initiatives as insufficient to address the magnitude and complexity of the difficulties observed [27,28]. Additionally, concerns have been raised regarding the

appropriateness of some institutional responses [29,30]. In this context, school communities do not simply passively adopt approaches and categories originating from the expert field of mental health; rather, they reinterpret, adapt, and apply them to concrete situations in school life, such as emotional crises, social withdrawal, relational conflicts, behavioral dysregulation, attendance difficulties, or academic performance problems.

The situated appropriation of these languages and categories in school life constitutes the focus of the present study. The aim is to analyze the social representations of adolescent mental health in educational settings from the perspectives of secondary school students, teachers, and parents/caregivers. Through a qualitative analysis of individual and group interviews, the study seeks to identify the main meanings associated with mental health, how adolescent mental health is characterized today, and the frameworks through which it is explained, evaluated, and addressed in school life.

Methods

Design

An interpretive qualitative study [31] was conducted to analyze the social representations of adolescent mental health held by secondary school students, teachers, and parents/caregivers in educational settings. This approach enabled examination of the meanings, knowledge, evaluations, and practical orientations through which different school actors interpret adolescent mental health, as well as the ways in which they understand its causes, manifestations, and potential approaches. Social representations were understood as collectively constructed systems of knowledge that enable groups to make sense of particular phenomena and guide their everyday actions [32, 33].

Participants

A total of 124 participants were recruited from 12 locations across Chile, representing the northern, central, and southern macro-regions of the country: Arica, Coquimbo, Elqui, Quillota, Santiago, Chillán, San Pedro, Concepción, Hualpén, Hualqui, Florida, and Lonquimay. These locations were selected to include regional capitals, intermediate-sized cities, and less densely populated communities, as well as both urban and rural areas, ensuring that the representations collected were not limited to a single geographical or cultural context.

Participants were selected through maximum variation purposive sampling [34], considering gender, age, educational level attended or taught, geographical location, and socioeconomic diversity as criteria for heterogeneity. Socioeconomic diversity was promoted by considering participants' municipalities and residential areas during recruitment. The inclusion criteria were as follows: (a) students aged 14–17 years who were enrolled in secondary education (Grades 9–12); (b) teachers were currently teaching at the secondary school level; and (c) parents/caregivers were the adults responsible for students enrolled

in secondary education. Additionally, all participants were required to have lived in Chile for at least five years and to be Spanish speakers.

Individual and group interviews were run. From the students, 9 participated in individual interviews and 43 participated in 8 group interviews; 10 teachers participated in individual interviews and 33 participated in 7 group interviews; and 29 parents and caregivers participated in 6 group interviews. Each participant took part in only one interview format. The detailed distribution by participant, interview format, location, and gender is presented in Table 1.

Table 1
Distribution of participants by participant group, interview format, location, and gender.

Participant	Interview Format	Location	N	Women	Men
Students	Individual	Chillán	1	1	0
		San Pedro	1	1	0
		Hualpén	1	1	0
		Concepción	1	1	0
		Santiago	1	1	0
		Lonquimay	2	1	1
		Arica	1	1	0
		Coquimbo	1	1	0
Students – Individual interview			9	8	1
Students	Group	Chillán	5	3	2
		Arica	4	3	1
		Elqui	5	2	3
		Santiago	4	1	3
		Lonquimay	7	4	3
		Concepción	7	5	2
		Hualqui	7	2	5
		Florida	4	4	0
Students – Group interview			43	24	19
Students Total			**52**	**32**	**20**
Teachers	Individual	Concepción	4	2	2
		Lonquimay	2	1	1
		Elqui	1	0	1
		Santiago	1	1	0
		Chillán	1	1	0
		Arica	1	1	0

Note. In individual interviews, *N* refers to the number of interviewees; in group interviews, *N* refers to the total number of participants in the groups conducted in each location. Each participant took part in only one interview format.

Participant	Interview Format	Location	N	Women	Men
Teachers – Individual			10	6	4
Teachers	Group	Elqui	5	4	1
		Arica	5	2	3
		Santiago	4	1	3
		Hualqui	5	2	3
		Lonquimay	4	1	3
		Florida	6	4	2
		Chillán	4	2	2
Teachers – Group			33	16	17
Teachers – Total			**43**	**22**	**21**
Parents/caregivers	Group interview	Concepción	5	4	1
		Florida	4	3	1
		Lonquimay	7	6	1
		Quillota	4	3	1
		Santiago	4	3	1
		Arica	5	4	1
Parents/caregivers –			**29**	**23**	**6**
Total			**124**	**77**	**47**

Note. In individual interviews, *N* refers to the number of interviewees; in group interviews, *N* refers to the total number of participants in the groups conducted in each location. Each participant took part in only one interview format.

Data Collection

Data collection combined in-depth individual interviews and group interviews. Individual interviews allowed for a deeper exploration of participants' meanings, experiences, and interpretative frameworks. Group interviews, in turn, facilitated the exchange, negotiation, and comparison of shared meanings, a dimension that is particularly relevant to the study of social representations as a collective product [35–38].

The interviews were conducted using a flexible thematic interview guide that was common to the three participant groups but adapted in its language and examples for each group. The interview guide was

piloted beforehand, allowing for refinement of the language, sequence of questions, and appropriateness of examples before final implementation. Consistent with the qualitative nature of the study, the interviewer adopted an active role by requesting clarification, probing emerging issues, and exploring tensions within participants' accounts.

Both individual and group interviews were conducted by a single interviewer. Approximately half of the interviews were conducted by the principal investigator and co-investigators, while the remaining half were conducted by previously trained interviewers. A brief sociodemographic and contextual questionnaire was also administered.

Fieldwork was carried out between May 2024 and December 2025. All interviews were conducted face-to-face in spaces provided by the participating institutions or at locations agreed upon with the participants that ensured privacy during the conversation. The interviews lasted between 45 and 90 minutes, were audio-recorded with participants' prior consent, and were transcribed verbatim for analysis.

The completion of fieldwork was guided by the principle of information sufficiency [39], consistent with a reflexive thematic analysis approach [40]. Data collection concluded when the material gathered supported a consistent interpretation of the main meanings, tensions, and differences across participant groups and when additional interviews did not yield substantively different analytical dimensions from those already identified.

Data Analysis

The data were analyzed using MAXQDA version 26.0.0, following the principles of reflexive thematic analysis [41, 42]. This approach conceptualizes analysis as an interpretive and situated process in which the research team's background, theoretical frameworks, and analytical sensitivity contribute to the construction of meaning from the data [43].

The analysis followed the six phases proposed by Braun and Clarke [42]: familiarization with the data, initial coding, generation of candidate themes, review of the themes in relation to the dataset, definition and naming of themes, and production of the analytical report. In the first stage, two members of the research team independently read a subset of the transcripts in full and conducted initial coding. They subsequently compared their codes, discussed interpretive differences, and progressively refined their scope. The purpose of these discussions was not to establish intercoder reliability but rather to strengthen the reflexivity of the analysis, examine alternative interpretations, and clarify the relationships between the topics explored, the codes, and the excerpts from the dataset.

This procedure was repeated in two additional rounds of coding using the remaining material. The entire dataset was coded by both researchers, and their coding was integrated into a shared analytical file in MAXQDA. This integration made it possible to identify recurring patterns, contrasts, and overlaps across codes, as well as to retrieve relevant excerpts for the progressive development of candidate themes.

Considering the diversity of participant groups involved, the analysis was initially conducted separately for students, teachers, and parents/caregivers. In the second stage, the codes and preliminary themes were reviewed across participant groups, comparing convergences, nuances, and tensions. Based on this process, analytical themes were developed to account for the shared social representation of adolescent mental health in educational settings while preserving the internal differences and specific perspectives contributed by each participant group. The candidate themes were discussed with the other members of the research team to review of their internal coherence, refine their scope, clarify their labels, and enrich the resulting interpretations.

Reflexivity

The research team comprised professionals with expertise in mental health, social sciences, and qualitative research, including psychology, sociology, and anthropology. Team members had diverse professional backgrounds in clinical, social, community, organizational, and research settings.

Throughout the analytical process, it was explicitly acknowledged that some members of the research team held critical perspectives regarding the expansion of medical-psychiatric categories in the field of mental health. This position was addressed reflexively to avoid an *a priori* critical readings of participants' accounts and to prevent automatically interpreting references to diagnosis, treatment, or specialized care as merely expressions of medicalization. To this end, the distinction between the categories used by participants, the interpretations developed by the research team, and the theoretical frameworks informing the analysis was discussed during analysis meetings.

Ethical Procedures

The study was approved by the Ethics Committee of the Concepción Health Service (CEC-SSC 24-04-23) and was conducted in accordance with ethical standards for research involving human participants [44].

All adult participants provided written informed consent before participating. For participants under 18 years of age, written informed consent was obtained from a parent or legal guardian, and informed assent was obtained from the adolescent using age-appropriate language. When required, authorization was also obtained from the participating schools.

Participation was voluntary, participants received no financial compensation, and they were free to withdraw from the study at time without any consequences. Although the interviews did not directly explore personal experiences of psychological distress or mental health problems, procedures were established in case such issues arose spontaneously during the interviews. During fieldwork, it was not necessary to activate any additional support or referral procedures related to distress associated with participation.

To protect confidentiality, interviews were assigned identification codes, personal information was stored separately from the analytical material, and transcripts were anonymized by removing the names of individuals and educational institutions. The findings are presented in aggregate form, preventing the identification of individual participants.

Results

The analysis of the data generated through interviews with students, teachers, and parents/caregivers led to the development of five cross-cutting analytical themes. Together, these themes capture the most significant elements of the social representation of adolescent mental health identified across the different participant groups. Although some differences in emphasis were noted, a high degree of convergence was generally observed among the participant groups. The themes are presented below. Selected quotations were edited slightly to improve readability.

Mental Health: Between Well-Being and Problems

The concept of mental health is organized around two dominant meanings across the different participant groups. On the one hand, it refers to well-being, balance, and peace of mind, understood as states of emotional stability and healthy relationships with oneself and others. On the other hand, it immediately evokes mental health problems and disorders, as well as the diagnoses, treatments and professionals, associated with them. Participants did not perceive these two meanings as contradictory but rather as reflecting the breadth and ambivalence of the concept.

Although well-being is sometimes described as multidimensional and holistic, it is primarily centered on the emotional domain and understood as a state characterized by calm, stability, and the ability to cope with negative emotions.

Mental health is how we are doing mentally—whether we are well, whether we are not, whether we are in balance or emotionally stable. I think mental health is also closely related to the emotions that we experience. (Teacher, group interview, Florida)

At the same time, participants pointed out that the positive dimension of mental health becomes visible precisely through the contrast with the difficulty of maintaining or achieving it. As a result, the concept of mental health often immediately evokes problems, diagnoses, or forms of distress.

But I also feel that when you hear the term, the more negative side of mental health comes to mind, like the bad side, things like depression or anxiety—more related to problems. (Student, individual interview, Chillán)

Among teachers, this problem-oriented dimension becomes even more central, as mental health is perceived as a reality that often exceeds the capacity of educational institutions to respond.

We could talk about mental health in positive terms. However, in education, mental health becomes relevant as a shortcoming, as a threat that is more visible and has become more pronounced, especially among young people today. (Secondary school principal, individual interview, Concepción)

Given the centrality of emotionality in the concept of mental health, the main characteristic attributed to adolescents with good mental health is the ability to regulate emotions. Additionally, teachers and parents/caregivers place particular emphasis on social interaction skills. Taken together, this first theme shows that mental health is represented less as a bounded clinical category than as a hybrid language in which emotional well-being, everyday distress, and mental disorders are closely intertwined.

A More Expressive and Open Generation, but Also More Fragile

When asked about the strengths of today's youth, participants consistently highlighted a "new sensitivity" among adolescents, characterized by a distinct approach to valuing and expressing emotions compared to previous generations. In particular, participants emphasized the greater importance placed on mental health, the ability to recognize and communicate emotions, and a heightened receptiveness to others' distress.

I think we maybe have more attitude. We see things from a different perspective than they were seen before. For example, with mental health, it used to be much more stigmatized. Now it's more normalized. We can express how we feel more openly and more directly. (Student, individual interview, Santiago)

This openness toward mental health, as well as the willingness to discuss problems and seek help, was also viewed positively by adult participants, who contrasted it with previous generations, in which these issues were less visible or even considered taboo.

So, I think that has changed the way mental health is approached. In our generation—at least in mine—it wasn't very common to talk about psychologists. Going to therapy wasn't normal. Today there's more information, and mental health is approached differently. (Teacher, individual interview, Vicuña)

Attention to emotional issues is directed not only toward themselves or their peers but also toward interpersonal relationships more generally. One teacher illustrated this with a question that, according to his account, students frequently asked:

"Teacher, are you happy?" (Teacher, group interview, Hualqui)

Young people are described as more expressive and less constrained by traditional cultural norms. All participant groups highlighted this, in contrast with previous generations.

They say what they think, and they feel they have the right to express themselves and to be heard, whether by their parents or their teachers. I appreciate that, you know? Because, just as you say that you learn from your children, I feel that this braver way they have of being themselves also makes you stop and think, "Yeah, that's true." (Parent/caregiver, group interview, Lonquimay)

However, whereas students tended to view this openness as a generational strength, teachers and parents/caregivers frequently referred to its potential drawbacks. Characteristics such as greater emotional expressiveness, a willingness to discuss mental health, and the expectation of being heard were also interpreted as possible indicators of greater fragility among younger generations.

Now, because people pay so much attention to emotions and young people are so willing to show what they feel, it's normal for them to fall into these… maybe not necessarily mental health imbalances, but things that can affect their mood. (Teacher, group interview, Florida)

In this way, young people's emotional openness is represented ambivalently: as a cultural advance over the silencing of distress, but also as a characteristic that, from the adult perspective, may be associated with greater emotional vulnerability.

Although students acknowledged significant mental health challenges among their peers, they disagreed with the notion of generational fragility.

Adolescent Mental Health: Widespread and Complex Distress, but Not Entirely New

The different participant groups consistently described the current state of adolescent mental health in critical terms. Among teachers, this perception is associated with changes in school life: mental health problems have become an increasingly central concern, capable of transforming educational practices, and the boundaries of the teaching role.

More than 35% of the students at our school have some diagnosis related to mental health. (Secondary school principal, individual interview, Concepción)

I see it as completely overwhelming. Nowadays, the school's main problem is mental health rather than academics. I've noticed this generational shift, where it has become difficult to maintain academic expectations. (Teacher, individual interview, Santiago)

Parents/caregivers described a similar scenario, characterized by the high prevalence of mental health issues, treatment, and medication use among adolescents.

Just to give you an example, we're organizing the graduation trip. We've already received the forms for all 30 students, and half of them are taking medication for mental health. I've heard my son say that this or that person has been struggling, or their parents tell us about it. (Parent/caregiver, group interview, Concepción)

From the students' perspective, the assessment was also critical. Their accounts emphasized the frequency of distress, anxiety, frustration, social comparison, and the feeling of being overwhelmed by the amount of information and stimuli to which they are exposed.

I think young people's mental health is in pretty bad shape for several reasons. Technology helps us connect and gives us access to resources, even professionals, but social media makes us compare ourselves a lot. We're so connected and have so much information that we've gotten used to everything happening quickly. When we don't get those quick responses, anxiety hits us, and we become frustrated. (Student, individual interview, Chillán)

Participants also referred to insecurity, low self-esteem, low frustration tolerance, and fear of failure as common features of adolescent distress.

Being insecure about yourself in every way, being afraid of failing, being afraid that something will go wrong, not being able to achieve something, becoming frustrated and not knowing how to deal with it, feeling insecure about how you look physically, whether you're thin or not, whether you have more than someone else or less than someone else. (Student, individual interview, Vicuña)

These experiences were associated with emotional dysregulation, anxiety and depression disorders, self-harm, eating-related problems, neurodevelopmental diagnoses, and problematic substance use.

The pandemic was identified as a factor that both intensified these problems and made them more visible. In adolescents' accounts, social isolation was associated with greater introspection, worry, and distress.

It's like everyone's thoughts keep going around and around in their heads. And during the pandemic, it got even worse because you were alone all day, locked up, so you had more time to think about things. (Student, individual interview, Concepción)

However, this perception of widespread and increasing distress was qualified by the participants themselves. Several noted that mental health is now more visible and that there is greater openness to talking about problems that previously remained hidden or were dismissed. Adolescents particularly emphasized this point and valued the current opportunity to recognize distress and seek help.

Now it's no longer such a taboo subject. You can say, "I'm not doing well; I need to see a specialist for my well-being." The perception of those who seek help from psychologists has changed significantly. Previously, it was often frowned upon. (Student, individual interview, Lonquimay)

At the same time, the increased visibility of mental health issues was also associated with problematic effects. Some adults expressed concerns about a tendency toward overdiagnosis or the reinterpretation of experiences through clinical categories that might instead reflect personality differences, everyday challenges, or diverse ways of being in the world.

When someone is struggling, we often assume they represent the majority. However, for every child diagnosed with depression or exhibiting symptoms of these symptoms of "ADHD" or "autism," sometimes they're simply an introverted child or someone who prefers solitude, and people tend to give them some

other psychological label. While discussions about these issues were less common in the past due to ignorance, now it's like we've gone to the other extreme. (Teacher, individual interview, Santiago)

Taken together, this theme shows that adolescent mental health is represented as a field of widespread and complex distress, though interpretations of its novelty vary. Participants suggested that the rise in mental health problems coexists with a greater social capacity to identify, acknowledge, and respond to these issues, as well as with concerns about the potential overexpansion of clinical categories.

Family Relationships and Social Media: Contextual Factors in Adolescent Distress

Participants identified various circumstances that contribute to adolescent distress, with the quality of family relationships and immersion in the digital world —particularly social media— emerging as the most significant factors among teachers, parents, caregivers, and students.

The family is viewed as a central source of validation and support, whose presence is considered essential for promoting adolescent mental health.

The role of the family is extremely important because that is where validation comes from. If a family provides consistent support, then one could say that the adolescent is likely to have good mental health. (Teacher, group interview, Hualqui)

However, contemporary family life is often described negatively, especially by teachers and parents/caregivers. In some cases, this perspective takes the form of blaming mothers and fathers, while in others it is linked to the challenging social conditions in which parenting takes place. In both scenarios, family life is portrayed as impoverished, characterized by limited day-to-day support and weakened communication within family relationships.

I believe what clearly affects them is the absence of adults who are truly involved in their lives. It's not enough to ask, at seven or eight in the evening, "How was your day?" Many times, I've heard responses like, "My mom doesn't care. My mom isn't interested. I hardly ever see my mom." (Teacher, group interview, Florida)

Social media, in turn, is also presented as a crucial element in understanding contemporary adolescent subjectivity. It is described not only as a space that consumes time and reduces face-to-face interactions but also as a constant source of anxiety, social comparison, and dependence on external validation, expressed through responses to messages or the number of "likes" received. Among adolescent girls, the effects of social comparison are described as particularly intense with regard to body image.

On social media, they see other people's profiles and stories about things they wish they had, which can negatively impact their self-esteem. That's when they may start to feel bad. (Student, individual interview, Chillán)

Although adolescents acknowledge some positive aspects of social media, such as access to informative, motivating, or useful content that promotes well-being, their overall assessment tends to be critical. The problem lies not only in its addictive nature but also in the type of content to which adolescents are exposed, which may encourage rapid—and not always beneficial—identification with others' experiences of distress.

I don't think it's entirely negative because, if used well, it doesn't have to be harmful. However, you're still more exposed to seeing things that may not be appropriate for your age—or perhaps shouldn't be seen at all. Hurtful comments and people sharing their mental health struggles, which may not be stable, are often presented as positive examples or normalized. (Student, individual interview, Concepción)

Taken together, family relationships and social media function as the two primary everyday frameworks for understanding adolescent distress. Both situate suffering beyond the individual, albeit in different ways: the family is represented as a source of support or relational neglect, whereas social media is represented as an environment of exposure, comparison, and emotional intensification.

Between Social Causes and Individual Responses to Adolescent Mental Health

While adolescent distress is consistently explained in terms of contextual factors —particularly the quality of family relationships and the influence of social media— the responses described by participants tend to focus on the individual, especially through referrals to specialized mental health services. Among students, teachers, and, to a lesser extent, parents/caregivers, the primary concern identified are the barriers to accessing timely and high-quality professional care.

In this context, psychopathological diagnoses play a significant role. Their high frequency, interpreted as an indication of difficulties requiring specialized care, reinforces the centrality of professional intervention as the primary response. One participant stated that "more than 35% of the students [at his school] have some diagnosis related to mental health" (Secondary school principal, individual interview, Concepción), while others referred to even higher figures.

Among adolescents, the opportunity to access psychological treatment is highly valued, regardless of whether a psychopathological diagnosis is present. However, diagnoses and pharmacological treatments are viewed with caution. The primary need identified is for genuine listening, support, and guidance, along with the perception that adults do not take their distress seriously enough and instead tended to dismiss it as an expression of a supposedly "fragile generation."

Adults often think, "They're just kids; they're probably sad, and that's normal—it'll pass." Now, the narrative is often, "Someone says something to them, and they get offended." But people fail to realize the impact of their words. More conversations with parents or your siblings are needed to understand what is happening and to solve problems, as the seriousness of an issue often becomes apparent only when it escalates into a really big problem. (Student, individual interview, Hualpén)

Some adolescents emphasized that this listening can also come from meaningful non-institutional relationships, suggesting that strengthening these connections may serve as a possible alternative or complement to responses focused solely on professional care. In this regard, some participants questioned reducing mental health to therapy or medication, although no clearly defined alternatives emerged.

Teachers collectively criticized the lack of resources within the health system and the resulting barriers to access. Simultaneously, they also proposed solutions involving schools themselves, including changes in pedagogical practices, strengthening relationships with students, enhancing collaboration with families, and providing teachers with training in mental health.

In that case, we should begin by looking at what kind of relationships and connections are we able to build with our students. Once we earn their trust, students come to class with a different attitude. They are more willing to learn, enjoy being there, and feel good. (Teacher, group interview, Florida)

Teachers, in particular, expressed a willingness to receive more training and support to address mental health issues within the school setting.

I think it's important to support those of us who are, as they say, on the front line. Although I don't feel overwhelmed by the mental health problems in my class, I do feel burdened because sometimes the necessary tools simply aren't there. So I believe addressing that would also be important. (Teacher, group interview, Hualqui)

Although the role of mental health specialists is emphasized from a predominantly clinical perspective, reflections also emerged regarding the limitations of this approach. Some participants suggested that simply expanding the availability of psychologists or psychiatrists would be insufficient to address problems that extend beyond the scope of individual clinical care.

I also think it's a mistake to believe that having an army of psychologists or psychiatrists will solve a problem that doesn't solely belong to the field of mental health, but rather to a way of life that is constantly under threat. (Teacher, group interview, Florida)

In general, the more structural proposals tended to remain relatively vague. Participants emphasized the need for more comprehensive approaches involving not only the health and education systems but also families, support networks, and broader social environments.

We need a public policy that is aware and inclusive. Everyone must be involved—not just schools. Families, support networks, and the context in which the child lives all need to be part of the solution, because we can't address this problem by focusing solely on the child. If we want to prevent this, many different actors must take action, as this doesn't happen simply because the child is a risk factor in themselves. (Secondary school principal, individual interview, Concepción)

Among parents/caregivers, many of these perspectives were echoed, but criticisms also emerged regarding the current understanding and approach of mental health. In particular, participants questioned the tendency to explain problems through individualizing diagnostic labels, the overdiagnosis of mental health conditions, and the risk that these diagnoses may become ways of justifying behaviors or generate increasing demand for professional treatments.

Taken together, these findings reveal a complex tension in the social representations of adolescent mental health: while the causes of distress are located in the social and relational environment, the responses are primarily formulated in individual terms, although they are mediated through institutional services whose legitimacy is itself partially questioned.

This asymmetry—social in its explanation but individual and institutional in its intervention—is not explicitly recognized by participants. Nevertheless, it consistently shapes their understanding of and responses to the phenomenon, raising questions about the scope and limitations of this interpretative framework.

Discussion

The present study examined the social representations of adolescent mental health in school settings from the perspectives of secondary school students, teachers, and parents/caregivers. The findings indicate that adolescent mental health is consistently represented across all participant groups as a critical issue in contemporary society. This representation is shaped by a central tension: distress is primarily explained in terms of relational, family, school, and sociocultural conditions, whereas the available responses tend to be organized around diagnostic categories, professional referrals, and individualized interventions.

Across all participant groups, mental health is understood primarily in positive terms, as emotional well-being and emotional regulation. However, the term also evokes a recognizable negative dimension associated with mental health problems, treatment, and specialized mental health services. This representation reflects the broad scope that the concept has acquired since its institutional adoption [45]. Paradoxically, this holistic and integrative perspective entails a potential risk: because no clear distinction is established between its positive and negative dimensions, the absence of positive emotional states or the expected level of well-being may itself be interpreted as a mental health problem. Studies such as that by Haslam et al. [46] have shown that well-being and mental health evoke different fields of meaning: whereas the former is associated with satisfaction, balance, or quality of life, the latter is typically linked to disorders, treatment, medication, and therapy. Consequently, equating these two concepts may encourage psychopathologizing interpretations of a wide range of experiences of subjective distress [47].

The understanding of mental health in emotional terms permeates various aspects of its representation. This centrality of emotions can be understood as part of a broader cultural process in which certain psychological discourses have contributed to positioning the recognition and expression of emotions as

the central dimensions of subjectivity and personal difficulties [48, 49]. Consistent with this emphasis, anxiety, depressive experiences, emotional dysregulation, and low frustration tolerance emerge as the most common and socially recognizable expressions of mental health problems.

The value attributed to mental health is thus closely linked to the value assigned to emotions, legitimizing experiences that, in other contexts, might have been repressed or silenced, as reflected in participants' accounts highlighting marked generational differences in this regard. Accordingly, participants—and young people in particular—view the greater visibility of adolescent mental health problems today as a positive development because forms of suffering that have always existed are now being recognized and addressed, whereas previous generations had few opportunities to express them.

However, this positive implication, highlighted by some authors [50, 51], exists in tension with the recognition of a complex adolescent mental health situation described by all participant groups. While it is possible that problems currently receiving attention would have previously gone unrecognized, this alone does not fully explain the extent of the difficulties described today.

The interpretation of this phenomenon constitutes the main point of disagreement among the participant groups. Adults tend to interpret the new adolescent sensitivity as involving both positive aspects and greater vulnerability, whereas adolescents often perceive these characterizations as forms of devaluation. Young people acknowledge the existence of widespread suffering but reject the notion that it reflects greater fragility. This difference is significant because it highlights that this disagreement concerns not only the magnitude of distress but also its moral interpretation: either as a legitimate expression of suffering or as evidence of generational weakness.

Despite these differences, participants showed substantial agreement in their explanatory frameworks, locating distress primarily within the social context, particularly in relation to family relationships and social media. However, this contextual understanding is not matched by an equivalent shift in intervention strategies, which remain largely focused on the individual. Distress is frequently described in psychopathological terms, and diagnoses serve as mechanisms of validation that facilitate access to resources and professional support.

This asymmetry between the understanding of the phenomenon and the available forms of intervention is particularly evident in educational settings. Schools thus become the context in which this dissociation takes concrete form: participants recognize the contextual nature of the problems, yet the most clearly defined strategies remain centered on the clinical work of specialized professionals. Schools appear overwhelmed by a problem they cannot ignore but that extends beyond their primary educational mission, leading them to seek external support in addressing it. Although proposals emphasizing stronger pedagogical relationships, teacher training, greater collaboration with families, and more comprehensive approaches are mentioned, they do not emerge as clearly defined or widely shared alternatives.

The social representations of adolescent mental health in educational settings are shaped by broader sociocultural processes, among which psychologization and the social expansion of psychiatric frameworks are particularly significant [23, 46, 52]. The findings are consistent with the relevance of these processes for understanding both the forms that mental health problems take and the responses to address them [53].

These findings suggest the need for caution regarding educational responses that, while intended to recognize adolescent distress, may prove ineffective or even produce paradoxical effects [54]. In particular, one immediate risk is the indefinite expansion of the language of mental health to interpret difficulties inherent to everyday life, as well as school-, family-, or relationship-related problems. Another issue requiring critical attention is the emotionalization of mental health, as it shapes the ways in which distress can be recognized. When distress is defined predominantly in terms of emotional experience, other dimensions of adolescent suffering—relational, educational, material, or normative—may become subordinated to a discourse centered on emotional regulation. In this way, emotionalization not only expands what becomes visible but also shapes the legitimate ways of naming, interpreting, and addressing distress [30].

On the other hand, a sustained focus on individuals' emotional experiences may also entail significant risks. In this regard, strategies focused exclusively on strengthening emotional competencies or expanding teachers' capacity to provide emotional support may produce paradoxical effects because they reinforce attention to these experiences while obscuring other equally relevant structural determinants [30, 55].

The findings of this study should be interpreted in light of several limitations. The analysis is limited to the Chilean educational context and the specific participant groups included in the study, which restricts its scope. Additionally, the qualitative design does not allow for statistical generalization. The use of individual and group interviews provided access to the explicit understandings of students, teachers, and parents/caregivers, but it does not capture the implicit dimensions of the phenomenon or allow for the direct observation of the institutional practices through which these representations are enacted in school life.

Overall, the findings show that adolescent mental health does not constitute a stable object but rather a field of meanings in which different ways of naming, explaining, and addressing distress converge. Its growing centrality within educational settings reflects not only the magnitude of the problem but also broader transformations in contemporary ways of understanding and managing suffering. The challenge is not to reduce attention to mental health in schools but to prevent it from becoming the exclusive framework through which adolescent experience is understood. A key remaining question is how to promote institutional responses that are directed not only toward improving detection and referral but also toward strengthening the school and relational conditions that enable distress to be recognized and addressed without immediately translating it into clinical terms.

Declarations

Funding

This study is part of Fondecyt Project No. 1240526, entitled *Social Representations of Young People's Mental Health,* funded by the Chilean Ministry of Science, Technology, Knowledge, and Innovation through the National Agency for Research and Development (ANID).

Acknowledgements

The authors gratefully acknowledge the financial support provided by the National Agency for Research and Development (ANID), through CIADES – CIN250054, for covering the article processing charges associated with this publication.

Conflict of Interest

The authors declare that they have no financial or non-financial conflicts of interest related to this study.

Ethics Approval

The study was approved by the Ethics Committee of the Concepción Health Service (CEC-SSC 24-04-23) and was conducted in accordance with the principles of the Declaration of Helsinki. All adult participants provided informed consent before participation. For participants under 18 years of age, informed consent was obtained from a parent or legal guardian, and informed assent was obtained from the adolescent.

Data Availability

The datasets generated and analysed during the current study are not publicly available due to the sensitive nature of the qualitative data and confidentiality restrictions. Anonymised excerpts are included in the manuscript. Additional de-identified materials may be made available by the corresponding author upon reasonable request, subject to ethical and confidentiality requirements.

Consent to publish

Not applicable.

Author Contributions

Gabriela Nazar: Conceptualization of the study, methodology, data analysis and interpretation, writing of the manuscript, and critical revision of the manuscript.

Leonor Benítez: Data collection, data analysis and interpretation, writing of the manuscript, and critical revision of the manuscript.

Pamela Grandón: Conceptualization of the study, data analysis and interpretation, writing of the manuscript, and critical revision of the manuscript.

Germán Lagos: Data collection, organization and management of empirical material, support for qualitative data analysis, and critical revision of the manuscript.

Caterin Romero: Data collection, organization and management of empirical material, support for qualitative data analysis, and critical revision of the manuscript.

Félix Cova: Conceptualization of the study, development of the theoretical framework, data analysis and interpretation, drafting of the original manuscript, and critical revision of the manuscript.

All authors read and approved the final version of the manuscript.

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