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"It's the complete stigma behind it."

Exploring how and why mental health stigma impacts on disclosure and help-seeking behaviours: A

thematic analysis

Rebecca Nuttall

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Abstract

Mental health illnesses are some of the most prevalent and most stigmatised illnesses in society today. The stigma associated with mental health has detrimental effects on many people and further research is necessary to deepen our understanding of how and why it has such a negative impact, especially in a student population where stressors and life changes can result in the first onset of symptoms for young people. The current study aimed to explore the topic of anxiety, looking specifically at disclosure and help-seeking behaviours. Twelve participants completed the GAD-7 and the Mini-SPIN and were then interviewed about their current and past experiences with anxiety, exploring who they had decided to disclose to, whether they had sought help, and whether they had experienced any barriers. Using guidelines for thematic analysis, the interviews were analysed, and three themes were identified: "*Disclosure patterns*", "*Social media impact on mental health disclosure*", and "*Barriers to disclosure*". Findings from this analysis revealed that students do face barriers when it comes to mental health disclosure and help-seeking, especially stigma-related barriers, such as a fear of losing friends upon disclosure, being perceived or treated differently, and barriers due to self-stigma and institutional stigma (work and university). This research can offer potential improvements to university policies and counselling services, particularly when some barriers experienced are those within universities, i.e. a lack of knowledge and information offered about the services available and difficulty approaching services. This research also highlights possible ways stigma could be reduced and discusses strengths, limitations, and areas for future research.

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Dedications and Acknowledgements

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Introduction and Literature Review

It is common knowledge that mental health illnesses affect millions of people worldwide, regardless of one's country, culture, or status. Data from the World Health Organization (WHO, 2017) estimated that at least 264 million people around the world are living with an anxiety disorder, whilst depression, considered to be the leading causing of disability around the world, is estimated to affect more than 300 million people (WHO, 2018). Despite the overwhelming prevalence of mental health illnesses, specifically the two mentioned above, they are still very misunderstood and stigmatised. When compared to even less common mental illnesses, such as schizophrenia or psychosis, the misunderstanding and stigmatisation is even more prevalent, resulting in negative stereotypes and prejudice (Rössler, 2016). The effects of mental ill health can affect, not just the individual themselves, but many different and important aspects of their life, such as socialising, studying, and working (Eisenberg, Golberstein, & Hunt, 2009; Grøtan, Sund, & Bjerkeset, 2019).

Anxiety disorders, which are the main focus of this current study, including Generalised Anxiety Disorder (GAD), Panic Disorder, and Social Anxiety Disorder (SAD), amongst many others, are some of the most commonly diagnosed mental health issues worldwide (Bandelow & Michaelis, 2015; Baxter, Vos, Scott, Ferrari, & Whiteford, 2014; Stein & Craske, 2017). Despite differences and symptoms, all of them share some general symptoms and are usually categorised by intense and persistent feelings of fear and anxiety (Mental Health Foundation [MHF], 2019b). For this research, GAD is defined as excessive anxiety and worry in regard to general everyday events and activities, such as work, family, and money, whilst SAD is defined as a persistent fear of social/performance situations and exposure to unfamiliar persons, which may result in avoidance of that situation. These definitions are more concise versions of those in the *Diagnostic and Statistical Manual of Mental Disorders* (5th Edition; DSM-V) (American Psychiatric Association [APA], 2013). Key symptoms that are necessary for a diagnosis of these disorders, based on criteria from the DSM-V (APA, 2013), whilst not explicitly part of the above definitions, are relevant for this study's inclusion criteria. Stigma, by definition, is "a mark of disgrace associated with a particular circumstance, quality, or person." ("Stigma", 2018).

Prevalence of mental health and anxiety disorders

At the global level, WHO (2017) noted that anxiety disorders are more common amongst females than males (4.6% vs. 2.6%, respectively), and that as many as 7.7% of females are estimated to suffer from an anxiety disorder compared to 3.6% of males in the Region of the Americas. In the UK, 2017 figures based on a survey of just over 9000 children and young people highlighted how girls between the ages of 17 and 19 were twice as likely to have a mental health disorder compared to their male counterparts, with over half admitting they had self-harmed or attempted suicide (Siddique, 2018). Research by Kessler, Berglund, Demler, Jin, Merikangas, and Walters (2005) discovered that by the age of 14, half of all life-long mental health disorders have already occurred, and by the age of 24, at least three-fourths have. A meta-analysis by de Lijster et al., (2017) explored and estimated the age of onset (AOO) of different anxiety disorders and specific subtypes. Out of 1028 studies, only 24 met the inclusion criteria. The estimated mean AOO for anxiety disorders in general was 21.3 years and was highest for GAD at 34.9 years. This study indicates that anxiety disorders tend to occur around the ages of 20, but that anxiety subtypes differ in their AOO. One difference between de Lijster et al's., (2017) study and Kessler et al's., (2005) study is that the former found a later AOO for anxiety compared to the latter, indicating that over the years, AOO for anxiety and anxiety subtypes actually occurs much later than what was initially found. However, although both studies researched AOO, there were differences in their study designs, which means these findings, especially when compared, may want to be taken with caution. Kessler et al's., (2005) was just one single study using the National Comorbidity Survey Replication (NCS-R; Kessler & Merikangas, 2004), albeit a study that resulted in data from 9282 respondents aged 18 and older. De Lijster et al's., (2017), on the other hand, was a meta-analysis of 24 studies that met the inclusion criteria. Sub-analyses were carried out on these studies, with six of these focusing specifically on GAD, resulting in a relatively small combined sample size of 2333 participants (1640 female and 693 male), and even smaller sample sizes within each study, in which to draw conclusions from. The meta-analysis was also unable to control for age since many of the studies sampled did not provide a mean age. This was raised as a limitation and the researchers acknowledged that older samples could result in a later AOO. When this is taken into consideration, since age could not be identified, one might argue that this could be a potential explanation for the late AOO that was identified for GAD.

Worldwide student mental health

Whilst the prevalence of mental health is striking globally, it is also prevalent within a student population. In medical students, for example, Ibrahim and Abdelreheem (2015) discovered 43.9% and 57.9% of Egyptian medical students and 29.3% and 51.1% of pharmaceutical students suffered from anxiety and depression, respectively, from a study of 164. These findings indicate that individuals undertaking what could be considered a high-pressure degree may suffer significant distress and mental health problems and highlights the prevalence of mental health disorders in students, particularly in medical students. Other studies into this specific population have identified similar, with cross-sectional data from these offering support to the prevalence of these mental health problems amongst medical students and staff (Ahmed, Banu, Al-Fageer, & Al-Suwaidi, 2009; Dyrbye, Thomas, & Shanafelt, 2006; Khan, Mahmood, Badshah, Ali, & Jamal, 2006; Schwenk, Davis, & Wimsatt, 2010; Wahed & Hassan, 2017). Studies from other international universities have found results that suggest that anxiety and depression are common amongst other students on other courses, including in Australian (Brimstone, Thistlethwaite, & Quirk, 2007), Japanese (Tomoda, Mori, Kimura, Takahashi, & Kitamura, 2000), Norwegian (Nerdrum, Rustøen, & Rønnestad, 2006), Pakistani (Ul Haq, Dar, Aslam, & Mahmood, 2018), and Turkish students (Bayram & Bilgel, 2008).

In America, The Center for Collegiate Mental Health (CCMH; 2019) published an annual report from the 2017 – 2018 academic year which included data from 152 college and university counselling centres and 179,964 college students. Although a number of data sets were available, the Clinician Index of Client Concerns (CLICC) focused primarily on identifying which mental health disorder an individual suffered from. Clinicians filled in the CLICC on behalf of their client using a "check all that apply" method, and out of 69,596 students, anxiety was one of the highest concerns (61.8%), with depression and stress being the second and third (49.8% and 43.9%, respectively). When narrowed down to the primary concern, again, anxiety was the most common (23.2%), whilst depression and specific relationship problems were second and third (19.2% and 7.7%, respectively). Although these results are interesting and indicate the prevalence of mental health amongst a student population, the report is only indicative of mental health in America, whilst the other studies mentioned offer a wider view of mental health across different countries. As the

primary focus of the current study is students from UK universities, it is important to discuss the mental health of UK students.

UK students and mental health

A web-based survey of 1129 students by Bewick, Gill, Mulhern, Barkham, and Hill (2008) found that one-third of UK students suffered from clinical levels of psychological distress and significantly higher levels of anxiety compared to depression. Psychological distress, despite having no solid conceptual definition, is normally rooted within the context of stress and distress, and is understood to be a state of emotional suffering, relating to the stress and difficult demands that can be hard to cope with in day-to-day life (Arvidsdotter, Marklund, Kylén, Taft, & Ekman, 2015; Ridner, 2004). Bewick et al., (2008) measured psychological distress using an online measure called the CORE-10, a shorter version of the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM) (Barkham et al., 2013). They found that psychological distress increased upon entering university, with distress levels being highest during the first semester of both year one and year three, and at no point during their course did distress levels drop back to how they were before individual's registered for university. A survey of 1061 British students found that over a quarter (27%) had a mental health problem. Whilst a specific course of study was not disclosed, 25% were full-time postgraduates, 15% were full-time first- and third-year students, and 19% were full-time second year students. Of these, 74% of 18- to 24-year olds indicated that they suffered from depression-related problems, 77% suffered from anxiety-related problems, and 16% suffered from an eating disorder (YouGov, 2016). Contrasting to these findings, Weale (2019) discussed how a 2018 poll of 37,500 UK students from 140 universities suggested that psychological distress was on the rise. 87.7% of respondents said they struggled with feelings of anxiety and 21.5% said they had a current mental health diagnosis, with 8.4% of these suffering from an anxiety problem. Second and third year students reported the highest levels of anxiety and loneliness, potentially attributable to higher academic pressures, considering only second and third year marks contribute to final degree classifications, or the possibility that they may be in different seminars, tutor groups, and/or general modules compared to their friends (Macaskill, 2013), as well as the impact of student debt (Adams & Moore, 2007). This does show that mental health problems are still prevalent within students, yet it does appear to show a 5.5% decrease in the number of

students suffering from one (27% in 2016 to 21.5% in 2019). Here, it is important to consider the differences in sample size (1061 (YouGov, 2016) vs. 37,500 (Weale, 2019)) when offering possible explanations for this. It would be reasonable to assume that making comparisons between a sample of 37,500 and a much smaller one of 1061 would result in what could be considered a relatively large decrease. Having said that, of the 27% (286) of students in the YouGov (2016) study who suffered from a mental health problem, 77% (220) said this was anxiety. When compared to the findings offered by Weale (2019), 21.5% (8063) said they were diagnosed with a mental health problem, and 8.4% (677) said this was anxiety, and so, arguably, it appears that both student anxiety and student mental health, in general, has actually risen in the years between these studies. However, it should be taken into consideration that despite 8.4% being diagnosed with anxiety, 87.7% (32,888) said they suffered with "feelings" of anxiety. These feelings are not necessarily indicative of an anxiety disorder, as many people deal with regular feelings of anxiety in day-to-day life, attributable to multiple things, such as stress, work, exams, etc. As the current study was focused on those who had a diagnosed mental health problem, or had previously been diagnosed with one, the above comparisons are based on the statistics which indicate a diagnosed mental health problem, rather than the broad "feelings" of anxiety. The 5.5% decrease is not necessarily an adequate reflection of the number of students that do suffer from mental health problems, but rather a reflection of the sample size differences between these two studies and the comparative percentages of those with a mental health problem. Be that as it may, the research discussed does highlight how university can be a continuous time of distress for students and, thus, it is integral that support is available to ensure students are able to successfully complete their degree (Bewick, Koutsopoulou, Miles, Slaa, & Barkham, 2010).

Universities offer one-to-one support through counselling, although it may not necessarily be adequate or available when students require it the most. Broglia, Millings, and Barkham (2018) carried out an online survey with the heads of 113 UK student counselling services and found that higher education, further education, and sixth form students received counselling with referrals to these services increasing over a 3-year period. The increased demand for counselling echoes what has been noticed in recent years, with more students seemingly requiring it compared to years ago. This could possibly be

due to the introduction and increase of tuition fees over the years, as well as the change from students grants to loans, meaning additional hardship for low-income families (Bewick et al., 2008; BBC, 2016; Thorley, 2017). It could also be due to the heightened awareness and recognition surrounding mental health problems, through things such as Mental Health Awareness weeks, World Mental Health Day, and World Suicide Prevention Day (MHF, 2019a; Time to Change, 2019), which may have led to more diagnoses.

Although the above studies and surveys are useful in showing the statistics of student mental health, one limitation is the quantitative, cross-sectional methods used to gather them. Percentages and measures from surveys can help in highlighting the prevalence of mental health problems, but there are many disadvantages in how they are carried out. Studies may use different measurement tools to measure the same disorder. For example, multiple measures have been used to measure schizophrenia across a number of studies (Wei, McGrath, Hayden, & Kutcher, 2015, 2016), making it difficult to compare findings and mental health rates. Additionally, utilisation of self-report methods, although quick to distribute and requiring fewer resources, can lead to overestimations of mental health prevalence, as was found by Thombs, Kwakkenbos, Levis, and Benedetti (2018); rates of depression, especially in low-prevalence areas, were exaggerated, resulting in misinformation about the number of individuals who required help and treatment. Sample sizes for surveys also differ, subsequently meaning that possible comparisons may not accurately reflect increases or decreases. Alongside issues with methodology and prevalence rates, quantitative methods also fail to grasp how these individuals cope and understand their own mental health experiences, which can be better explored using qualitative methods (Bryman, 2016), especially in the context of the current research.

Disclosure patterns, help-seeking and stigma

It is important to understand what stigma is in order to explain and understand why it has an impact on disclosure. It is conceptualised to be a socially constructed mark of disapproval, disgrace, or shame, and results in disadvantages, discrimination, status loss, and a lack of opportunities for those that experience it. A 1999 report from the US Surgeon General emphasised just how detrimental mental health stigma is, labelling it a "formidable obstacle to future progress in the area of mental illness and health." (U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General, 1999, pg.

3). Stigma may present itself as the individual's own internalised self-stigma or stigma they may perceive from the public (Haddad & Haddad, 2015). Public stigma is the negative attitudes, stereotypes, and discrimination that is directed at those who are deemed to be different to the general population, whilst personal stigma, or self-stigma, is the internalisation of these public attitudes, resulting in negative self-endorsed stereotypes and prejudices, as well as low self-esteem and self-worth (Corrigan & Rao, 2012). Stigma can impact on students' decisions to disclose information to professionals, family, and friends. Storrie, Ahern, and Tuckett (2010) found that students in America avoided seeking help because they perceived having a mental health problem as being weak and they were unwilling to use their university services as they believed their emotional problems would be misunderstood, resulting in stigmatisation for being in emotional distress. Medical students also believed their professional lives were in jeopardy and that there were potential implications for career progression if their mental health problem(s) were revealed. Furthermore, findings from a replication of the National Comorbidity Survey reported that at least one-fifth of individuals receiving treatment for their mental health withdrew due to perceived public stigma (Motjabai et al., 2011), indicating that even after seeking help, stigma still impacted on their treatment.

This stigma surrounding mental health illnesses has resulted in a decreased likelihood of disclosure (Carpenter & Greene, 2013). Choosing to disclose about one's mental health may lead to stigmatisation, judgement, and could have a negative impact on wellbeing and mental health. However, it could lead to peer support and improved mental health (Verhaeghe, Bracke, & Bruynooghe, 2008), and the development of a supportive social network (Bos, Kanner, Muris, Janssen, & Mayer, 2009; Garcia & Crocker, 2008; Reavley & Jorm, 2014). Avoiding disclosure and concealing is more likely to reduce the chances for help and support and may cause increased stress and psychological challenges (Pachankis, 2007). Many may not disclose or seek help because they do not want to be labelled mentally ill or face the stigma that is associated with it (Corrigan, 2004), whilst others may fear being ostracised, losing friends, or jeopardising potential opportunities (Jaffe, 2011). It must be noted that not all disclosure results in help-seeking and distinguishing between disclosure that results in this behaviour and disclosure that may not necessarily be based on wanting help, e.g. distress disclosure, is important. Distress

disclosure is considered to be an individual's willingness to disclose about psychologically distressing personal experiences to others (Ward, Doherty, & Moran, 2007). Kahn and Hessling (2001) also offer a distinction between distress disclosure and self-disclosure, indicating that self-disclosure can include disclosure of negative and unpleasant thoughts and feelings, but also includes disclosure about more trivial things, like hobbies and interests. One model of disclosure is the Disclosure Decision Model (DDM; Omarzu, 2000), which outlines how individuals follow different decision-making processes, such as the content to disclose, the breadth and duration of disclosure, and the depth of their self-disclosure before they decide on whether they will disclose. The Distress Disclosure Index (DDI; Kahn & Hessling, 2001) is used to measure distress disclosure and results have shown that increased disclosure is associated with fewer psychological symptoms and greater well-being (Kahn, Wei, Su, Han, & Strojewska, 2017), professional help-seeking attitudes and intentions (Kahn, Hucke, Bradley, Glinski, & Malak, 2012), and individual's tend to benefit more from therapy and have more positive attitudes towards it (Kahn, Achter, & Shambaugh, 2001; Vogel & Wester, 2003). Another model, the Disclosure Decision-Making Model (DD-MM; Greene, 2009), has also been used to explore this type of disclosure and in students, self-consciousness, social support, and femininity seemed to indicate higher distress disclosure, whilst shame was associated with lower distress disclosure (Greenland, Scourfield, Maxwell, Prior, & Scourfield, 2009).

Individuals may conceal their mental health for fear of being stigmatised or treated unfavourably, with many worried that others may find out about their mental health (Wahl, 1999). Whilst self-concealment could be considered non-disclosure, Schrimshaw, Siegel, Downing, and Parsons (2013) and Meidlinger and Hope (2014) offer distinctions, stating that disclosure tends to be the revealing of information to others, whereas concealment tends to be the prevention of disclosing information, especially stigmatising information. In this sense, self-concealment can be seen as an individual's active attempts to not only avoid disclosure, but to also try and prevent any type of disclosure about their problem. Further to this, Jackson and Mohr (2016) discuss how disclosure may be driven by a need for greater levels of trust or closeness, whilst concealment may be driven by wanting to prevent embarrassment or stigmatisation. Kelly and Achter (1995) found that self-concealment was positively associated with higher levels of distress and a greater avoidance of seeking help,

whilst Cepeda-Bonito and Short (1998) discovered that low social support was associated with a greater need for psychological help, but when self-concealment was high, this need was reduced. A recent systematic review of 19 articles by Grice, Alcock, and Scior (2018) found common factors affected disclosure and concealment, including anticipated stigma, relationship with the person they wanted to disclose to, and the rules and beliefs about mental health problems. One qualitative study that was reviewed highlighted how some individuals felt obligated to talk about their mental health in order to build and improve their personal relationships, whilst another showed how some individuals felt as though mental health was something that should not be discussed.

One noticeable finding is how family and friends appear to be a preferred source of help and support compared to professionals (Rickwood et al., 2007; Rüsch, Brohan, Gabbidon, Thornicroft, & Clement, 2014; Rüsch, Evans-Lacko, Henderson, Flach, & Thornicroft, 2011; Salaheddin & Mason, 2016). A recent survey carried out by the Higher Education Policy Institute (HEPI) (Neves & Hillman, 2019) found that from a poll of 14,072 students, 66% of them would be happy for their parents to be contacted about their mental health in extreme circumstances and 15% in any circumstances. Multiple factors could tie into this, such as the closeness of the relationship, a high level of trust between both parties, and the knowledge that they would not feel stigmatised. Significant differences arose when undergraduate students that were aged 26 and over (881) were compared against the total sample, with 24% of these not wanting their parents to be contacted. Given that many mature students may feel independent at that age or may not necessarily have direct contact with their parents, it is reasonable that this group may not want their parents to know about their mental health.

Barriers to mental health care

Considering the prevalence of mental health in students and the different factors that impinge on disclosure and help-seeking, one question stands: if mental health problems are this prevalent in young adults and students, why do many not seek help? In answer to this, a growing body of research suggests that young people are reluctant to seek help and tend to face barriers when they do. Although anxiety disorders are highly treatable through means such as therapy or medication, UK statistics have shown that young people aged between 16 and 24 are less likely to receive mental health treatment compared to other age

groups (MHF, 2016), which may deter them from seeking help, considering they may not receive it. Psychosocial factors such as poverty, a lack of access to mental health services, and mistrusting the service provider have been given as reasons for the underuse of mental health services in students (Masuda, Anderson, & Edmonds, 2012), whilst a lack of awareness and understanding surrounding mental health, gaps in service provisions, and a fear of being stigmatised by friends or tutors have also been cited as barriers (Collins & Mowbray, 2005).

According to British university tutors, 27% believed that the student's unwillingness to access or receive help from mental health services was one of the biggest difficulties they encountered, believing it to be due to the stigma of disclosing mental health problems (Stanley & Manthorpe, 2001). Yet, despite their unwillingness to utilise services, personal supervisors were a source of help for students, second only to family and friends. Out of the 429 tutors who responded, 26% believed their lack of skills and experience was a problem for students who came to them for help, whilst 30% of them thought they had been useful in offering support. Furthermore, Martin (2010) stated that stigma is a powerful barrier that impedes on students seeking and receiving help and she found that nine participants out of 54 specified that a fear of being judged, stigmatised, or being treated differently to other students meant they did not want to disclose information about their mental health. However, 34 students said they had not disclosed to university staff, citing things such as privacy and confidentiality, not feeling like it was necessary to disclose, and bad past experiences as reasons for their non-disclosure, and so, the nine participants who specified stigma affected their disclosure are not necessarily generalisable to the wider student population. Salaheddin and Mason (2016) discovered that stigmatising beliefs, difficulty accepting help, perceiving their problem as trivial, and the fear of negative outcomes were barriers to seeking help for 38 participants out of 45 (84%), whilst 37% to 84% of students who screened positive for depression or anxiety at a large public university cited scepticism about effective treatment and an unawareness of services as reasons why they did not seek help (Eisenberg, Golberstin, & Gollust, 2007).

Research Aims

Over the years, research into anxiety and mental health in general has grown, largely due to the increased interest and understanding of the impact they have on those who live

with them. It is vital that this area continues to be researched and explored in order to facilitate further discussion, extend people's understanding about how difficult these illnesses can be, and to help reduce the stigma surrounding them. However, there are some limitations to the research discussed above, such as the use of quantitative, cross-sectional methods to gather findings, and so, it is important to approach this topic area using different methods, like in the current research. More research is necessary to uncover how stigma impacts on students and, in turn, how this affects their decisions on disclosing information about their mental health. Knowing this information may offer potential improvements to counselling services and university policies, especially if they are able to understand the reasons behind students' unwillingness to disclose or seek help. The current study utilised a mixed methods approach, by using questionnaires and interviews with a number of fellow university students from a university in the North of England, in order to:

1. Explore the topic of anxiety, stigma, and help-seeking behaviours, looking specifically at the topic of disclosure.
2. Explore where an individual feels as though mental health stigma has an impact on their decision to seek help.
3. Explore how an individual decides whom to disclose information regarding their mental health to, and why they might decide to disclose information to certain people above others.

Methodology

Design

      This study utilised a mixed-methods design which included two questionnaires and a semi-structured qualitative interview. The use of questionnaires was to gain an understanding of which type of anxiety the participants had experienced (GAD or SAD), allowing the questions to be tailored to explore this more effectively and guide the direction of the interview. Semi-structured interviews were used to explore the research topic in a more in-depth way and to gauge the participants own feelings and thoughts about the topic at hand. A qualitative method is a much more appropriate method compared to quantitative methods to gain in-depth information. Quantitative methods tend to deal with information that can be measured, resulting in a numerical result, whilst qualitative methods explore the "how" and "why" of a topic, producing a larger range of information to analyse and a more comprehensive understanding of the topic.

Sample

Participants

      Purposive sampling was the chosen sampling method for this study. This is a nonprobability sampling technique and although there are limitations, such as subjectivity in the sample chosen resulting in one that may not necessarily be a generalisable representation of the population, they are useful to use, especially when the researcher has limited time and resources (Etikan, Musa, & Alkassim, 2016). Purposive sampling is mainly used in qualitative studies and involves deliberately and carefully choosing participants that possess the necessary qualities or fit the criteria required for the study at hand (Etikan et al., 2016), with the belief that they will provide information that is unique and rich in value (Suen, Huang, & Lee, 2014). This differs from a method such as convenience sampling. Whilst this method is similar, it involves sampling members of the target population that fit more practical criteria, like availability and accessibility, and is used in both quantitative and qualitative research (Etikan et al., 2016; Suen et al., 2014). As this research aimed to explore the topic of anxiety in university students and had set criteria necessary for inclusion, purposive sampling was a more appropriate method to use. The type of purposive sampling used was typical case. This type of method emphasises depth and similarity amongst participants and can be used to explore a phenomenon that is "typical" or "average" within

a population (Palinkas, Horwitz, Green, Wisdom, Duan, & Hoagwood, 2015). In regard to this study, I was interested in exploring anxiety in students, particularly the disclosure of anxiety. This meant that participant recruitment was focused on students with anxiety, or those who had suffered with it in the past, in order to ascertain what their experiences were like.

Since qualitative methods were used, a small sample size is generally more acceptable, as the resulting data is in-depth, rich, and focuses on the individual's feelings and behaviours around the research area. Marshall (1996) points out how for qualitative studies, sample sizes can vary based on the research question, with simple questions potentially requiring samples in the single figures and more complex questions requiring a larger sample and multiple sampling techniques. Additionally, Crouch and McKenzie (2006) explain how small samples, especially for interview-based qualitative research, are beneficial, allowing for a close association between the researcher and respondent, resulting in rich and in-depth data. Braun and Clarke (2013) categorised sample sizes for a project using thematic analysis by the type of data collection and the size of the project at hand. For small projects that used interviews as the method of data collection, they recommended between six and 10 participants. Whilst unclear how these numbers were decided on, justification seems to come from the researcher having enough data to identify patterns, but not too much that it is hard for them to manage. Research from Guest, Bunce, and Johnson (2006) provides a basis for the above findings. In their study, data saturation seemed to occur after the analysis of their twelfth interview and new themes emerged less frequently after this point. The current study aimed to explore the topic of anxiety, stigma, and help-seeking behaviours in students, specifically focusing on their decisions pertaining to the disclosure of their mental health, and when looking at the above research on sample sizes and the size and scale of the research at hand, the 12 participants who took part and were interviewed appeared to be an adequate number.

Inclusion and exclusion criteria

The main inclusion criteria was a list of symptoms that related to both GAD and SAD, based on criteria from the DSM-V (APA, 2013). Participants had to have had an experience of any of the following:

- Avoiding activities in which they are the centre of attention
- Becoming easily annoyed or irritable

- Being so restless that it is hard to sit still

- Fear of judgement/embarrassment

- Feeling afraid as if something awful might happen

- Feeling nervous, anxious or on edge

- Not being able to stop or control worrying

- Trouble relaxing

- Worrying too much about different things

If participants had experienced any of the above, either in the past or present, they were asked to contact the researcher for more information about the study.

The only exclusion criteria was if they were not currently students at the university. The two questionnaires had upper and lower limits to scores although this did not exclude anyone from taking part. Rather, if they scored a certain score or above on either of the questionnaires, they were advised to seek help from their General Practitioner (GP), per the recommendations from the questionnaire creators (six or above on the Mini Social Phobia Inventory (Mini-SPIN) (Connor, Kobak, Churchill, Katzelnick, & Davidson, 2001) and 10 or above on the Generalised Anxiety Disorder Questionnaire (GAD-7) (Spitzer, Kroenke, Williams, & Löwe, 2006).

Procedure

Identifying and recruiting participants

The study was advertised around the university campus using flyers (see Appendix A) asking for participants who had experienced symptoms of anxiety to email the researcher if they would like to take part in a research study. Emails (see Appendix B) were sent out to 28 course leaders across the university with details about the study and it asked if they were willing to forward the email on to their students to find potential participants. Seven of these course leaders replied to confirm they had circulated it. Any students who received the email or saw the recruitment flyer and wished to take part emailed the researcher to express their interest. It is unclear whether all the emails received from students showing an interest were due to a circulated email or from viewing the flyer around campus. As anxiety in males is an under-researched and stigmatised area, it was important to try and interview both males and females, and recruitment targeted students in typically male-dominated

disciplines, like engineering. An information sheet (see Appendix C) was emailed to those interested, giving them more information about what the study would entail, and prospective participants were then offered the choice to take part in face-to-face or email interviews.

Data collection

For those who opted for a face-to-face interview, a date, a time, and a location on campus were decided upon. On arrival, the participant was provided with a consent form (see Appendix D) and another copy of the information sheet, which reiterated what the study would entail and covered the options for withdrawal and taking breaks if they felt distressed throughout. Once consent forms were signed and returned, participants were asked to fill in two questionnaires to measure their anxiety (discussed further in the *Materials* section). The questionnaires were used to verify the inclusion criteria and ensure those who were taking part had in fact experienced symptoms associated with anxiety, either in the past or present. Although the questionnaires reviewed anxiety symptoms over a week or a 2-week period (Mini-SPIN and GAD-7, respectively), participants were not excluded if their scores were particularly low. Instead, the interview allowed further exploration and I was able to ascertain whether the participants had experienced their anxiety in the past or were currently experiencing it. It is worth noting that low scores on these questionnaires were not and are not necessarily indicative of a participant's anxiety in general, as they were only measuring anxiety symptoms over a certain period of time. It could be that low scores were a result of participant's symptoms being mild throughout the time periods in question, and therefore, are not illustrative of particular periods where their anxiety symptoms are more severe. These questionnaires were also used to help guide the direction of the interview and tailor the questions to explore the anxiety the individual had. For instance, those who scored higher on the social anxiety questionnaire were asked questions pertaining to that rather than generalised anxiety, and vice versa. The first questionnaire was the GAD-7 (see Appendix E), a seven-item scale that was used to measure GAD, whilst the second was the Mini-SPIN (see Appendix F), a three-item scale used as a screening tool for SAD. Once the questionnaires were completed, scores were totalled and given as feedback to the participant. As mentioned earlier, those who scored above a certain score were advised to speak to their GP. The participant was then told about the

interview and what would happen and were informed it would be recorded for research purposes with their consent. The participant was eased into the interview process by being asked a few starter questions prepared beforehand from an interview guide (see Appendix G), which asked about their experience of university life. After this, the purpose of the interview was explained and information regarding stopping the interview at any point, avoiding answering any questions that may distress/make them uncomfortable, and taking a break if they needed to was reiterated before the main questions were asked. Participants were asked a series of questions that explored their anxiety symptoms, their help-seeking behaviours, stigma, and their decision making around disclosure and help-seeking. The direction of the interview was tailored to the replies received. The final question was an opportunity for the participant to ask any questions they may have had or to disclose any information that might not have been covered during the interview. The audio recording was then terminated, participants were thanked for their participation, and given a debrief sheet (see Appendix H), explaining the study they had taken part in and contact details for possible support services they could contact if they felt distressed following their participation.

For email interviews, participants were sent a file that contained an information sheet, a consent form, and the two questionnaires which were all password protected. This ensured that if the email was accidentally sent to the wrong person, they were unable to access the document. Participants were asked to read through the information sheet, sign the consent form to ensure they understood what the study entailed and what they would be taking part in, fill out both questionnaires, and then return all documents in the file. Another email was then sent which outlined the time frame for the email exchange (1 month), the timeframe for general replies, and the hours between which replies would be sent (9am – 5pm). They were asked the same starter questions to ease them into the interview and the purpose of the interview was explained. The main questions were then emailed, three per email, and the flow of the interview was, again, tailored to the replies received. Reminder emails would have been sent after a week of unresponsiveness, enquiring as to whether the previous email had been received (and if not, that it could be resent), and if they would still like to take part, but since all participants saw the interview through until the very end, reminder emails were not necessary. After answering the final

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question, participants were thanked for taking part and sent the debrief sheet, providing them with the relevant support services if they required it.

Data storage

All data collected throughout this study was stored on the university servers. All documents were password protected and were stored in a folder within the researcher's personal university K: drive which only they had access to. A back up copy of any work was also kept on the university servers, per the university's guidelines on data storage. For face-to-face interviews, an encrypted recording device was used to ensure data confidentiality. The recordings were then uploaded into the researcher's K: drive and were stored in a password protected file, allowing easy access for the transcription process. For all email interviews, participants were sent password protected documents and participants had to ensure documents were sent back password protected. Any research data that was stored on pen drives before being uploaded to university servers was stored in a password protected file/document which only the researcher had access to.

All research data is stored at the university for a period of 10 years after the completion of the project and participants were informed of this before taking part in the study so they were aware of how their data would be stored after completion. The information regarding other data storage, such as password protected folders/documents, was also included in the information sheet and consent form, so participants were aware of how their data would be stored throughout the study.

Measures

Two measures were chosen for this study. The first was the GAD-7. Past research evidence from Spitzer et al., (2006) indicates that it has good reliability and good criterion, construct, factorial and procedural validity, with sensitivity and specificity optimised at 89% and 82% respectively, whilst Löwe et al., (2008) found that the GAD-7 is a reliable and valid measure of anxiety, especially in the general population. This measure is also widely used amongst medical professionals as a screening tool for anxiety, resulting in further evaluation and referral if the total score is over 10. Comprised of seven questions, this questionnaire measured whether certain aspects of general anxiety had bothered the participant over a two-week period and included questions such as "Being so restless that it is hard to sit still?" and "Feeling afraid as if something awful might happen?". Participants had to answer on a

scale of zero to three, with zero being "not at all" and three being "nearly every day". The scores were totalled out of 21 at the end and scores of five, 10 and 15 were the cut off points for mild, moderate, and severe anxiety, respectively. For those who scored over 10, further evaluation from a GP was recommended.

The second questionnaire was the Mini-SPIN. Research from the creators of this found that a cut-off score of six or more resulted in 88.7% sensitivity, 90.0% specificity, 52.5% positive predictive value, and 98.5% negative predictive value, with this measure also possessing 90.0% accuracy in diagnosing SAD (Connor et al., 2001). Seeley-Wait, Abbott, and Rapee (2009) found strong support for this measure and its ability to identify those with SAD from those without it, with their findings suggesting the Mini-SPIN is both reliable and valid as a measure of SAD. This three-item, self-rate scale is a smaller version of the original 17-item Social Phobia Inventory (SPIN) (Connor, Davidson, Churchill, Sherwood, Foa, & Weisler, 2000). The questions measured aspects of social anxiety over a one-week period and included these three statements: "Fear of embarrassment causes me to avoid doing things or speaking to people," "I avoid activities in which I am the centre of attention," and "Being embarrassed or looking stupid are amongst my worst fears." Participants had to rate each statement on a scale of zero to four, with zero being "not at all", and four being "extremely". Again, the scores were added up at the end to give a total out of 12, and those who scored six or higher were advised to speak to their GP for further evaluation.

Ethical considerations

An ethics applications form was submitted to the School Research and Ethics Panel (SREP), and ethical clearance was obtained (SREP/2017/116).

Confidentiality and anonymity

The ethics form covered the issues of confidentiality and anonymity in detail. For confidentiality, all participants who took part in this study were assured that their personal information would be kept confidential at all times unless anything they discussed in the interview indicated that they, or anyone else, was at risk of harm. If this was the case, personal information was passed onto the relevant person(s) to ensure the participant received proper support. This was a plan that was in place, but no participants who were interviewed indicated at any point during their interview that they, or anyone else, was at risk, and so this plan was not utilised during this study. Any information discussed during the

interview was unable to be linked back to any participants and they were given an ID number which was used for quotes during write up. The data from face-to-face interviews was recorded and only listened to by the researcher during transcription. Email interviews were carried out between the researcher's university email account which was more secure than using a personal email account. Whilst system administrators may have been able to view these exchanges, causing this to be the only difficulty in ensuring email confidentiality, there were ways to minimise any inadvertent disclosure. The senders email address/user ID was not used for any quotes, and instead, the ID number given to them during the pre-interview stage was used.

Regarding anonymity, as mentioned above, any quotes that may have contained any identifiable information, such as specific services, university staff, health service staff, and organisations, were omitted, and instead, have been referred to as such: "When I attended [name of service] …"

Safety and wellbeing (for participants and researcher)

Due to the nature of the research, it was paramount that participant's safety and wellbeing was taken into consideration and that safeguards were in place for them. All participants were given the right to withdraw from the study at any point, as well as the right to withdraw their data, and to decline answering any questions that may have caused them discomfort or distress. For any participants who took part in the full interview and wanted to withdraw their data afterwards, a time point was indicated on the information sheet and debrief sheet, which informed them of the cut-off point for withdrawing data. Participant's had to email the researcher, quote their ID number, and inform the researcher that they would like their data to be removed. Despite the right to withdraw their data, no participants chose to do so, and all data collected from the 12 who participated has been included.

Every effort was made to ensure no psychological harm/distress came to participants. However, the sensitive nature of the topic, and the fact participants were asked to talk about their mental health, may have exacerbated their anxiety, and some participants may have felt uncomfortable or distressed throughout the interview process or afterwards. To reduce this, participants were offered the option to stop or pause the interview, especially if there were any obvious signs of distress/discomfort present, and

were given some time to compose themselves, before either continuing with the interview or withdrawing. All participants were aware of this and it was reiterated throughout the interview process whenever distress became apparent. A debrief sheet was provided at the end of the interview with information for different support services that could be accessed if participants required them, including the university's counselling services, local support services around the area, student specific services, and details for well-known mental health services, e.g. MIND/Samaritans. For those participants who scored over six on the Mini-SPIN or 10 on the GAD-7, they were reminded and were encouraged to speak to their GP for further support and evaluation.

The researcher's safety was also important throughout this study and safeguards were also in place for them. All face-to-face interviews were carried out on the university campus. All dates, times, and room locations were emailed to the researcher's supervisors and an email was sent upon leaving the interview.

Analysis method

For the analysis stage, thematic analysis was used. Commonly used in qualitative research, this is a useful method for those who are unfamiliar with more complex types of analysis, and it involves identifying and analysing themes and patterns within the research data (Braun & Clarke, 2006). Using thematic analysis meant a much richer and more detailed description of the data was uncovered. It can also be used across a wide range of theoretical positions, resulting in flexibility, and it does not require a detailed theoretical knowledge, meaning it is a much more accessible form of analysis (Braun & Clarke, 2006). Throughout the analysis, codes were identified within all the interview transcripts and common themes and sub-themes were identified and created. Coding of the first interview was also carried out by the researcher's supervisors, bringing up the issue of inter-rater reliability. This refers to the reliability of multiple data collectors and coders and the extent to which they agree on and interpret the data at hand (McHugh, 2012). Although similarities and agreements on certain codes were found by the researcher and the supervisors, there were also differences in how sentences were interpreted for the creation of that code, causing some disagreements. There is literature surrounding inter-rater reliability, and yet, there is little literature surrounding it in relation to coding in-depth semi-structured interview data (Campbell, Quincy, Osserman, & Pedersen, 2013). An early study by Armstrong, Gosling,

Weinman, and Marteau (1997) found that when six researchers were asked to identify themes from a focus group transcript, they were in close agreement on basic themes, but "packaged" each theme differently due to the way they interpreted statements. Whilst this research does not focus on a single respondent interview, it does show how similarities and differences of opinion can arise between researchers, which can affect the inter-rater reliability.

Braun and Clarke's (2006) thematic analysis method was the chosen method used and it is comprised of six different stages. Stage one involves familiarising yourself with the data available. This requires multiple read throughs of your interviews, identifying initial patterns and themes, and getting to understand your data before beginning the next stage. Throughout this analysis, all interviews were read through multiple times to gain an understanding of data that was to be worked with and to identify any relatable patterns. The second stage is when coding begins. After making sense of the data and generating an initial list of possible patterns and ideas, code production begins. Codes tend to identify a specific feature of the data that is interesting and could be grouped together to form patterns. They are not just limited to one particular pattern/theme and it is not uncommon to find that they can fit into more than one potential theme. Stage three is when themes are identified and happens after all data has been coded. This stage essentially involves analysing the codes identified, combining these to form a theme and identifying quotes that can help explain them. The codes from this research were collated, grouped together and initially formed around seven different themes, many of which were refined in the next stage. Stage four begins after initial themes have been developed and usually requires reviewing and further refining these themes until permanent final themes are identified. Some of the themes initially developed may collapse into each other, so, two separate themes may be grouped to form one theme, or some may need to be separated. It is important that the themes developed relate to the research question at hand and are able to adequately help answer what is being explored. The process of creating and developing themes was slightly time-consuming and many had to be refined before being finalised. After refining, three themes were identified that helped answer the current research question. The fifth stage involves defining and naming the themes created. This, in short, involves defining and capturing the essence of the theme and what it covers and captures.

The three themes developed all related to the research question, with one covering disclosure and help-seeking, one covering stigma, and one covering the wider impact of social media on mental health. The sixth and final stage is producing the report. After finalising and defining themes, the final analysis and write-up takes place. Through the use of the themes and quotes that pertain to and help explain that theme, the report should result in a story of the data with sufficient evidence to help support and illustrate any claims and arguments made.

Findings

At the beginning of this study, 18 individuals contacted the researcher and expressed an interest. However, only 12 of them enquired for more information and confirmed that they would be willing to take part. All 12 of these students were from a university based in the north of England and were interviewed; nine via face-to-face and three via email. The students ranged from those undergoing undergraduate study to those in postgraduate study (ages 20 – 42), with seven of these being female and five being male (see Table 1). For confidentiality reasons, courses have been omitted from the table as identification of students may have been possible.

Participant	Age	M/F	Cultural background	GAD-7 score	Mini-SPIN score	Received therapy before?	Interview type
1	22	F	British	12	7	Yes	Face-to-face
2	29	F	British	16	7	Yes	Face-to-face
3	20	F	British	9	3	Yes	Face-to-face
4	42	M	American	14	5	Yes	Face-to-face
5	21	F	Chinese/East Asian	8	10	Yes	Face-to-face
6	40	F	British	7	3	Yes	Face-to-face
7	Not disclosed, but mature student	M	Colombian/Hispanic	2	0	Yes	Face-to-face
8	20	M	British	16	4	Yes	Email
9	Not disclosed; indicated mature student	F	British	13	2	Yes	Email
10	20	M	British	6	7	Yes	Face-to-face
11	Not disclosed	M	British	18	9	No	Face-to-face
12	Not disclosed	F	British	16	8	Yes	Email

Table 1: A table to show the information of all the participants who took part.

As mentioned previously, Braun and Clarke's (2006) thematic analysis was used for this research and three overarching themes were created. These were: '*Disclosure patterns'*, '*Social media impact on mental health disclosure'* and '*Barriers and stigma experienced'*. All of these aim to explore how and why mental health stigma impacts upon disclosure and

help-seeking behaviours and they all contain sub-themes, allowing for a more thorough and in-depth understanding of the participant's overall experience (see Figure 1). These findings will be discussed and considered in relation to previous research and implications for future study and further understanding of the current research topic will be examined. Furthermore, whilst unknown at the start, this research and the topic explored resulted in shared beliefs and experiences between the participants, offering support to Guest et al's., (2006) research about sample sizes and further affirming that 12 interviews can be sufficient for qualitative research.
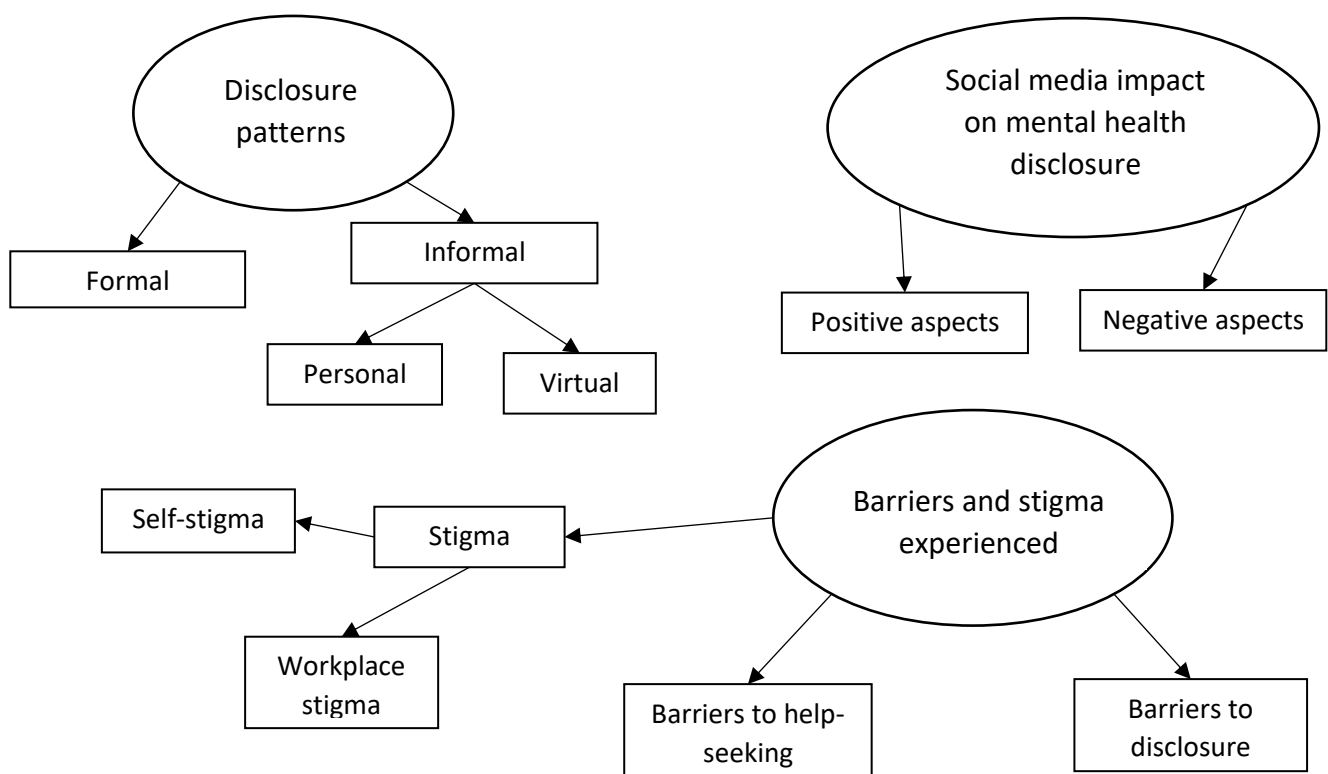
Figure 1: Final thematic map showing the final three themes and their sub themes.

Disclosure patterns

      This theme encompassed and highlighted the different ways each participant disclosed information about their mental health and who they decided to disclose to. Two sub-themes were created: "*formal disclosure*", which related to participants choosing to disclose to those in specialist and non-specialist areas and included the codes "general practitioners (GPs)", "counsellors/therapists", "supervisors/tutors" and "work managers", and "*informal disclosure*", which covered participant's disclosure to individuals from non-professional areas. Two small sub-themes branched off from this theme; "*personal*", which

included codes such as "real life friends", "family", and "romantic partners" and *virtual*, which covered online disclosure through codes such as "blogs/social media" and "online friends" (see Figure 1). Some common patterns emerged from the interview data surrounding who participants initially decided to disclose to upon first experiencing their anxiety symptoms and who they fully disclosed, part disclosed and did not disclose to, with reasons behind these disclosures linking into both of the sub-themes discussed above.

Formal disclosure

Five participants indicated that they had initially disclosed to someone that would come under the "*formal*" sub-theme: three to a counsellor/GP, one to a psychotherapist, and one to their university tutor. Throughout each interview, some participants implied their depth of disclosure and reasons were identified for why some participants disclosed in-depth and why some did not. GPs were one of the most common professionals that participants chose to disclose to. Participant one, for instance, experienced a change in her behaviour and started experiencing symptoms of her anxiety that she had never experienced before coming to university, and this prompted her to seek help from her GP. Whilst she did not actually specify the level of disclosure, from the quote below, it would seem she went into some depth about what she was going through:

… I was having panic attacks like every week, like, maybe even like multiple times a week [yeah]*, erm (.). And, I still don't really know, like, what it was, like, that was causing it, but I did go to the doctors then and that's when the doctor kind of just like, said to me, "Oh, maybe you have got anxiety," and like, she did do different tests on me and everything…* [Participant one, female, lines 133 – 138]

Participants five and eight both said that they had spoken to their GPs, but did not reveal the depth of disclosure, although both specified their reasoning behind visiting the GP and about how they were referred to counselling:

After speaking to my GP, because I was called to attend a GP after I took a quiz, that I think was on [university website] *about depression… I spoke to my GP, and she suggested that I speak to the counselling services at student services.* [Participant five, female, lines 108 – 111]

I think it was the fact I was unable to leave my house and attend school. I saw the GP soon after that, and the GP referred me to the counsellors. [Participant eight, male, lines 70 – 71]

For participant five, there was a slight confusion as to how her GP consultation actually came about. From the quote above, she specifies that she was called into the GP because of a quiz she took online, potentially resulting in a screening result which caused her GP to call her in for a further assessment, but little detail was given about how the consultation came about. However, further on in her interview, she mentions that she disclosed to her GP because she was fired from her job and struggled to cope with this, prompting her to speak to someone:

> I: … so, what caused you to actually speak to a GP?
>
> P: Erm, it was that time where I was—I've always kind of been in a tight financial situation, but that week—I basically, sort of, got fired from my part-time job…
>
> I: … so, that was kind of the moment where you went and spoke to a GP?
>
> P: Yeah, because I felt like I needed somebody (.) to talk to, and it had to be somebody who could, sort of, convince me to calm down a little bit more. [Participant five, female, lines 187 – 198]

This disparity in her account of what led her to speak to her GP can highlight the difficulties some individuals go through in taking steps and making sense of their anxiety. For some participants, it seemed as though they were able to recount their journey and what they went through quite easily, whereas others made some contradictions, as though talking about it and recalling their experience was a difficult thing.

Participant nine's reason for seeking help and disclosing to her GP appeared to be because of anxiety relating to her pregnancy and the safety of her baby, potentially indicating that she only really sought help when it came to worrying about the safety of others, rather than the safety of herself:

> The anxiety caused by pregnancy became unbearable and I began to worry constantly about the safety of my baby. I talked to my then husband and went to my GP. [Participant nine, female, lines 81 – 83]

She also explained that she had never spoken to her parents about her mental health. After speaking to her GP, however, her parents were made aware of her anxiety, which may indicate that formal services disclosed about what she was going through:

> Yes, my parents knew all about it. It was impossible to hide as I was covered in cuts from self-harming and they were informed when I took overdoses as an adult. [Participant nine, female, lines 88 – 90]

Participant 11 stated that he initially spoke informally to his mother, but that she encouraged him to speak to a GP, resulting in him disclosing:

… I've only talked to (.) my erm, [pause] mum and GP about it. [Participant 11, male, line 75]

Counsellors and therapists were another group that participants disclosed to, indicating that professional disclosure, particularly in this study, is favoured by both males and females, and young and mature students. There were only three participants who did not indicate disclosure to this group or specify that they had never spoken to them. Again, some were explicit with their level of disclosure, whilst others were briefer and more unclear. Participant two indicated she had spoken to counsellors and the quote below seems to imply that she tends to speak quite in-depth to her counsellors:

… I wouldn't say specifically today, because I'm not going into that much detail… but [yeah]*, when I've spoken to counsellors… I tend to feel quite rubbish later on that day… because it brings stuff up and you're talking about stuff and then, I might find I go home and have a big cry* [yeah]*, and then maybe tomorrow or the day after, I feel a little bit better.* [Participant two, female, lines 284 – 289]

Participant three was the only person who found hypnotherapy worked best for her in terms of helping her understand and control her anxiety:

*… the only person who ever really (.) knows the full in-depth story of why I felt that way, erm, was the hypnotherapist that I saw, because when I went to counselling, I never opened up, because I didn't feel comfortable… whereas with my hypnotherapist, she was lovely (.) erm, and straight away she was like, "*I can definitely help you as long as you're willing to help yourself,*"… she was kind of the only person that I opened up to fully.* [Participant three, female, lines 96 – 103]

Only two participants said that they had never spoken to, or no longer spoke to counsellors, which were participants three and 11:

… truthfully, I know counselling doesn't work for me, so there's just no point in me going there again... because I kind of dealt with things in the hypnotherapy and closed that box; now, when I try and do things or talk about everything again, in a lot of detail, it just brings the same feelings up, and I end up for a couple of days not feeling well, mentally, because of it… I kind of feel like I don't know how to deal with it… I kind of feel that if I go along that route of trying to seek help again, unless it was with the person that I had hypnotherapy with [yeah]*, I just feel like it—I couldn't.* [Participant three, female, lines 320 – 334]

I: … Do you think there would be any situation(s) where you would seek help from like a counsellor or a professional?

P: … if I started to get really bad and down, and started to, erm—what's the word? Isolate myself [yeah]*.* [Participant 11, male, lines 91 – 94]

Other formal specialists and non-specialists that participants spoke to were psychoanalysts, psychologists, supervisors, teachers, tutors, and work managers, with most of this disclosure seemingly being part-disclosure, although some could be considered full disclosure. Participant four, for example, spoke about his disclosure to psychologists and psychiatrists below:

… I generally have been fairly open with my—with psychologists and psychiatrists that I've seen over the years. Erm, the first couple, I may not have been that particularly honest with, but then again, I was younger, erm, and as I've grown up and as I've matured, I've definitely been more open and willing to talk with my psychologists about my—you know, the issues that I'm going through. [Participant four, male, lines 190 – 195]

Whilst he initially started off partly disclosing about his problems as well as being dishonest with the first few specialists he talked to, he went on to talk about his willingness to disclose, openly and honestly, as he got older.

Almost all the participants interviewed had, at some point, disclosed about their mental health to someone who would come under the "*formal*" disclosure sub-theme. There were quite a few similarities throughout the interviews. For instance, a few participants indicated that they had sought help and spoken to more than one type of counsellor, either for help with different aspects of their mental health, or until they had managed to find the best type of counselling/therapy for them. This was especially evident with some of the female participants in this study:

Erm, well, because when I was 11, the symptoms, initially, were caused by a death, I was sent to counselling that dealt with children with bereavement. Erm, so it wasn't actually for anxiety, it was just more coping with loss… when I came away from that I still had the same anxiety symptoms… then after that, I actually went to another counsellor… but again, came away from it not feeling like it had done much… then I actually went to hypnotherapy [oh, okay] *… I went every week for a year… and that was the only thing that worked to help me control it*. [Participant three, female, lines 65 – 89]

Informal Disclosure

Six participants talked about how they initially disclosed to someone who would come under the "*informal*" sub-theme. Four of these disclosures were to the participants' mothers, one was to the participant's sister and boyfriend, and one was to the participant's ex-husband. Informal disclosure has been split into two other sub-themes: "*personal*", such as real-life friends, family, and romantic relationships, and "*virtual*", consisting of online relationships. Although these online relationships could be considered personal by the interviewee themselves, for this analysis, they will be considered as a virtual relationship only so as not to cause any confusion.

<u>*Personal*</u>

Family members were one of the most common groups that participants chose to disclose to informally. Most chose to speak to their parents, mainly mothers, although some indicated they had disclosed to their siblings, and one participant said he had disclosed to his grandmother. A few participants implied the depth of this disclosure through their quotes, whilst some were slightly vague about the level of detail they had shared. It seemed that most disclosure to family members bordered on part-disclosure, rather than complete, full disclosure. For example, whilst she may have only fully disclosed to her hypnotherapist, participant three explained that anxiety was a common thing in her family which made it easier for her to talk to them and helped her normalise what she was experiencing:

*Like I said, most people, apart from my dad, have anxiety. My dad and my grandma are the only people that don't. Everyone else in my family does and is on some form of medication or has had help… I'll say sometimes, like, "*do you ever get this feeling?*" and they'll be like, "*yeah, I feel like this too," then I'll kind of feel more normal.* [Participant three, female, lines 108 – 113]

Participant 11 explained how the first person he always speaks to about his anxiety and his mental health is his mother, citing a high level of trust as one of the main factors for this:

… I usually go to my parents first, so my mum, because I don't really like to bother my stepdad. Erm, and then, if she tells me to go to the GP, then I'll go to the GP. Erm, I kind of do what I'm told [yeah]*, (.) erm, just because, again, I'm unsure and I prefer the trust in someone who I know I can trust [laughs].* [Participant 11, male, lines 71 – 75]

If she [his mum] *wasn't understanding, I feel like I never would have went* [sic] *and got help, because she's the only person I trust… I trust the word of my mother more than I do the GP* [yeah]*, because my mother is a little bit more open to the things they'll tell you, whereas a GP will like to sugar coat it… my mum's a little bit more strait-laced. She'll tell you outright what it is.* [Participant 11, male, lines 177 – 183]

In contrast to the above quotes, participant nine found disclosure to those close to her to be a difficult process and she talked about her struggles with suicide and feeling as though she would be misunderstood if she did disclose resulting in non-disclosure for a long time:

I tried to commit suicide at the age of 12 because I didn't think I could talk to anyone about how I was feeling and coping. I kept my feelings inside for a very long time, as I didn't feel my parents would understand or sympathise. [Participant nine, female, lines 78 – 80]

She was the only interviewee to talk about how her children were aware of what she had gone through, albeit inadvertently. She stated that she was devastated when they found out, which implies she might not have wanted them to know or may not have wanted them to find out the way they had done. Despite this, she spoke about how her eldest child experienced similar problems to her and how this allowed them to support each other:

My oldest kids found out about my last overdose by mistake, and I was devastated that they had heard about it… my eldest child has similar problems to me though, so she knows what I've been through as we support each other. [Participant nine, female, lines 177 – 182]

Grandparents appeared to be a difficult area of disclosure for two participants, whilst participant 11 seemed to be the only one to talk about how he had disclosed to his grandmother:

And then, my grandmother (.) who also has a bit of anxiety has been very understanding, she's also a [participant reported occupation]. *So, very helpful.* [Participant 11, male, lines 188 – 189]

Generational divides and age differences made disclosure to those considerably older than them difficult and participant 12, for example, spoke about how a lack of understanding and a difference in the way mental health was viewed in her grandparent's day as reasons for this difficulty and unwillingness to disclose:

If I opened up to certain people in my life about mental health, for example, like distant relatives or grandparents, I feel like I would experience stigma, as they have very

different opinions on mental health compared to me, probably due to a generational thing. They think mental health disorders such as depression are over-diagnosed and would probably say to someone with the condition to "suck it up!" [Participant 12, female, lines 235 – 240]

Participant five discussed how she struggled to broach the topic of mental health with her mother, stating that a cultural divide made this disclosure difficult. Instead, she indicated that she had initially spoken to her sister and her boyfriend about her anxiety:

P: *… after you first kind of experienced these symptoms and stuff, what did you initially do?*

I: *I–I spoke to my sister and my boyfriend* [yeah]. [Participant five, female, lines 93 – 95]

P: *No. The thing with my parents as well… she's* [her mum] *like older-generation Chinese, who thinks mental illnesses aren't a thing.*

I: *Ahh, so it's quite difficult to kind of even talk about it?*

P: *Yeah. I won't—I won't even try to.*

I: *Do you find that quite hard not being able to explain to them?*

P: *Yeah. In a—in a way, but… we* [her and her sister] *just try not to bring anything up that can lead to a sensitive conversation if we can.* [Participant five, female, lines 125 – 134]

In contrast to participants five and nine, and their reluctance and struggle to disclose to members of their family, there weren't many differences between age and gender in this area. Both male and female participants specified disclosure, specifically to their mothers, and this was also the case for young and mature students. Only two participants alluded to disclosure to their fathers, whilst others indicated "parents" and "general family":

Well, they [his family] *know about it, erm (.) but, it's one of those things that (.) it's— it's difficult for them to talk about really… particularly my mother… she's a bit old fashioned… her mind is still kind of in the, you know, like the 50s America… I've always found it's more awkward, more than anything, talking with them about mental illness… I'm definitely more comfortable talking with her* [his sister] *about it than just like, my mum or dad or my aunt, or whoever.* [Participant four, male, lines 326 – 344]

Friends were the next group that participants chose to disclose to, but surprisingly, this group was most common for non-disclosure with half of the participants interviewed discussing reasons for this. Two female participants explicitly talked about full disclosure,

which were participants one and 12, whilst participants two, three, six and seven implied part-disclosure to their friends:

… one of my friends who I ended up moving to university with and living with, she became like a massive support system for me. And, I kind of feel bad, because she was [laughing] like the person that I kind of like told everything to, and she became like [yeah] the one person I'd really speak to… she was just the closest person to me, so I just felt like I could tell her anything. [Participant one, female, lines 202 – 207]

… I guess there's people I've talked about it more in-depth with, and people where you just sort of, acknowledge that you know where they're coming from… [Participant six, female, lines 193 – 195]

Half of those interviewed discussed their difficulties with disclosing to their friends, and the majority attributed this non-disclosure to a fear of judgement, a lack of understanding, fear of losing friendships, and the stigma they would experience:

… I think with people that I'd known for longer, it was harder to talk about with them, and I actually got more negative reactions from my older friends, because I think [pause], they've maybe known me as—in a certain way, and they had ideas about who I was, and—and then to (.) to kind of say, "oh, well, I've changed now and this is how things are now," was more difficult… [Participant six, female, lines 213 – 218]

… I have got a group of friends, but, because of the course, they're all very much into sport [yeah], very competitive, very like (.) laddy… so, like, I don't really gel with too many of them (.) to the extent that I'd be able to tell them about, you know, this sort of stuff. [Participant 10, male, lines 116 – 121]

For the male participants especially, all their accounts about non-disclosure seemed to relate to one another, with most revealing that they were reluctant to disclose for fear of being seen as weak:

… in the interactions that I've had with them [his friends], erm, they can be quite cruel of others that they suspect have mental illness [inaudible], it's kind of like that, you know, mental illness being like a weakness, and you know, it's just that stigmatisation… I'm hesitant to tell them about it, because I worry that I will be less (.)—they'll see me as less of a person. [Participant four, male, lines 165 – 170]

But I think for boys, especially the sort of boys on my course, you know, laddy. I think things like anxiety and depression are definitely stigmatised and then that definitely prevents people who have it from speaking openly about it, because you know, you come across as weak or those sort of negative attributes. [Participant 10, male, lines 182 – 185]

Romantic partners/interests were the last group that participants chose to disclose to informally. Seven participants, both male and female and young and mature, talked about how they had disclosed to potential romantic interests, or their significant other:

Erm, I think, in terms of like dating and stuff… I've opened up to people about things and they've kind of like, used that as like, a way to be like, "oh, no, like, I can't deal with that, like I can't deal with your anxiety," *and whatever. So, that's always like affected like, the way I date people… I've not really been open with people about like, my anxiety and about like how I feel about certain things* [yeah]*, because I've had people use that against me.* [Participant one, female, lines 380 – 386]

 … when I'm a little down, like, I'm married, and I have no problems speaking with my wife as well… but sometimes… I don't want to worry her, because I think it'll work itself out… it depends, you know? It's not like something you talk about a lot, but sometimes, you find the moment to talk about it… when I really feel like I had to, I've done it. [Participant seven, male, lines 293 – 302]

I have spoken to my partner and my close friend at university about my mental health and it encouraged them to speak about their past and current mental health problems to me, so it benefitted all of us… they know the full extent of my depression and anxiety too, unlike my parents. [Participant 12, female, lines 166 – 171]

Participant five, mentioned previously, spoke about how she disclosed to her boyfriend about her mental health, but she also spoke about how because he was Japanese, it was a struggle for him to fully understand because of his beliefs and understanding about mental health, which links back to a point made about cultural differences:

… and my boyfriend, with his culture, because he's Japanese… there's not a lot of mental health issues being discussed at all in his culture, so he sort of doesn't really understand most of it… whenever I try to speak to him about it, it's just a case of "are you not thinking overthinking this?" *and* "are you sure you have to go to the GP for that?" *and to be honest, that didn't really help [laughing].* [Participant five, female, lines 96 – 101]

Virtual

Virtual disclosure (via social media) was only spoken about by participant one and she spoke about her disclosure to her online friends. Through blogging, she had come in contact with, and forged close friendships with individuals who experienced similar problems to her, resulting in a mutual understanding and lack of judgement from those she told:

Like, I keep a diary and I've got a blog that I normally like, write on [yeah]. *Erm, I don't really go into that much detail about my mental health, but I've met (.) friends on there, who have had like, similar experiences to me and they've become like really close friends that I know I can speak to about anything and they just won't* [yeah]—*won't judge me at all.* [Participant one, female, lines 232 – 237]

… I think when I first started writing about it, I'd go into such detail and I'd share it on my Facebook, and people would always know what I was going through… I don't want that to be the only thing that defines me as a person [yeah]. *So, then I kind of stopped writing about it as much…* [Participant one, female, lines 399 – 404]

Participant one's hesitancy towards further online disclosure and her attempt at distancing herself from being defined solely by her anxiety is something that many individuals who suffer from anxiety attempt to do. Distancing and refusing that label of anxiety can sometimes help people cope and may help them feel as though they are more than just their mental health. She spoke about this further on in her interview, briefly touching on those that choose to define themselves by what they go through:

… I've met people in the past, who I feel like all they are is their mental illness. All they are is them fighting for like (.) recognition of like mental illness and stuff… it's a strange one, because people are building identities on what they've been through and, I think, there's a line between [sighing]—I don't know. [Participant one, female, lines 438 – 442]

Social media impact on mental health disclosure

Social media and social networking sites (SNS), such as *Twitter* and *Instagram*, featured prominently throughout all the interviews and many talked about the positive and negative impacts this has had on their mental health. Two sub-themes were created under this theme: "*positive aspects*", which looked at how social media could have a positive impact on mental health, which included the codes "celebrity influence", "encourages wider discussion", "normalisation and relatability", and "*negative aspects*", which looked at the negative side to social media and how it can have a debilitating effect on mental health, including the codes "creates mental health", "misunderstanding", "toxic environment". One distinct difference when it came to the social media aspect was between the young and mature students. Although both groups did talk about social media, it appeared that this area was favoured more by the younger students, which one might expect given how social media is more frequently used by those in the younger generation. Many of the relevant

quotes used to illustrate the points made below are from young students, with only one or two from mature students.

Positive aspects

A noticeable feature from interviews was how social media plays a role in encouraging wider discussion, especially amongst the youth and those struggling with similar problems. Participants two and five, for example, spoke about how social media plays a role in promoting mental health awareness, alongside other types of movements, such as body positivity and the LGBTQA+ community:

… I think it's a good way of getting messages out there to a lot of people, but at the same time, it's that double-edged sword. On like Instagram, for example, you've got people who are like all about body positivity and promoting wellness, and mental health, and accepting you know, who you are for what you are. [Participant two, female, lines 371 – 375]

… the thing we're currently seeing, sort of, on social media and just the media in general, is that people are trying to promote the awareness for mental health, and it's kind of similar with the LGBTQA+ movements… I'd say it's definitely positive, because it's getting more people aware… [Participant five, female, lines 246 – 253]

The online support available and the use of social media groups to communicate with others experiencing similar was mentioned, and knowing people experienced similar and felt the same type of way helped make it slightly more relatable. The normalisation of mental health was also brought up by participant five who believed that normalising mental health might be a good thing and would help those struggling to come forward and talk about their own problems:

But I don't think normalising it would be too bad of a thing [yeah]*… if you normalise it, then people who actually have troubles might find it easier to speak out…* [Participant five, female, lines 267 – 269]

Positives are, you know, you spend most of your time on your phone and you see stuff about mental health and how it needs to be more widely accepted… it can be positive, because you're communicating with people through things like Facebook*, there's groups of people who have mental health problems.* [Participant 10, male, lines 205 – 216]

Celebrity influence was spoken about by four participants. They mentioned how celebrities who openly talk about their mental health could have a positive impact on those who idolise them. Participant three talked about how individuals who idolise someone

famous who experiences similar problems to them may feel slightly more normal knowing a celebrity actually struggles the same as everyone else. Participant 12 referenced Prince Harry, who opened up about his mental health after his mother's death, and Chester Bennington from *Linkin Park*, who committed suicide after battling depression, to highlight how mental health amongst celebrities is more common than people believe. She used them both as an example to illustrate how their struggles could help encourage the general public to view mental health differently, and to help others in similar situations to open up rather than struggle alone:

> *For example, Prince Harry opening up about his mental health in dealing with his mother's death. They* [the royals] *have set an example and I feel that it may/will encourage members of the general public to think of mental health differently; like, it can happen to anyone no matter who you are, how wealthy you are, etc.* [Participant 12, female, lines 281 – 285]

Negative aspects

The prominent negative aspect of social media usage was the stigma that stems from it, most notably from the use of SNS such as *Facebook, Instagram,* and *Twitter*. Most participants implied some type of social media culture, inferring that many individuals who use these websites tend to misunderstand mental health and talk about it as though it is some kind of trend. The stigma associated with having a mental health problem, and the misunderstanding of this from those online, had an effect on many participant's mental health. Participant one was the only one who indicated social media disclosure and she pointed out how it can be a hard thing to deal with, especially when people disclose about their own struggles. She spoke about how people on social media tend to talk about mental health without properly understanding the implications behind their words. There seems to be a trend of people using these terms for comedic value or to exaggerate rather than to highlight the seriousness of them:

> *… social media can be quite a draining place… to always go on and see people being so open about everything, like, I know that sounds really horrible, but* [yeah]*, to go on and see people being like, "*I'm so depressed today," *and like, "*I'm thinking of killing myself," *and all this, like it can be a really hard thing to deal with… if I'm going through a good spell… I see a tweet like that, it just takes me back to feeling like* [yeah]*, like shit…* [Participant one, female, lines 408 - 415]

Like, on social media, people will have been throwing terms around [yeah]*, and, I think that's kind of stigmatised it… people will be like,* "oh, I'm so depressed today,*"* "oh my God, this just happened and now I'm really anxious," *or,* "I'm currently having a panic attack,"*…* [Participant one, female, lines 453 – 457]

The subject of social media having a negative effect on those with mental health problems was discussed and many spoke about how it is a toxic environment and dangerous to their mental health. Participant two spoke about the struggle to feel comfortable in your own skin when apps such as *Instagram* cause people to compare their life and image to those on there. Participant three voiced her opinion on how she believed social media creates some form of mental health and makes it seem as though mental health is some kind of trend, whereby people claim to have things such as depression or anxiety to fit in. The dangers of SNS was a common point amongst some of the male participants, with participants four, eight, and 10 speaking about how online bullying and self-esteem issues can affect mental health. Participant 12 spoke about how she believed many younger people suffer with mental health problems nowadays because they are concerned with superficial things, such as how many likes they get on a social media post:

… on Instagram*, you've got all these pictures of things; pictures of perfect people who've been photoshopped, or filtered or whatever, to look perfect… it's this dichotomy of kind of, "*I know I should be telling myself that I'm fine in my own skin, I am who I am and that is just how it is," *but also,* "oh, look! God, I should be better, I'm not thin enough, I'm not this, I'm not that," *because, there's that other stream of photos…* [Participant two, female, lines 376 – 382]

*… I think social media creates—creates some form of mental health, definitely… don't get me wrong, I'm on social media, but often, I'll be like, "*no, I'm going to delete it," *because, you look at other people and you compare… it is toxic, and it is bad for mental health. I think it encourages it sometimes… I kind of feel like mental health has become a trend* [mhm]. [Participant three, female, lines 407 – 417]

… I believe it overall has a negative effect on people of all ages… it allows other people to compare and contrast their lives with others, particularly in a negative light. However, I do believe this is mainly why more young people have reported to suffer with mental health problems as they can be more concerned with how many likes they get on an Instagram *or* Facebook *post… they think other people's lives are much better than theirs.* [Participant 12, female, lines 311 – 318]

Some discussed how it can be hard to differentiate between people who are genuinely struggling with their mental health, those who define themselves by it, and those

who use anxiety and depression as a way to garner attention whilst not fully understanding the seriousness behind what they are saying:

I would say that some people do sort of, over-exaggerate and just kind of, write down things that seem really serious, when the reality is, it's a mild inconvenience... if you normalise it, then people who actually have troubles might find it easier to speak out, but then, you also get like "imposters", and so then, you risk not being taken seriously. [Participant five, female, lines 265 – 271]

Overall, it was evident that participants believed social media was both a positive and negative thing. The positives, which mainly seemed to be celebrity influence and encouraging wider discussion, are especially important when you consider how widely used SNS' are. Mental health being discussed will hopefully help to encourage those who are struggling to come forward and speak about their own issues, ultimately leading to further help and support, and celebrities who openly talk about their mental health may be of some comfort to those who idolise them, helping them feel less alone with their own struggles. However, the negatives associated with social media could be considered to heavily outweigh the positives. Nowadays, it could be argued that many young people are too preoccupied with it and the toxic environment that may stem from this may have disastrous effects on people's mental health. Sometimes, it can be hard for individuals to separate their real life from their social media life, and although mental health is more widely talked about within the younger generation, there are still many people who misunderstand how damaging their words can be.

Barriers and stigma experienced

This theme looked at stigma and explored participant's feelings on mental health stigma, whether this had affected their decisions to disclose or seek help, and why this might have been. It also looked at the different types of barriers participants faced when it came to wanting to disclose to people and seek help. Three sub-themes were created: "*barriers to disclosure*", relating to the barrier's participants faced when disclosing, including codes such as, "misunderstanding", "lack of trust" and "generational/cultural differences". "*barriers to help-seeking*" was the next sub-theme, which included codes such as "lack of accessibility" and "problems associated with services." The third was "*stigma*", covering things such as personal/self-stigma, public stigma, workplace stigma and ways to reduce

these to encourage more openness. There was some overlap between quotes for all of these sub-themes, with some quotes identified being applicable to all three.

Barriers to disclosure

Collectively, participants seemed to worry about being misunderstood if they chose to disclose to someone. Many stated that one of the reasons why they chose to withhold disclosing from people was because they felt as though the person and/or people they were going to tell would not understand them, and some who were misunderstood after previous disclosures were reluctant to disclose again. Most indicated that they felt their friends would misunderstand them and this tended to be the group that participants chose not to disclose to, although GPs, grandparents, and parents were amongst those mentioned in relation to misunderstanding:

… I'd mention it to my friends [yeah]*, but then it'd piss me off… they'd like (.) say they understand it, but then… like, I'd act out because of my anxiety and they'd be like, "*hmm, why are you doing that?" *… it's not their fault they don't understand* [yeah]*, like, I'm not saying that…* [Participant one, female, lines 211 – 215]

I would say close friends, and even sometimes doctors… I think it's very easy for a doctor to give you a prescription, but it's not very easy for them to understand <u>why</u> you feel a certain way, or to even understand <u>that</u> you feel that way. [Participant three, female, lines 167 – 171]

Generational differences also linked in with the above worry of being misunderstood and also leads into the worry of being stigmatised. For those participants who wanted to disclose to their grandparents or older relatives, they revealed that the age difference and their grandparent's beliefs made it hard for them to broach the subject and discuss this with them. Non-disclosure, or in one participants case part disclosure, to grandparents was common amongst the younger students, albeit there were only three who spoke about this specific topic. This could suggest that some individuals may choose to focus solely on disclosing to their immediate family, rather than their extended family, and this brings up aspects such as relationship closeness or trust that might influence this decision.

… grandparents! Because, they were kind of brought up in the age where, you know, anxiety wasn't a thing—well, it probably was, but it wasn't discovered, you know, so people just get on with it as people still think you should do… so, I don't tell my grandparents. They have no idea that I'm on antidepressants, they've got no idea that I've got anxiety. I just don't tell them because I know that if I told them, one: they wouldn't understand… and two,

they're very much of the belief that you shouldn't be taking tablets, you know, so I shouldn't be on antidepressants, because they're not doing me any good… so, yeah, I just wouldn't even go there with telling them [mhm]*, because they just wouldn't get it [laughing].*
[Participant three, female, lines 175 – 187]

Some participants voiced that they were reluctant to disclose because they were afraid of being perceived differently. Earlier on in participant one's interview, she spoke about how she had *"very high expectations of herself"* [line 181] but followed this up by saying *"I'm not really too bothered about what other people think of me…"* [line 182]. However, when asked about disclosing to her friends, she contradicted her earlier statement and the quote below indicates a worry of being perceived differently and misunderstood:

… it was just the fact that they wouldn't understand and the fact that I'm very cautious of like, how I come across to other people and I never want to be that person who's always moaning about things, like [yeah]*, I don't want to be the person who's always got a problem, that always has to speak to their friend, so that's another reason why I don't really speak to people so much…* [Participant one, female, lines 227 – 232]

Participant four said that he had not told his friends because they tended to view those with mental health in a negative light and could be quite cruel, saying, *"I'm hesitant to tell them about it, because I worry that I will be less (.)—they'll see me as less of a person."* [lines 169 – 170]. The fear of bothering someone or possibly being perceived as a burden by telling them about his anxiety was mentioned in participant 11's interview – his hesitancy to disclose was a mixture of being worried that he would bother the person with his disclosure and also a need for trust:

… I don't really want to bother the person by telling them that, unless it's needed. And, next is a trust thing; if I don't trust the person, I won't even be friends with them.
[Participant 11, male, lines 85 – 87]

Whilst the above barriers were spoken about by a number of participants, some gave reasons that pertained to their own experience and were barriers that only they had felt, rather than all the participants as a whole. For example, participant two spoke about how her mother also suffered from mental health issues, but indicated a hesitancy to speak to her, whilst participant seven, on the other hand, said he did not want to tell his wife because he was afraid of worrying her:

My mum suffers and has done with depression for most of her life… the reasons we're stressed, and down aren't the same, but going through similar things, I can talk to her about stuff, but sometimes I don't want to… I don't want to add to her worry, considering what she's already got. [Participant two, female, lines 469 – 476]

… I don't want to worry her [his wife]*, because I think it'll work itself out… sometimes, you find the moments to talk about it, and sometimes you prefer to say,* "I don't want to worry her. She's doing her stuff; you know? I don't want to worry her." *But, you know, when I really feel like I had to, I've done it.* [Participant seven, male, lines 298 – 302]

Past experiences of disclosure had resulted in participant three losing friends due to their misconception and misunderstanding of anxiety, causing her to avoid future disclosure to them:

I think through past experiences of telling. Erm, as soon as you say to someone like, "oh, yeah, I've been to the doctors and you know, they've told me that I've got anxiety," *instantly, for someone… who doesn't have anxiety and has never been diagnosed… I've found that they start to distance themselves… they feel like you're a very vulnerable person, and I think it's almost like someone doesn't know what to say to you, and they feel like whatever they say will upset you or cause you to feel worse… it has happened to me* [yeah]*, and even really close friends, like best friends who I used to see like every day and speak to every day, now they just don't talk to me… I think through that way, and definitely for me, I've lost friends through it, and I think I still could.* [Participant three, female, lines 468 – 485]

The worry of hurting those close to her by disclosing to them about the full extent of her mental health was brought up by participant 12 and it appeared that this was a hinderance:

Yes! I have felt barriers and I still feel them every day… I still feel like talking to my parents and opening up to other friends about it is more challenging, as I don't want to hurt them as I care about them, but at the same time, I would be completely terrified of their reaction to it. [Participant 12, female, lines 226 – 231]

Barriers to help-seeking

Over half the participants interviewed insinuated that the accessibility of services and the problems associated with these, such as waiting times/lists, were some of the biggest barriers they had faced, and they implied that these barriers needed to be broken in order to facilitate an easier process. Most of the help-seeking topic was spoken about by female participants, both young and mature, whilst only three of the male students offered their views.

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… I self-referred to [participant reports services] *… I had, erm, like an initial assessment in* [participant reports area] *and she said, "*it's fine, I will refer you, but it's a six-month waiting list." *And, it's a bit frustrating, because (.) I don't need the help in six-months, I need it now.* [Participant two, female, lines 133 – 137]

You ask for help, tell people you're self-harming and struggling, and you have to wait six-to-eight months for help… it's the waiting times that does the most damage. [Participant nine, female, lines 211 – 213]

Previous negative experiences with mental health services was also a common topic that seemed to occur throughout a few interviews, and these seemed to be difficulties faced by some of the female participants, in particular. Participant five, for example, insinuated that her negative experience reinforced the idea that these services were unhelpful, resulting in a reluctance to consider seeking help from them again:

… I spoke to my GP, and she suggested that I speak to the counselling services at [participant reports services]. *But, erm, the lady wasn't particularly helpful… she sort of avoided the issues that I wanted to talk about, and kind of focused on some other problems that I mentioned. So, I kind of wanted to book in then for a separate appointment (.), and she said, "*yeah, I'll see you next week!" *and it ended up being a whole month later. And, I thought that wasn't particularly helpful, so I didn't really go back to that.* [Participant five, female, lines 110 – 117]

Likewise, participant nine spoke about her previous experience with mental health services and talked about how the lack of help and support available for her, as well as how the negative preconceptions and conclusions that GPs and social services tend to have beforehand, put her off seeking and asking for help. She further alluded to experiences of others that she knew and explained how she believed the system in place for seeking and receiving help is "wrong", whilst the services available are inadequate and judgemental towards those who do seek and require the help:

Services are not well advertised. When I was first becoming ill, there wasn't the same awareness and acceptance of the condition, so not many people knew where to go for help. When I took my first overdose, I was treated in A&E, and after a quick chat with a doctor was sent home with no support at all… I think the services are very lacking. I also didn't want to seek treatment as I had my kids living with me and I was afraid they'd have been taken away. When I eventually did ask for help with self-harming, true to form, they reported it to [participant reports services] *… this didn't really endear me to the services and I quickly learnt not to ask for help, no matter how bad I feel.* [Participant nine, female, lines 130 – 146]

The worry of telling someone in authority about problems stops people from getting help. I've known suicidal people lie to their doctors for fear of being taken into hospital or having [participant reports services] *involvement with their children. I know a woman who stays in an abusive relationship as they've told her they'll take away her kids if she's raising them alone, even though she loves her children and is an excellent mother. The system is all wrong.* [Participant nine, female, lines 202 – 207]

Participants one and three spoke about their hesitancy to seek help from their GPs, with both discussing how the tendency for GPs to prescribe drugs and medications immediately, rather than offering alternative options or genuine understanding towards their situation, is off-putting:

… I'm really on the fence with (.) like (.) professional help, per se… I don't agree with the way GPs will just throw drugs at something that can be sorted like, through like a simple talking therapy or whatever. [Participant one, female, lines 322 – 325]

Two male participants brought up and spoke about the topic of asking for help. Participant eight alluded to how there is a propensity to view mental health as a taboo subject, especially within the general population and those who are less understanding towards those who suffer. The taboo and stigma surrounding mental health makes it difficult for individuals, with many of those suffering not actually knowing how to ask or where to even go to seek help, whilst participant 10 mentioned that his university had failed to inform and emphasise the services available for those who are struggling with their mental health:

If more people understood that it's an illness and it's nothing to be ashamed of, then I think more people would not only have so many misconceptions about it but would actually seek help. I also think a lot of people don't know how to ask for help, because it's such a taboo subject, but if it was more openly talked about, then people might be more aware of the support that's out there for them. [Participant eight, male, lines 128 – 133]

… they could place more emphasis on mental health throughout the year [yeah] *… you know, they just push for grades and push for achieving the exams and stuff, and they haven't mentioned once, the lecturers, like, you know, "if you're suffering, if you're feeling any anxiety or anything – you can go to here, you can go to here." Erm, they didn't do that in the induction week either, which I think is pretty critical* [yeah] *… just in those first two weeks, having a counsellor come in, or someone within the department just saying, "look, we're here whenever. Here's our email," erm, would have probably helped a lot… I think it's quite important that they do put more of an emphasis on it, definitely.* [Participant 10, male, lines 146 – 160]

From the above quotes and the overall analysis of interviews, it seemed as though participants sought or considered seeking help from professionals, rather than people like their family or friends, which suggests that help-seeking, particularly for these individuals, is something they may conceptualise to be an "official" act. Although disclosure seemed to be to both formal and informal parties, help-seeking appeared to be limited to just professionals, with some speaking about their previous experiences with help from services and GPs, and some indicating that there was a lack of information about what help is available across the university campus. Despite this finding, this is not to say that help-seeking is the same for everyone and this highlights the individual differences that may arise. Help-seeking may take many forms and there may be individuals that choose to seek help informally from their friends, family, or significant other, for example. This research gives an insight into students who choose or consider professional help, rather than the help that could be offered off those from non-professional areas.

Stigma

Whilst this sub-theme was one in itself, it does overlap slightly into the sub-themes spoke about above. Two smaller sub-themes branch off from this, which are self-stigma and workplace stigma. Stigma, in general, was a rather prominent barrier that participants seemed to talk about when it came to struggling to disclose and seek help. Some mentioned how they felt as though stigma had impacted on their willingness to disclose or how misunderstanding and stigma had resulted in negative reactions and, therefore, their reluctance to disclose further. Others touched on how they thought stigma needed to be broken down in order to encourage more people to disclose and be more open:

…like, I've opened up to people about things and they've kind of like, used that as like, a way to be like, "oh, no, like I can't deal with that, like I can't deal with your anxiety," and whatever… I've not really been open with people about like, my anxiety and about like how I feel about certain things [yeah]*, because I've had people use that against me.* [Participant one, female, lines 381 – 386]

Erm, kind of going back to that stigma there is about mental illness, erm (.), I really haven't told any of my friends… in the interactions that I've had with them, erm, they can be quite cruel of others that they suspect have mental illness [inaudible], it's kind of like that, you know, mental illness being like, a weakness, and you know, it's just that stigmatisation… I'm hesitant to tell them about it, because I worry that I will be less (.)—they'll see me as less of a person… [Participant four, male, lines 162 – 170]

When it came to help-seeking, participants four and 12 spoke about the stigma surrounding this, with only participant 12 explicitly talking about how a reduction in stigma would encourage her to seek help:

… I definitely think if mental illness and mental health was less stigmatised, I would think that people would be less frightened and more confident to actually go out and seek the help that's available out there. [Participant four, male, lines 247 – 250]

I would be more inclined to seek help and open up about it if there wasn't such a stigma associated with mental health and if more people understood it. [Participant 12, female, lines 253 – 254]

Although the above quotes only sum up a few participant's feelings on the topic, there was an evident pattern from all interviews, whereby all participants felt as though a reduction in stigma would help alleviate the stress and the worry associated with disclosure and help-seeking and would make this process much easier and more likely for anyone struggling.

The theme of viewing mental health the same as physical health and acknowledging that both physical and mental health are equally as detrimental as each other was spoken about in a few interviews. Participant two spoke about the stigma towards mental health and attributed this to the fact it is largely invisible, whereas, physical disabilities and physical problems are much more accepted because they can be seen, whilst participant nine made a comparison between mental health and physical health, and said that people should embrace what they are going through, rather than feel ashamed of it:

*…I ended up having a bit of a breakdown in my tutor's office on Monday… I said, "*I'm really sorry." *She said, "*would you apologise if you had a physical disability?" *and I said, "*well, no." "So, why are you apologising about this? It's no different." *And, there is that stigma. Because it's invisible…* [Participant two, female, lines 218 – 222]

I just think it's important that people don't feel ashamed of any condition they have. People go on Embarrassing Bodies *to flaunt the most personal parts of their bodies and yet people won't talk about depression or serious mental health problems? It's silly.* [Participant nine, female, lines 242 – 245]

Some participants discussed how different groups and cultures experience stigma and indicated that the older generation and men tend to avoid talking about their mental health problems, compared to the younger generation and women, who are much more

open about it. Participant seven, for example, spoke about his own experiences with working in America and Europe, and discussed the differences towards mental health in those environments, with American culture seemingly being less open and more afraid of being perceived as weak, compared to European culture:

… there's certain demographics that definitely… need help in opening up—a lot of older people, like my grandad will never—I don't know if that's because he's a man or if it's because he's older and they've been taught to like get on with it… like in your 20s and your early 20s, it's a lot more normal to kind of be open about it [a lot more accepted]*, yeah.* [Participant one, female, lines 446 – 451]

… in America, I really noticed that people never spoke about their own life, like, "how are you? Excellent. How are you? Perfect." *Like, even if you're broke or your mother died or something bad happened, people really want to look strong! I think it's part of the culture. And, I think in South America… France... Italy... from what I've seen, people are more open to speaking about the worries that they have and things like that.* [Participant seven, male, lines 227 – 233]

… I know a lot of people I talk to who have anxiety, they've never gone to their GP about it, because they're male and they don't want to feel inferior… there's a lot of weird, erm, misconceptions and fallacy… I do think it would be a lot easier for people if there was a little bit more understanding and awareness. [Participant 11, male, lines 196 – 208]

Self-stigma

Self-stigma seemed to impact on two of the mature female students in particular, with both of them talking about how they found it hard to admit to themselves that they were struggling. Participant two spoke about how self-stigma affected her and was a barrier to her seeking help compared to stigma from the public:

… I don't think it was stigma that was stopping me [from seeking help] *… I think it's probably the issue with myself, telling myself that it's not okay.* [Participant two, female, lines 294 – 296]

Participant six alluded to the denial of her mental health a few times stating that she did not feel as though she identified as someone with anxiety and attributed this to her own internal stigma:

… I couldn't accept myself, or I couldn't recognise that I was depressed… and I think, because I'd always been a bit nervous before [yeah]*, I could kind of (.) dismiss the anxiety as well… I just didn't want to accept a) like, what had happened to me, and b) like, that I was maybe depressed and anxious… I wasn't dealing with what was going on mentally…* [Participant six, female, lines 244 – 255]

… I think at the start… I didn't want to recognise that I had depression and anxiety, and that was like my internal stigma, which I've probably got from society. [Participant six, female, lines 374 – 376]

Both participants illustrate the different effects of self-stigma and how this can affect an individual. Participant two spoke about self-stigma affecting her decision to seek help and how she would be hesitant to seek help under certain employers because of it. Participant six spoke about how she had seemingly internalised society's negative attitudes towards mental health and did not want to acknowledge that she was actually suffering from depression and anxiety.

Workplace stigma

Three participants spoke about stigma in relation to work, with two implying dishonesty with their work colleagues and one speaking about how she felt as though admitting to struggling with a mental health problem, especially when she is considered to be the professional, would lead to being stigmatised:

… I know the effects of mental health [inaudible]*, accepted placements in it, so you know, from a professional point of view, it's fine to tell people to get help… it's alright when you're telling patients who are there to seek support, but if you're like, the professional who's got problems… you feel like there's stigma towards being the professional with the illness and having the mental health illness… it's like, you can't help other people if you're not right yourself* [mhm]. [Participant two, female, lines 299 – 306]

If I needed to take a sick day off work because of a panic attack or I physically couldn't get out of bed because my depression tells me so, then I would tell work that I have a stomach bug or fever, for example. To me, there is still a stigma there, as I can't be openly honest about my mental health, and instead fake a lie about a physical illness or ailment. [Participant 12, female, lines 254 – 259]

Whilst employers are unable to discriminate against individuals with a mental health problem under the 2010 Equality Act (Government Equalities Office, 2015), the fact that participants feel as though they cannot be honest to their employers about their struggles is telling of the stigma that still surrounds mental health in the workplace.

Participant two indicated that she would be hesitant to tell her future employers about her mental health, especially if she was in a healthcare role. This also links to a part of her interview where she said she did not want to tell her tutors about her anxiety, as she thought this would hinder her chances of employment in the future:

–we've been talking about registration for when we, erm, qualify [yeah]. *And, you know, you need to sign a declaration to say you're fit for practice… and some of them* [her tutors] *I'm weary about talking to than others, because I think "*are you going to say that I can't practice because I've got mental health problems, and I'm anxious, and you know…*" I'm anxious that it's going to affect my future career and what I'm doing… and they've got the power to say, you know, whether you're fit or not.* [Participant two, female, lines 205 – 214]

Discussion

The following section will look at the current research findings which will be discussed in relation to previous research findings, and potential future areas of research will be offered. Overall, the aims of the present study were to explore the topic of anxiety, looking specifically at disclosure, help-seeking behaviours, and the effect of mental health stigma in order to see whether this has an influence on disclosing or help-seeking. Using research theories previously discussed, this discussion will attempt to explain these findings. The analysis carried out reported three different themes: *"Disclosure patterns"*, "*Social media impact on mental health disclosure"*, and "*Barriers and stigma experienced"*.

Patterns of disclosure

The first theme was "*Disclosure patterns".* Formal disclosure was heavily favoured towards GPs and counsellors/therapists, with all participants indicating and talking about disclosure to at least one, if not, both of these groups. Informal disclosure seemed to be spread slightly evenly across both family and friends, but non-disclosure to friends was prominent, and participants did discuss their reasons for feeling as though they were unable to talk to this group.

Formal and informal disclosure

Previous research into disclosure patterns has resulted in mixed findings. Some individuals do indeed disclose, either to professionals or non-professionals, and do receive assistance and treatment, yet many choose to avoid disclosure altogether, or only choose to disclose to certain people above others. Dew, Morgan, Dowell, McLeod, Bushnell, and Collings (2007) found that more trust in agencies and institutions, rather than just a single practitioner, would help make a GP a preferred point of contact for disclosure and help-seeking. They acknowledged the high level of trust in health professionals and the services they provide, but also noted that non-disclosure to GPs appears to be prominent.

One area of formal disclosure that was mentioned was therapy. Some indicated that they had seen multiple therapists before finding one that they felt comfortable with and were able to freely disclose to. One participant found hypnotherapy was the only thing that helped her manage her anxiety and she explained that she felt uncomfortable with the

other therapists she had spoken to, whilst another spoke about how she had been dishonest with some of her therapists until she found someone that worked best for her. Research has shown that most therapies are effective when they are tailored to the individual. Norcross and Wampold (2011), for instance, highlighted how psychotherapy should be individualised and tailored to the person alongside his or her diagnosis, whilst Silfvernagel, Gren-Landell, Emanuelsson, Carlbring, and Andersson (2015) tentatively concluded that Computerised Cognitive Behavioural Therapy (cCBT) that is tailored to the individual could be useful for adolescents suffering with anxiety disorders when paired alongside standard clinical treatment. Mair (2016) discussed how university students were encouraged to use self-help methods, peer-to-peer support, or even online support services, and echoing Silfvernagel et al., (2015), cCBT has been found to be effective in treating depression and anxiety, especially for students and adolescents (Richardson, Stallard, & Velleman, 2010), making this a potential way to provide help, particularly for those who might not be comfortable with face-to-face support. These studies, alongside the findings from the current research, show that there is not a "one size fits all" approach when it comes to therapy, and that each individual attempts to align their therapy until they find the best one for them.

However, although it is important for individuals to identify a therapy that suits them, it is also vital that the therapy allows for therapeutic alliance in order to promote an effective therapeutic relationship between the individual and the therapist. Whilst many researchers have offered definitions for the concept of therapeutic alliance, also referred to as the helping alliance or the working alliance (Greenson, 1965; Luborsky, 1976; Zetzel, 1977), Bordin (1979) gave a more concise definition that was comprised of three components essential for a collaborative relationship and an optimal alliance. These were: (1) the emotional and personal bond created between the client and the therapist, (2) their shared agreement on tasks, and (3) their shared agreement on therapeutic goals. For a shared agreement on tasks and goals to be achieved, the client and the therapist must share the same positive beliefs and ideas about treatment goals in order to utilise the most effective and relevant methods for this outcome. Clients must believe in the therapist's ability to provide the best possible help and, in turn, the therapist must be confident in the client's own resources. Additionally, research has highlighted how emotional experience, i.e. the client's ability to approach and experience emotions during therapy, can be beneficial

and result in symptomatic relief and positive treatment outcome (Fisher, 2016; Greenberg, 2012; Watson & Bedard, 2006; Whelton, 2004). It is evident that the best possible outcome in regard to therapy is more likely to be achieved from a mixture of individualised therapy and a therapeutic alliance. Disclosure to therapists and specialists may indicate that individuals feel as though they are able to provide them with the most help and advice in that situation, as well as being able to help them come to terms with and cope with what they are experiencing. Although it is not explicitly mentioned in participant's interviews, those who spoke about their preferred therapy may have forged a strong therapeutic alliance and achieved the best possible outcome.

Informal disclosure was favoured by a lot of participants in the current study with many giving reasons for and against this decision. Six chose to disclose to an informal party initially, with four choosing to disclose to their mother. Whilst disclosure to friends was not an initial decision for some, many spoke about disclosure, or non-disclosure, to their friends or fellow students. Research has found that some reasons for non-disclosure to university services or fellow students are the fear of other students thinking less of them or being treated unfairly by their university because of their illness (Equity Challenge Unit, 2014). Some support for the current research findings comes from Reavley, Morgan, and Jorm (2018) who found that selective or full disclosure was more common when it came to friends and family, and selective or non-disclosure was more likely when it came to workplace supervisors, education institutes, and healthcare settings. Venetis, Chernichky-Karcher, and Gettings (2018) found that students choose which friends to disclose to depending on different factors, with closeness being one of these. Many participants in the current study indicated that friendship disclosure was based on the closeness of the relationship and the level of understanding these friends could offer. Previous research has shown that disclosure to family and friends is highly favoured and that these two groups are a preferred source of help and support (Rickwood et al., 2007; Rüsch et al., 2011, 2014; Salaheddin & Mason, 2016). The current study's findings do suggest that familial disclosure is favoured more, with many participants fully and partly disclosing to at least one, if not more than one, family member. On the other hand, there were nuances in friendship disclosure, with some choosing to only disclose to those they were close with and others providing reasons as to why they had not disclosed to this group at all. Disclosure to family,

friends, and romantic partners may indicate a need for trust and closeness and may imply that some individuals only feel comfortable disclosing to people they feel a strong sense of trust with or a lack of judgement from. For some, this disclosure could have been due to the relatively similar experiences, the strength of the relationship, both romantic and platonic, or just the general level of trust between the two individuals, making it easier for people to open up, which may offer potential explanations for why some participants did or did not disclose to certain people.

Although it is easy to speculate why the participants in the current study chose to disclose or not disclose to certain people, these findings could be better explained through the use of models and theories. Omarzu's (2000) Disclosure Decision-Model (DDM) explains how disclosure stems from considering multiple different elements in the decision-making process. The content, the depth, the breadth, and the duration of self-disclosure all play an integral part in this model. It proposes that the process of disclosure and the decision behind it is activated by the potential achievement of social rewards, such as social approval, relief of distress, and social control. Each of these result in different things, e.g. disclosure for relieving distress could be an individual's way of talking about their problems and revealing negative emotions instead of being for the purpose of seeking help, linking into the concept of distress disclosure (Kahn & Hessling, 2001; Ward et al., 2007). Disclosure goals can be combined but could also result in conflict. Disclosing distressing information to someone who the individual is close to may advance the relationship in terms of intimacy or trust. However, if they wanted to disclose about a particularly distressing experience, but their need for social approval is more important, a conflict will arise, resulting in potential non-disclosure.

There are three stages to the DDM, and they are as follows: (1) situational cues, the potential goals after the disclosure, and the saliency of the goal will lead to disclosure or non-disclosure. If "yes" is answered to all of those things, (2) individuals consider whether there is an appropriate target to disclose to and whether this is the most appropriate strategy. If "yes" again, (3) individuals weigh up the subjective utility, i.e. the perceived value of the outcome from disclosure, and the subjective risk of disclosure, i.e. the perceived risks that may occur after disclosure, such as social rejection, betrayal, or discomfort to the chosen listener. Subjective utility results in a decision on breadth and

duration, whilst subjective risk results in a decision on how much to reveal. Using this model could help explain the findings from various participants and may be especially useful in helping to explain the differences in levels of disclosure. It has already been acknowledged that family and friends are a good source of support for individuals and that many prefer to disclose to these compared to professionals (Rickwood et al., 2007; Rüsch et al., 2011, 2014). Many individuals will most likely have a close relationship with these groups, especially if they feel comfortable enough to disclose. Using the DDM's framework, participants would have decided on their goals and their target and believed that disclosure was an appropriate strategy and would then have had to weigh up the potential risks and outcomes of disclosure. One could assume that fully disclosing to their family and friends suggests that the perceived outcomes outweigh the perceived risks. Part-disclosure, on the other hand, may mean the perceived outcomes and risks are equal, resulting in participants choosing how much to reveal and the duration of this disclosure. Furthermore, non-disclosure to these individuals may be due to participants believing that the potential risks of disclosing are much higher than those of the outcomes.

The finding of non-disclosure to friends, in this study, contrasts to findings on friendship disclosure that have been previously mentioned. Given that research indicates friendship disclosure is favoured (Rickwood et al., 2007), this could highlight the individual differences that occur. Whilst some individuals may feel comfortable disclosing to friends and may come to this decision based on the factors above, it does not necessarily mean this is the same for everyone, and other internal or external influences may impact on someone's decision to disclose to their friends. Additionally, one might argue that disclosure, especially in the present study, is quite nuanced, and using labels such as family and friends, or even counsellors and therapists, to illustrate who people disclose to may be too broad. For example, participant 11 only fully disclosed to his mother, but chose to partly disclose to his brother and his grandmother, whilst participant three chose to partly disclose to her close friends but did not disclose to any of her other friends. Similarly, participant one fully disclosed to some counsellors, but also partly disclosed to some counsellors (see Table 2). This adds a layer of complexity to these findings – whilst these labels do indicate these disclosure differences, and highlights the individual preferences for formal and informal disclosure, it also shows how disclosure to individuals in the same category, i.e. counsellors,

can vary, raising even further questions about what facilitates each type of disclosure and to whom.

Another model that may be useful in explaining these disclosure patterns is the Disclosure Decision-Making Model (DD-MM; Greene, 2009). This model proposes that individuals make different assessments before their disclosure, including assessing the information to disclose, evaluating who to disclose to, and whether they perceive that disclosure will result in an intended outcome (Greene, Magsamen-Conrad, Venetis, Checton, Bagdasarov, & Banerjee, 2012). In the context of mental health, the assessment of information to disclose may involve the discloser considering factors such as stigma, symptoms, perceived social support, and demographic factors, such as age or gender (Pahwa, Fulginiti, Brekke, & Rice, 2017). For the assessment of potential receivers, the discloser evaluates the relationship quality, the anticipated reactions that may occur from a potential disclosure target, and whether they are confident that the receiver will react to the disclosed information in a way that is favourable or not (Greene et al., 2012). The disclosers combined appraisal of all of these factors will lead to decisions about what they will disclose and who to.

Using this model, participants disclosure could be explained in various ways. Professionals, such as GPs and counsellors, may not be considered a close relationship. However, with the prior knowledge that these individuals are a source of support and guidance, participants may choose them as a disclosure target with the belief that their response to disclosure would result in a favourable outcome and help. There may be low perceived stigma from a professional as mental health would not be a particularly misunderstood area for them, which may make participants feel as though disclosure to this group is preferable. Research has shown that variables such as self-stigma, anticipated benefits, and self-disclosure had the largest effect on a student's decision to seek professional help (Nam, Choi, Lee, Lee, Kim, & Lee, 2013). Seeing as all 12 participants spoke about full disclosure to professionals, it would be possible to conclude from either of these decision models mentioned that participants may have perceived subjectivity utility to outweigh the subjective risk (DDM) and that disclosure to professionals was responded to in the way the participant anticipated (DD-MM). Friends and family would most likely be considered close relationships. However, despite whether an individual is close to a family

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member, in the context of the DD-MM, participants would have had to assess factors such as the age, gender, and background of their potential receiver. A number of participants spoke about their reluctance to disclose to older family members, which links to the assessment of information in regard to demographic factors. Older generations, it could be argued, are more likely to have been brought up in an era where mental health was less talked about and stigmatised, with these attitudes and beliefs potentially still ingrained. Participants who indicated non-disclosure to this group may have experienced stigma or negative reactions from possible previous disclosures, and if so, when deciding on a potential receiver it is less likely to be someone who the individual anticipates would react negatively, such as grandparents.

One participant spoke about her difficulty with disclosing to her Chinese mother because of her older generational Chinese beliefs. Although she could talk to her Japanese boyfriend about her struggles, with the lack of mental health awareness in Japan, he was not able to offer real support. Using the models, she would have had to consider the age factor and the cultural factors for both of these individuals, as well as their anticipated response to disclosure (DD-MM), or whether potential rewards are achievable and whether disclosure is the best strategy (DDM). In the case of her boyfriend, for example, rewards such as increased intimacy or trust in the relationship may have been possible, but the risk of potentially being misunderstood may have resulted in a lack of depth. Furthermore, she may have perceived a potential lack of stigma from this disclosure and may have felt the quality of the relationship and a positive or supportive reaction could have been achieved, and therefore, the decision to disclose was chosen. However, Deva (2002) explained how the ignorance and prejudice towards individuals with a mental health problem in Asia can be attributed to the initial development of mental health care in the poorer areas of Asia and the use of mental asylums to treat those who were mentally ill. Moreover, Taplin and Lawman (2012) spoke about how mental health care in Japan is stigmatised, which deters individuals from seeking help. Japanese awareness surrounding mental health is low and the public's perceptions and understanding about it are usually stigmatised, henceforth, why this participant may have felt that disclosure to her boyfriend was an appropriate choice but may not have anticipated the potential difficulties of him not fully understanding.

The above models provide useful explanations for the potential processes' the participants had to go through in order to disclose to someone in their life. Both models involve identifying and considering multiple different factors before disclosure, appraising the information to disclose, as well as contemplating how much to disclose and how long to disclose for, and establishing who is a suitable disclosure target, and both models adequately explain disclosure in the current study. The DD-MM is useful in explaining both formal and informal disclosure. When identifying a disclosure target, someone that has experience in the field of mental health is likely to result in less stigmatisation and these individuals are able to offer support and guidance that non-professionals may not be able to. For informal disclosure, the DD-MM is able to explain disclosure by, for example, considering the cultural and generational factors that may have an effect on how the disclosed information is received. This model highlights the different aspects that need to be appraised, such as cultural background, demographics, response to disclosure, etc., in order to facilitate disclosure. One should take into consideration that the DD-MM is usually used more in the context of health disclosures, e.g. HIV/AIDS, cancer, etc., and, although it can explain mental health disclosure, other disclosure models may be best suited for this. The DDM seems to focus on the social aspect of disclosure, such as social approval or social control, and it appears to offer a more comprehensive explanation for informal disclosure, specifically to family and friends. It would be safe to assume that the majority of individuals, if not all, want to feel socially accepted, as well as advance their personal relationships in life, whether these are platonic or romantic. The DDM seems to provide an effective explanation about the information that needs to be considered and the goals individuals are after in order to receive these social rewards. It should be noted that the DDM also focuses on the self-disclosure of information and individuals may disclose information in order to relieve distress. Kahn and Hessling (2001) have offered distinctions between both self-disclosure and distress disclosure, and therefore, it may be difficult to know for certain whether the participants decisions in this study were of self-disclosure with the intention to potentially receive help and guidance or whether it was a distress disclosure decision. Table two, below, illustrates the type of disclosure each participant spoke about and who they chose to disclose to.

| Participant | M/F | Type of disclosure | | | | | |
| | | Full | | Part | | Non | |
		Formal	Informal	Formal	Informal	Formal	Informal
1	F	GP and some counsellors	Mum, certain friends, and social media	Some counsellors	Online friends		Romantic relationships
2	F	GP, counsellors, and university tutors		University wellbeing centre	Mum, friends, and boyfriend		
3	F	Hypnotherapist		GP and some counsellors	Mum, family in general, and close friends	Counsellors	Grandparents, other friends
4	M	GP and psychotherapist		Psychologists, PhD supervisors, and university counsellors	Mum and sister		Friends
5	F	GP		Counsellors	Sister and boyfriend		Parents
6	F	GP and counsellor		Manager, counsellors through work, personal tutor, learning mentor	Friends met through social activities		Some older friends
7	M	Therapist	Parents	Psychoanalyst when younger	Wife and friends		
8	M	GP	Mum, girlfriend, and family in general	Teachers and counsellors			
9	F	GPs, therapists, and counsellors	Ex-husband, parents, university peers, and romantic relationships		Children		
10	M	Counsellor	Parents and girlfriend	Lecturers and tutors (both indirectly know)			Friends
11	M	GP	Mum		Brother, grandma, and manager	Counsellors	Friends
12	F	GP	Boyfriend and close friend		Mum and stepdad		Friends and grandparents

Table 2: A table to illustrate who participants disclosed to and the type of disclosure reported.

Social media disclosure

There has been a lot of previous research looking at mental health and social media disclosure and it would be beneficial to explore this area, especially as this may offer links and support to the impact of social media on mental health, which will be discussed further on. Moreno et al., (2011) looked at mental health disclosure from college students on the

SNS *Facebook*. They sampled 200 college student's profiles and looked at status updates over a one-year period. Findings revealed that 25% of profiles displayed status updates that included depressive symptoms, and 2.5% of those sampled met the criteria for Major Depressive Episode (MDE). Participants who used *Facebook* frequently, or garnered responses and online reinforcement from more than one online friend, were more likely to post status updates disclosing about their depression. Egan, Koff, and Moreno (2013) also found that students were more likely to think mental health references by their peers on *Facebook* were either serious calls for help or status' for attention. This offers support to the current findings, with a number of participants mentioning how they were apprehensive to believe individuals who posted on *Facebook* as they were unable to differentiate whether these people were genuinely posting because they wanted help or whether it was a simply a cry for attention.

Research into social anxiety and SNS outlined how individuals who suffered from this were much more likely to use social media to socialise online with friends to compensate for their fear of socialising in real life, and they reported more self-disclosure to their friends and greater levels of comfort. Yet, whilst SAD was associated with internet use as an alternative to face-to-face communication, resulting in higher levels of self-disclosure and socialisation, it was also associated with lower quality of life and poorer well-being (Weidman, Fernandez, Levinson, Augustine, Larsen, & Rodebaugh, 2012). The popular website forum *Reddit* has also been researched. Findings show that users of this website tend to share information about their mental health issues, with some choosing to disclose in-depth about their problems. Many users self-disclosed on mental health subreddits as a way of self-expression, choosing to talk about their issues and the impact this has on their life, relationships, and work. Some also used these subreddits as a way to seek a diagnosis or information on treatment, and social support and anonymity appeared to be things that affected disclosure. *Reddit* does differ from other SNS, like *Facebook* and *Twitter*. Users may simply use the website for emotional support, as opposed to being used for emotional outbursts to followers, friends, or family, and the feature of anonymity allows users to disclose and express their feelings and views under the guise of disinhibition, knowing that they are unlikely to be stigmatised or judged by others (Choudhury & De, 2014).

The above research seems to indicate that social media disclosure is one type of outlet that is favoured by individuals with mental health problems. The anonymity that is offered on certain websites and from online support groups (OSGs) may encourage people to disclose and seek help knowing that they are less likely to be stigmatised. SNS, whilst anonymity is not always ensured, also appear to be favoured. For those who create close friendships on these websites and who bond with others over similar experiences or struggles, the thought of disclosing about their mental health and seeking help and comfort may not be so difficult, even more so if the topic of mental health has been broached before. From the current research, one participant discussed about how she had made friends online who she felt she could talk to about her problems and who she felt would not judge her. This can be a positive thing and can encourage those who may be hesitant about disclosing to find some comfort and reassurance from online friends, especially if there is a strong level of trust between them. Ultimately, this links back to points about friendship disclosure and the role friends can play in offering help and support. Social media is overwhelmingly popular with young adults, and with the acceptance and openness of this generation, it can sometimes be easier for people to disclose and talk to their friends about their struggles than it can be to talk to someone in a professional setting.

Overall, there is a broad spectrum of literature and theory that can explain these patterns of disclosure and it has been possible to offer potential reasons for why these participants disclosed the way they did using two disclosure decision-making models (Greene, 2009; Omarzu, 2000). This research has been able to provide a thorough and deeper understanding surrounding mental health disclosure in a student population and the different factors that can have an influence on this, such as closeness of relationships, potential risks and rewards involved with disclosing, and the anticipated reaction from the discloser's chosen target. However, it would be beneficial to further explore this area to provide more insight into decisions surrounding disclosure to both formal and informal parties.

Social media impact on mental health

The second theme that was identified in this research was "*Social media impact on mental health disclosure".* Although social media disclosure has briefly been spoken about in the previous section, this theme looked at the wider implications and impact that social

media can have on mental health. It was evident throughout this research that this had quite a large influence on a lot of participants, both positively and negatively. For positives, it seemed that the majority of participants believed that celebrity influence on SNS and in the media played a huge part in encouraging and facilitating the discussion of mental health, and helped participants feel as though they were able to relate their issues and their mental health to that of a celebrity. Others believed that social media helped them create friendships with people who had shared interests or struggled with similar issues.

Some research has identified the positive aspects of social media usage. Teenagers and adolescents are more connected than ever nowadays, and the use of websites, such as *Twitter, Facebook,* and *Instagram,* allows connections and socialisation to be easy and immediate. Social media has helped many young people bring awareness to issues, movements, and disadvantaged groups, such as Black Lives Matter, the LGBTQA+ community, or the #metoo movement (Ince, Rojas, & Davis, 2017; Lucero, 2017; Manikonda, Beigi, Kambhampati, & Liu, 2018), create and maintain friendships, educate others, increase confidence, independence, and social skills (Rosen, 2011), and search for support networks and information from a wide range of sources and OSGs (Chung, 2014). Early research has found that general internet usage actually decreased depression and loneliness and perceived social support and self-esteem increased (Shaw & Gant, 2002), whilst Valkenburg, Peter, and Schouten (2006) found that positive messages on SNS resulted in much higher levels of self-esteem, whilst negative messages had the opposite effect.

Celebrity influence

Research and media outlets have explored and spoken about celebrities and their impact on the younger generation and how celebrities being open about their mental health can help reduce mental health stigma and encourage people to talk about their own. Roberts (2018), writing a piece for Harper's Bazaar, covered a list of celebrities who have been vocal about their own mental health journey, and included some influential people such as Kendall Jenner, Zayn Malik, Demi Lovato, Prince Harry, and Beyoncé. When you consider that many of the celebrities named above are usually idolised and looked up to by young adults, this makes their honesty about their own struggles even more encouraging and important. On his own struggles with mental health, Zayn Malik (2016) of One Direction fame penned a first-person account for *Time* magazine, talking about how his anxiety and

the psychological stress of performing and being on stage had affected him to the point where he had to cancel his performance. He stated that sugar-coating it and acting like he had just taken ill would have been a disservice to his fans and indicated that he was not going to be ashamed of what he was going through. Although he feared negativity and hate over his cancellation, he was met with an outpouring of support and understanding from fans and many people alike who struggled with their own anxieties and their own problems.

Another influential figure, especially for young adults, is Demi Lovato, who has a large fan base of both young girls and boys alike. Lovato has always been incredibly open and forthcoming about her own struggles with addiction, bipolar disorder, bulimia, depression, and self-harm, as well as her treatment and time in rehab. Her openness about her own mental health has shone a light on the reality of these struggles in a way that many celebrities fail to do, and for individuals who struggle with their mental health, her story may help them feel less alone and may offer slight encouragement for them to accept and talk about their own struggles. As Edelstein (2018) says, Lovato's honesty and openness about her relapses accurately reflects the real reality of mental health; treatments may not necessarily be successful, new treatments may be needed, and adhering to a treatment regime may not always go to plan. Yet, managing it and taking steps to overcome it, or at least steps to cope with it and work on it, are better than struggling alone. It is evident that celebrity openness about mental health is helping to reduce the stigma associated with it and helping individuals who struggle feel as though they are understood. Knowing that someone they idolise struggles with similar problems may be a small comfort, especially when many people are under the misconception that celebrities do not struggle with their mental health because of their fame and the position they are in. Whilst mental health stigma is still a prominent thing, the positives of social media may help further reduce this and encourage more people to speak out or educate themselves about the topic.

Negative aspects of social media use

Despite the positives mentioned, there are negative aspects of social media that many may consider outweigh the positives. Participants discussed the stigma that stems from its usage and the tendency for people to misunderstand mental health and treat it as though it is a type of trend or a joke. The majority indicated that they were heavily affected from the negatives associated with social media, believing that it made their mental health

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worse. Past studies have found that its usage, in general, has a negative effect on an individual's mental health and overall wellbeing, and whilst not explicitly discussed in the current research, it is important to consider the wider implications of social media usage on mental health. Bhagat (2015) surmised that social media use is associated with things such as low self-esteem and low social confidence, as well as mental health problems, such as anxiety and depression, and physical health issues, like sleep and eating disorders. This is supported by Woods and Scott (2016), who found that those who were more emotionally invested in social media had lower self-esteem, poorer sleep quality, and higher levels of anxiety and depression compared to those who did not. Vannucci, Flannery, and Ohannessian (2017) looked at a sample of 563 adults, aged 18 to 22, and discovered that the more time people spent on social media, the more likely they were to have symptoms of anxiety. Daily social media usage was also associated with the likelihood of individuals having a possible anxiety disorder, and they inferred that clinicians should be aware and consider the role of social media in the context of treating those with anxiety. Furthermore, Muzaffar, Brito, Fogel, Fagan, Kumar, and Verma (2018) found that increased and repetitive use of *Facebook* resulted in increased symptoms of GAD.

Teenagers and younger adults are more socially connected and have been brought up in an age where social media and SNS are common and used daily, with this generation seemingly being dubbed the "Social Media Generation". Smartphones and the huge number of SNS available as apps, has allowed the younger generation to make vast amounts of connections with people or keep up to date with celebrities and the news. Looking at a sample of 296 students from three Iranian universities revealed that smartphone addiction positively correlated with mental health problems, including depression (17.30%) and obsessive-compulsive disorder (OCD; 14.20%) (Babadi-Akashe, Zamani, Abedini, Akbari, & Hedayati, 2014). Sherman, Payton, Hernandez, Greenfield, and Dapretto (2016) discovered that areas of the brain associated with reward processing, social cognition, imitation, and attention are activated when we see or receive a large number of likes on a social media post. Additionally, Seo, Jeong, Choi, Kwon, Park, and Kim (2017) outlined how teenagers have a possible predisposition for depression and anxiety and addicted teenagers scored higher on standardised tests to measure internet and smartphone addiction. Magnetic resonance spectroscopy scans also showed that addicted youth had increased levels of the

neurotransmitters gamma aminobutyric acid (GABA), which slows down brain signals, and glutamate-glutamine, which causes neurons to be more electrically excited, with GABA significantly correlating to internet and smartphone addiction, depression, and anxiety. Whilst not specifically focused on young adults, per se, this does illustrate how social media usage during teenage years, and the effects this can have on certain brain areas and on mental health, may potentially translate into adulthood. Furthermore, Primack et al., (2017) discovered that individuals who used between seven and 11 social media platforms were much more likely to have increased depression and anxiety symptoms than those who only used zero to two.

Research into the positives and negatives of social media on mental health varies. Some studies have found and continue to find it can have a detrimental effect on mental wellbeing and increase mental health problems (Bessière, Pressman, Kiesler, & Kraut, 2010; Campbell, 2017; Oberst, Wegmann, Stodt, Brand, & Chamarro, 2017; O'Reilly, Dogra, Whiteman, Hughes, Eruyar, & Reilly, 2018). Others have found that it can have the opposite effect, seemingly helping to alleviate and improve mental health, especially depending on the context it is used for (Bessière et al., 2010; Naslund, Aschbrenner, Marsch, & Bartels, 2016). There has also been research that shows no significant correlation between the use of SNS and its effect on mental health (Jelenchick, Eickhoff, & Moreno, 2013). Social media and mental health is an important area for further research to determine how these websites can affect the mental health of those who use them.

Barriers and stigma

The final theme was "*Barriers and stigma experienced*". Many participants spoke about the barriers they had faced when it came to seeking help or wanting to disclose, and they spoke about how mental health stigma had a large impact on this. There is a vast body of research that explores mental health stigma and its effect on individuals and, as Rössler (2016) states in his research, "the stigma attached to mental illness is ubiquitous. There is no country, society or culture where people with mental illness have the same societal value as people without a mental illness*.*" (Rössler, 2016, p. 1251).

Barriers to university disclosure and help

Barriers to disclosing and help-seeking within a university environment was discussed by a number of participants, particularly females. A lack of direction to university

services had a negative effect on participant's willingness to seek help, whilst those who did speak to services spoke about negative experiences deterring them from pursuing it further. One participant spoke about how she found the help at university to be adequate, but she received insufficient advice and guidance about services outside of university and said she would find it difficult to seek help upon graduating. Quinn, Wilson, MacIntyre, and Tinklin (2009) identified stigma, being seen as weak, not acknowledging or admitting they were struggling, a lack of understanding from those they wanted to disclose to, and the impact on future career prospects, as some of the barriers students felt affected their decision to seek help from their university services. Others such as a lack of time, believing treatment would not help (Tija, Givens, & Shea, 2005), concerns about privacy and confidentiality (Mowbray et al., 2006), and a lack of emotional openness (Komiya, Good, & Sherrod, 2000) have also been identified. A number of participants spoke about how they did not consider themselves as someone who struggled with anxiety or depression and so they felt as though they did not require help. Another spoke about how the services were advertised as "wellbeing and disability services" and as she did not consider herself disabled, she did not seek help. For some, services were not well-advertised, and they were reluctant to seek help since they were unsure of what was available to them. Improving the services at universities and emphasising where and what services are available could offer some guidance to those who do not know where to go and encourage them to consider the help on offer.

Reducing stigma

Participants collectively spoke about how reducing mental health stigma would encourage them to disclose about their problems to people and seek help when necessary. There have been many attempts to reduce stigma and efforts to reduce it further are still ongoing. Anti-stigma campaigns in a number of European countries, for example, have attempted to reduce stigma and discrimination towards those with mental health problems, but regardless of these advances and attempts to fight mental health stigma, de-stigmatisation is still essential to help improve and reduce negative public perceptions of mental health (Beldie et al., 2012). However, when it comes to the younger generation, stigma and being perceived as weak is not as prominent, and young adults and students especially, are more open to talking and seeking help. Colleges and universities are aware of the increase in student mental health. Many students report mental health problems and

seek help from campus therapists and services to the point where these services struggle to accommodate and provide adequate help to the increasing number of students who require them (Goodman, 2017; Lightfoot, 2018; Pedrelli, Nyer, Yeung, Zulauf, & Wilens, 2015; Xiao et al., 2017). Mental health stigma is steadily being minimised, and whilst it may not be as prominent within a student population or within the younger generation, there is definitive proof from the current study that it still has a detrimental effect on some individuals. It is unclear why stigma is less prominent when it comes to younger adults, but the rise of social media, the influence from high profile people discussing their own struggles, and the openness of this generation could be factors. Attempting to further normalise what is currently considered taboo in society would help to encourage more people with disclosing and help-seeking. This is especially true for the participants in the current study, where many voiced how stigma negatively affected them and was one of the reasons why they were hesitant to disclose and pursue necessary help.

However, even if continued efforts were made to reduce stigma, research has shown that when this has been attempted in the past, increasing the general public's understanding about mental health has not always resulted in improved acceptance of those who suffer (Schomerus et al., 2012). When anti-stigma campaigns have been utilised, there has still been limited evidence to show changes in discrimination, even after mental health prejudice was shown to decrease (Clement et al., 2013) and stigmatising attitudes have been shown to impact peer-to-peer support and younger people's initiatives to provide mental health support (Yap & Jorm, 2011).

University stigma reduction

One area where it is imperative for stigma to be reduced is in universities. Reavley et al., (2018) discovered that selective disclosure or non-disclosure was more likely when it came to workplace supervisors, educational institutions, and healthcare settings. Female participants in the current study were hesitant to disclose to university staff and services, with some worried that disclosing would impact on career progression, echoed by a number of studies (Chew-Graham, Rogers, & Yassin, 2003; Storrie et al., 2010; Venville et al., 2014). Tutors in universities have spoken about students being unwilling to receive or access help from services because of the stigma of disclosing (Stanley & Manthorpe, 2001), whilst Wynaden et al., (2014) noted that students were worried about stigma and discrimination in

response to disclosing, and as a result, this could result in isolation, loneliness and withdrawal from courses (Wynaden, Wichmann, & Murray, 2013).

In universities, social contact, stigma campaigns with a focus on reducing self-stigma, and education programmes that provide facts, recovery strategies, and personal stories of individuals with mental health have been shown to reduce stigmatising attitudes (Knaak, Modgill, & Patten, 2014; Lally, Conghaile, Quigley, Bainbridge, & McDonald, 2013; Spagnolo, Murphy, & Librera, 2008; Yamaguchi et al., 2013). Across the university sector, universities are aware of the increase in mental health and service needs, and there are attempts to improve this support further underway. The Department for Education (2019), for example, have recently identified four risks areas that can have an effect on first year students' mental health: (1) independent living, (2) independent learning, (3) healthy relationships, and (4) wellbeing. Sector groups, such as UCAS, the National Union of Students, and the Association of Colleges, have banded together to create the Education Transitions Network, a group focused on developing measures that will ensure students are able to smoothly transition from college to university and maintain good mental health.

Workplace stigma reduction

The workplace is another crucial area where stigma needs to be addressed and reduced. Current research findings tie into the research by Reavley et al., (2018) about selective/non-disclosure to workplace supervisors or in healthcare settings; they illustrate how participants felt as though they were unable to disclose to their place of employment because they feared they would face stigma or be judged from their colleagues. Stratton, Einboden, Ryan, Choi, Harvey, & Glozier (2018) discovered that non-disclosure about mental health illnesses was common, particularly in male dominated fields of work. Managers would never disclose, especially if they were considering career progression, and the manager's negative attitudes towards mental health meant they were unequipped and unprepared to support their employees if someone did disclose. Two female participants in the current study were undertaking courses that would lead to a healthcare role upon graduation and given their views and experiences surrounding workplace stigma and disclosure, this adds to the complexity of this area. Research has shown that mental health stigma, especially within a healthcare related profession, results in barriers to accessing quality care and treatment, and for a healthcare practitioner, this can negatively impact

their help-seeking behaviours (Abbey et al., 2011; Adams, Lee, Pritchard, & White, 2010; Henderson et al., 2014; Ross & Goldner, 2009). Issues, such as negative attitudes and behaviours, lack of awareness and skills, self-discrimination, and the risk of losing their job or their financial income (Knaak, Mantler, & Szeto, 2017; Stratton et al., 2018; Thornicroft, Rose, & Kassam, 2007) contribute to workplace stigma and effect an individual's decision to disclose, and sometimes workplace staff are discouraged from talking about their mental health and seeking help (Abbey et al., 2014; Ross & Goldner, 2009). Despite this, research has shown that healthcare students possess positive attitudes towards those with mental health problems and those who want to seek help, although they did not want to disclose about their own mental health (Chang et al., 2017).

In a systematic review of 16 studies into mental health stigma interventions, Hanisch, Twomey, Szeto, Birner, Nowak, and Sabariego (2016) discovered that anti-stigma interventions can improve employee's knowledge about mental health and result in more supportive behaviours towards people with mental health problems. Multiple studies emphasised that Mental Health First Aid resulted in changes in knowledge, attitudes, and behaviours, whilst things such as anti-stigma workshops, psychoeducation, and Crisis Intervention Training also resulted in positive changes in knowledge, attitudes, and/or behaviours. Furthermore, mental health disclosure in workplaces has the potential for individuals to receive special adjustments or accommodations that may be helpful (Brohan, Evans-Lacko, Henderson, Murray, Slade, & Thornicroft, 2014), whilst Knaak et al., (2014) identified key things for anti-stigma programs, including an emphasis on recovery, the importance of social contact, and teaching skills that ensure healthcare providers are aware of the things to say and do. Implementing some of the above methods in both universities and workplaces would be advantageous in helping reduce stigma, and through slowly normalising these issues and educating others on the realities of mental health, individuals may find it easier to disclose and make use of what services are on offer to them in these two environments.

Strengths and limitations of the current study

Strengths

This study explored an under-researched sample of individuals. Whilst research into mental health, stigma, and help-seeking is vast, research into these looking at a student

sample is less prominent. It has shed light onto an area that requires even further exploration to fully understand the experiences of students and mental health. Similarly, the sample included both young students and mature students, with ages ranging from 20 – 42, meaning that experiences were not just limited to a small age demographic, but were inclusive of both younger and older adults, allowing for a deeper exploration of the topic. Small comparisons were also able to be drawn from the different ages, showing how mental health can affect individuals depending on the stages they may be at in their life and how these individuals cope and deal with their experiences. Another strength is the use of semi-structured interviews. This type of interview allowed the participants to talk about what they deemed was relevant, with only minimal guidance and structure in terms of questioning, and so this, once again, allowed for a deeper understanding of the participant's own experiences with their anxiety, stigma, disclosure, and help-seeking. Furthermore, given the number of studies discussed that utilise a quantitative, cross-sectional method to gather their results, essentially limiting and reducing participant's experiences, this study is able to capture the essence and feeling of said experiences and offer a different approach to the topic area in question. The researcher being a fellow student is a strength and it is possible that participants would have been more open to discussing their concerns and experiences with a peer compared to a GP or a therapist, which may have potentially encouraged greater disclosure and a more in-depth and rich account of their own student experiences.

Limitations

Whilst the study did explore an under-researched area, only a very small student sample was interviewed, despite interest and responses from a number of students. Therefore, the results from this study are in no way indicative of or generalisable to other individual's experiences. If this study was to be replicated, a larger sample of students, from different backgrounds and cultures, may uncover even more information and provide more insight into the experiences of this group. Whilst a strength of the study was the different ages sampled, there is also a limitation to this, since there were only a very small number of mature students interviewed. The majority of participants who took part were younger students, with ages ranging from 20 – 23, whilst only three mature students disclosed their ages, which were 29, 40, and 42, and two chose not to disclose. Including mature students

adds another element to the research and as stated, allows for variations in experiences from different life stages. However, given the small number of mature students sampled, this again, is not necessarily generalisable to all mature student's experiences, especially for those on different courses or from different backgrounds. Further research into a sample of mature students only may be beneficial in advancing or adding to the literature in this area. Another limitation is the two questionnaires used. Although the GAD-7 (Spitzer et al., 2006) and the Mini-SPIN (Connor et al., 2001) are valid and reliable measures, one participant did indicate some confusion about answering the questions. He expressed how the available answers could be considered confusing and said the wording was awkward when it came to him choosing a box to tick. This ultimately raises the question of how individuals interpret the available responses and may result in answers that are not necessarily accurate. Additionally, the questionnaires only looked at mental health over a period of one or two weeks, which does not show an accurate reflection of the participants mental health in general.

Resarcher reflexivity

As with all research, but especially qualitative research, it is essential to consider the role of the researcher and reflect on the possibility of things such as their background and their assumptions towards the research area (Hesse-Biber, 2007, cited in Palaganas, Sanchez, Molintas, & Caricativo, 2017), their own subjectivity and values in the research process (Parahoo, 2006, cited in Palaganas et al., 2017) or their own personal experiences with the topic at hand (Berger, 2015). It is important to look at the degree to which these things may directly or indirectly influence how the researcher carries out their research (Jootun, McGhee, & Marland, 2009). Reflexivity is a very significant element of qualitative research (Dowling, 2006) and the general consensus is that it involves a level of self-awareness, an awareness of both internal and external influences, and the relationship between the researcher and the research topic (Dowling, 2006; Lamb & Huttlinger, 1989; Lambert, Jomeen, & McSherry, 2010).

In regard to the current study, a number of things could have influenced my role as a researcher and an interviewer. For one, my interest and own personal experiences with the research topic being explored may have influenced my line of questioning throughout interviews. Whilst I attempted to be as objective as possible, I felt there were times where I

drew on my own experiences to illustrate a certain point, especially sometimes in reply to a participant's response, which may have biased or influenced their subsequent response. Further to this, like with the interviews, I feel like my own personal experiences and struggles with anxiety may have influenced certain themes within my analysis. There were some significant areas from the interviews that I myself have experienced, for example, the social media aspects in regard to mental health and disclosing to certain individuals compared to others. Based on this, whilst objectivity was important and paramount, I do feel as though these shared experiences between myself and participants influenced, in part, some of the themes that were explored in my analysis and the resulting discussion. Additionally, my lack of experience in interviewing may have affected the quality of questions asked. Despite multiple practice interviews being carried out before participant interviews were undertaken, my inexperience may have hindered them, resulting in information that, whilst rich, was not necessarily as rich or in-depth at it could have been. Moreover, another aspect that may have influenced my role is that of me being a student. Participants may have felt more comfortable opening up to someone of their own age and someone who may be able to relate to the experiences they are going through, both in terms of their mental health and those of a student in general. This may not necessarily be achievable from someone in a position of higher authority, such as a counsellor. Given the informal setting and the easy-going nature of the interviews, despite the sensitivity and seriousness of the topic, I feel as though a sense of rapport was created between me and the respondents, and many were able to open up about their experiences in some detail.

Future research

A potential area of interest may be that of social media and mental health. The current study identified positive and negative aspects of social media usage yet more research may provide even more depth to this area. With social media playing such a big part in people's lives, especially those of the younger generation, it would be beneficial to explore and ascertain whether there are certain websites, above others, that worsen mental health. The Royal Society for Public Health (2017), for example, identified *Instagram* as being the worst SNS for mental health, and *Youtube* as the most positive, and so, further exploration as to what causes these SNS to be considered positive/negative may be useful for users. The benefit of online peer support could be another area that may be

advantageous to explore. The use of blogs or OSGs have shown that online support from peers is valuable when it comes to mental health. Further exploration of this area could provide more depth and may further highlight the positive aspects of social media use on mental health. Additionally, literature has shown how individuals can place weight on their social media interactions and rely on social media validation as a way to feel good about themselves (Children's Commissioner, 2018), with a lack of validation resulting in poorer mental health (Park, Kim, Lee, Yoo, Jeong, & Cha, 2015). More research into this and the overreliance on social media likes may be beneficial in ascertaining how this effects mental health and why this may be.

Mental health and coping mechanisms may also be of interest. Whilst not discussed in this study, participants spoke about the different types of coping mechanisms they used when their anxiety was particularly bad. It may be beneficial to look into whether there are any possible links between an individual's coping mechanisms and what effects these have on their mental health, which in turn, may provide help for individuals who struggle with their own. Information surrounding useful coping mechanisms could be especially helpful for those who have only recently started to struggle with their own mental health. Whilst certain coping mechanisms may not work for everyone, researching and discussing ones that individuals could utilise may be advantageous in alleviating and helping manage their anxiety in both the short and long term.

One benefit of this research is how it could offer prospective improvements to university services. It is evident from participants own experiences that, despite utilising the university counselling services available, many felt as though there were barriers that deterred them from seeking help earlier. One participant mentioned how her hesitancy to approach the counselling services being offered was because they were advertised as "wellbeing and disability services" and she felt she did not consider herself disabled. This may be off-putting to individuals and limit them from seeking the help they need. Universities may want to consider how their services are labelled in order to ensure students are able to feel comfortable approaching and taking advantage of what is available. Another participant mentioned how the services were useful, but there was a lack of advice and guidance presented to her about where she could find help after graduation. Providing this advice would be worthwhile, especially for soon-to-be graduates who may not be aware

of what is accessible outside of their university campus, but it would also be beneficial for those who may feel as though they need more help than what can be given at university. Furthermore, providing information about services and symptoms to look out for is important, particularly for students who have only just started at university. One participant mentioned how there was a lack of guidance about how to actually find the wellbeing services and believed that this could be an issue for students. Factoring in the stress that can come with the transition from college to university and the changes that are associated with this, such as financial considerations or moving away from home, new students may require this information and these services significantly more than those who have been there for longer, and it would be valuable to include this during open days, student induction weeks, at the start of every term time, and at intervals throughout the students' course. It may also be useful to assure students that there is confidentially involved with seeking help and disclosing, and that unless information disclosed indicates a potential risk of harm to the discloser or someone else, only the counsellor would know of their problems.

One of the largest problems when it comes to disclosure and help-seeking is that of stigma. The negative impact of this was evident within all participant's interviews and it is vital that this area is continuously explored in order to help diminish its effect, particularly in a student environment. A potential way of reducing this is through cultivating and facilitating the conversation around mental health. Many participants discussed how mental health stigma could be reduced if individuals were unafraid to talk about their problems, and yet, this type of reduction may only be achievable if the topic of mental health is slowly normalised, rather than looked down upon. Considering the negative societal attitudes towards mental health, finding ways to better educate not only students, but society in general, about the realities of mental health would be a start. Things such as peer support, anti-stigma campaigns, and awareness-raising programmes would all be valuable when it comes to minimising stigma and could help promote openness and positivity around what is considered to be a rather taboo subject. Future research may want to focus on and look into the benefits of these recommendations in order to ensure that people, especially students, are able to access the different types of support available without feeling stigmatised or judged. Providing them with a platform and a space where they are able to freely and openly talk about their mental health would be advantageous.

Conclusion

To summarise, previous research (Corrigan, 2004; Corrigan, Druss & Perlick, 2014; Corrigan et al., 2016; Dyrbye et al., 2015; Lannin, Vogel, Brenner, Abraham, & Heath, 2015) has explored links between mental health, disclosure, help-seeking behaviours, and stigma, and have found conclusive evidence to highlight how stigma has a negative effect on an individual's decision to disclose and seek help about their mental health. The current study explored this area, looking specifically at university students, and findings show that disclosure of anxiety, and mental health in general, is indeed influenced by stigma, most notably when it comes to disclosing informally to friends or older family members. In terms of formal disclosure, it seemed many participants were comfortable disclosing to professionals, although some indicated that finding the right professional resulted in much easier disclosure. Informal disclosure, especially to friends, was less likely, contrasting with findings from past research about friends and family as preferred support networks (Rickwood et al., 2007). Findings for disclosure and different disclosure levels were explained using two disclosure decision making models. Omarzu (2000) explained these through potential achievable rewards, such as social approval and relationship progression, whether disclosure was appropriate for the chosen target, and the subjective utility and risk associated with disclosing, whilst Greene (2009) explained these through the assessment of information, such as perceived stigma or social support, and the assessment of whether potential people to disclose to would react in the way the discloser anticipated.

Although mental health stigma was a barrier that hindered disclosure, there were others that were emphasised, such as fears of being misunderstood or perceived differently, a lack of time when seeking services and appointments, negative previous experiences with disclosure or services, the quality of relationships, and self- and workplace stigma. Being misunderstood and perceived differently seemed to be a barrier that deterred some individuals from opening up to their friends, although some indicated a potential misunderstanding of both mental health and their disclosure. Negative previous experiences with disclosure caused one participant to require a sense of trust, especially in romantic relationships, whilst negative past experiences with services made another participant feel as though she was unable to seek help in situations where it may be required. This study highlights reasons why participants chose to disclose or not and illustrates the significant

number of barriers that individuals still face when it comes to seeking help in a university setting.

Findings from this research could have potential implications for things such as university policies and stigma reduction. Universities may be able to use this research in order to help improve their services in a number of different ways, such as making services more accessible, providing more information about the services available, and making sure services are signposted properly. This may make students feel more comfortable utilising what is available to them. It may also be useful in helping university counsellors and staff understand what difficulties and barriers students are facing and why these things may be detrimental to them. Mental health policies across the majority of UK universities all aim to promote well-being in students, support those experiencing difficulties, and ensure confidentiality is respected and maintained. Improving policies for universities and students and reducing stigma, not just in an educational environment, but in society in general will ensure that individual's suffering from mental health problems are able to comfortable disclose and seek the help they require without fearing stigmatisation and ridicule. Stigma may never be something that is truly diminished, but if it can be reduced and better mental health outcomes can be achieved, then it is a very big step in the right direction.

Participants Required

Have you been bothered by any of the following:

- Avoiding activities in which you are the centre of attention?
- Becoming easily annoyed or irritable?
- Being so restless that it is hard to sit still?
- Fear of judgement/embarrassment?
- Feeling afraid as if something awful might happen?
- Feeling nervous, anxious or on edge?
- Not being able to stop or control worrying?
- Trouble relaxing?
- Worrying too much about different things?

This study will be running between March '18—May '18

If you answered *YES* to any of the above, I would like to invite you to take part in my postgraduate research. If you are interested at all, please feel free to take one of the tear-off slips below and get in contact with me for more information.

Please email: Rebecca.Nuttall@hud.ac.uk
Please email: Rebecca.Nuttall@hud.ac.uk
Please email: Rebecca.Nuttall@hud.ac.uk
Please email: Rebecca.Nuttall@hud.ac.uk
Please email: Rebecca.Nuttall@hud.ac.uk
Please email: Rebecca.Nuttall@hud.ac.uk
Please email: Rebecca.Nuttall@hud.ac.uk
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Appendix B: Email to course leader

Hi [insert course leader name],

I believe you are the course leader for the [insert course name]. I am currently a postgraduate research student in the School of Human and Health Sciences, and I am emailing to ask if you would be willing to circulate this email to students on your course to inform them of the current study I am running. I have received School ethical approval to conduct the study.

Dear student,
I would like to invite you to take part in my study. The study aims to explore how anxiety, specifically in university students, and mental health stigma, impacts on an individual's decision to seek help (or not). The study also aims to explore who people choose to disclose mental health information to. If you are interested, you will be offered the option to take part in a face-to-face or email interview. In both circumstances, you will be asked to fill in two short questionnaires to measure anxiety, followed by an interview. The interview will explore your experience of anxiety, including whether you have experienced mental health stigma, if you sought help and (if relevant) how you chose who to speak to.

If you are interested in finding out more please send me an email at Rebecca.Nuttall@hud.ac.uk, and I will be happy to answer your questions. I will also send you a detailed information sheet.

Thank you.

Kind Regards,
Rebecca Nuttall

University of HUDDERSFIELD
Inspiring tomorrow's professionals

Title of Project

"It's the complete stigma behind it."

Exploring how and why mental health stigma impacts on disclosure and help-seeking behaviours: A thematic analysis

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INFORMATION SHEET

You are being invited to take part in a study about mental health, stigma, help-seeking behaviours and disclosure. Before you decide to take part, it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it me if you wish. Please do not hesitate to ask if there is anything that is not clear or if you would like more information. Thank you for taking the time to read this.

What is the study about?

The purpose of this study is to explore the topic of anxiety, stigma and help-seeking behaviours, looking specifically at the subject of disclosure. Past research has found that mental health stigma has an impact on an individual's decision to seek help and an impact on whom they choose to disclose information to. More research into the impact of stigma on student's decision-making process, especially regarding disclosure, is necessary for a deeper understanding of how stigma effects those with mental health.

Anxiety, stigma and help-seeking behaviours – what do you mean by these terms?

For some, anxiety can be intense worrying about a wide range of situations or about one specific situation. Individuals with Generalized Anxiety Disorder (GAD), for example, tend to feel anxious over a long period of time, tend to feel restless or worried and tend to worry about lots of different situations, rather than just one. Individuals with Social Anxiety Disorder (SAD), usually have overwhelming fears surrounding any type of social situation. Everyday activities, such as speaking on the phone and shopping, can cause intense fear for individuals with this type of anxiety, amongst many other things (e.g. worrying/avoiding social situations, blushing/sweating or anything that may cause embarrassment). Stigma can be defined in two ways: public stigma, which refers to the stereotypes and prejudices from the public towards individuals that are considered different from the "norm", and self-stigma, which refers to the negative attitudes from the public that are internalised by individuals. Both stigmas can act as a barrier and a deterrent to seeking help for those individuals with mental health problems. Help-seeking behaviours are the different behaviours an individual may have exhibited to access help, e.g. getting a diagnosis, understanding their mental health, deciding to go to therapy sessions and to speak to their therapist, etc., and may also include the potential barriers an individual may have faced when it came to accessing or not accessing help and support.

Why I have been approached?

You have been asked to participate because you are a student at the University of Huddersfield, and you fit the relevant criteria to take part in this study.

Do I have to take part?

Participation in this study is completely voluntary and you are not obliged to take part. If you do decide to take part you will be asked to sign a consent form, indicating your agreement and understanding of what the study will entail. You will be free to withdraw at any time and without giving a reason. You also have a right to avoid answering certain questions during the interview if you feel uncomfortable doing so, and a reason will not be required. A decision to withdraw at any time, or a decision to not take part, will not impact on you in any way. If you decide to withdraw throughout the study, you have a right to decide whether you would like any information you have disclosed to be used, or whether you would like to withdraw this information. If you would like to withdraw this information, you can do so any time between your participation and the end of May. After this, the analysis stage will have begun and you will be unable to withdraw.

What will I need to do?

If you agree to take part in the research, after the consent form has been signed, you will be asked to take part in an interview and to fill in two questionnaires. The option of a face-to-face interview or an email interview will be offered beforehand. If you opt for a face-to-face interview, this will be recorded using an encrypted recording device. If you opt for an email interview, the email exchange will take place through my university email address. Before the interviews take place, you will be asked to fill in two small questionnaires about anxiety. Both interviews will consist of between six to ten questions; for face-to-face interviews, this should take approximately 30/45 minutes, whilst for email interviews, the length of exchange will be over a 1 month period, with a response time of 3 days. All face-to-face interviews will be conducted on campus, whilst all email interview responses will be sent during office hours (9 – 5). After the interview is completed, you will then be debriefed.

Are there any possible disadvantages to taking part in this study?

There should be no foreseeable disadvantages to you taking part in this study. Due to the nature of the study, and the sensitivity of the topic, care will be taken to ensure no psychological harm ensues. However, talking about mental health may be distressful for some, and if if you feel as though you have been psychologically harmed throughout the study, necessary support services will be provided before and after the study if you require them. If at any point throughout the interview, you feel distressed, the interview will be paused to allow you time to compose yourself. You will have the choice to continue on with the interview if you feel ready, or you can withdraw without giving a reason.

Will my identity be disclosed?

All the information that you disclose within the interview will be kept anonymised and kept confidential, unless you indicate that you or anyone else is at risk of serious harm, in which case I would need to pass this information on to my supervisors and to the relevant support. For face-to-face interviews, the interview will only be listened to by myself and anonymised

during transcription. If you have opted for an email interview, all emails will be exchanged between university email addresses, not personal email addresses. Please note, system administrators may be able to view these exchanges. To minimise inadvertent disclosure of your identity, your email address/user ID will NOT be used for any quotes, and any attachments (e.g. consent form), will only be shared via a hyperlink to UniShare. If you are unable to use UniShare, all attachments should be encrypted or password protected to ensure confidentiality.

What will happen to the information?

All information collected from you during this research will be kept securely in a password protected file that only my supervisors and myself will have access to. Any identifying material, such as names, will be removed, and instead, you will be referred to by an ID number in order to ensure anonymity. It is anticipated that the research may, at some point, be published in a journal or report. However, should this happen, your anonymity will be ensured, although it may be necessary to use your words in the presentation of the findings and your permission for this is included in the consent form. Research data, per the University's Guidelines, is to be stored at the University for a period of 10 years after the completion of the project.

Who can I contact for further information?

If you require any further information about the research, please don't hesitate to contact me or my research supervisors using the details below:

Researcher: Rebecca Nuttall

Email: Rebecca.Nuttall@hud.ac.uk

Research Supervisor: Dr. Kiara Lewis

Email: kiara.lewis@hud.ac.uk

Research Supervisor: Dr. Amanda Edmondson

Email: A.Edmondson@hud.ac.uk

Once again, thank you for taking the time to read through this.

University of
HUDDERSFIELD
Inspiring tomorrow's professionals

CONSENT FORM

Title of Research Project: "It's the complete stigma behind it." Exploring how and why mental health stigma impacts on disclosure and help-seeking behaviours: A thematic analysis

It is important that you read, understand and sign this consent form. Your contribution to this research is entirely voluntary and you are not obliged in any way to participate, if you require any further details please contact your researcher.

I have been fully informed of the nature and aims of this research as outlined in the ☐

information sheet version two, dated 15. 02. 18

I consent to taking part in this study. ☐

I understand that I have the right to withdraw from the research at any time ☐

without having to give a reason.

I understand that I have the right to avoid answering any questions that I am not ☐
comfortable answering without having to give a reason.

I give permission for my words to be quoted (by use of pseudonym). ☐

I understand that the information collected will be kept in secure conditions ☐

for a period of 10 years at the University of Huddersfield.

I understand that no person other than the researcher/s and facilitator/s will ☐

have access to the information provided.

I understand that any information that may be indicative of harm to myself, ☐

to others or to the researcher will need to be disclosed to the appropriate persons.

I understand that my identity will be protected by the use of pseudonym in the ☐

report and that no written information that could lead to my being identified will

be included in any report.

If you are satisfied that you understand the information and are happy to take part in this project, please put a tick in the box aligned to each sentence and print and sign below.

FOR FACE-TO-FACE INTERVIEWEES ONLY:

Signature of Participant:	Signature of Researcher:
Print:	Print:
Date:	Date:

FOR EMAIL INTERVIEWEES ONLY:

If you are an email interviewee, please click the box below to confirm you understand the information and are happy to take part in this project.

Name of Participant	Name of Researcher:
Confirm participation: ☐	Confirm receipt of confirmation: ☐
Date:	Date:

(one copy to be retained by Participant / one copy to be retained by Researcher)

Appendix E: GAD-7 questionnaire

<u>GAD-7</u>

Over the last two weeks, how often have you been bothered by any of the following problems?:

1. Feeling nervous, anxious or on edge?

    Not at all ☐

    Several days ☐

    More than half the days ☐

    Nearly everyday ☐

2. Not being able to stop or control worrying?

    Not at all ☐

    Several days ☐

    More than half the days ☐

    Nearly everyday ☐

3. Worrying too much about different things?

    Not at all ☐

    Several days ☐

    More than half the days ☐

    Nearly everyday ☐

4. Trouble relaxing?

Not at all ☐

Several days ☐

More than half the days ☐

Nearly everyday ☐

5. Being so restless that it is hard to sit still?

Not at all ☐

Several days ☐

More than half the days ☐

Nearly everyday ☐

6. Becoming easily annoyed or irritable?

Not at all ☐

Several days ☐

More than half the days ☐

Nearly everyday ☐

7. Feeling afraid as if something awful might happen?

Not at all ☐

Several days ☐

More than half the days ☐

Nearly everyday ☐

Appendix F: MINI-Spin questionnaire

<u>Mini-Social Phobia Inventory (Mini-SPIN)</u>

Thinking back on the past week, please rate how these three items have affected you on a scale of 0 – 4:

1. Fear of embarrassment causes me to avoid doing things or speaking to people

    0 = not at all ☐

    1 = a little bit ☐

    2 = somewhat ☐

    3 = very much ☐

    4 = extremely ☐

2. I avoid activities in which I am the centre of attention

    0 = not at all ☐

    1 = a little bit ☐

    2 = somewhat ☐

    3 = very much ☐

    4 = extremely ☐

3. Being embarrassed or looking stupid are among my worst fears

    0 = not at all ☐

    1 = a little bit ☐

    2 = somewhat ☐

    3 = very much ☐

    4 = extremely ☐

Appendix G: Interview guide

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INTERVIEW GUIDE

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- Face-to-face interviews: Greet interviewee upon arrival. Provide them with the information sheet and the consent form and gain consent. Provide them with the two questionnaires. Upon completion, explain that the interview will be recorded and begin the recording. For email interviews, email them the information sheet and consent form and ask them to return a signed form, either through unishare or in a password protected file. Give a timeframe of how long the interaction will last for (a month), the hours which I'll be able to reply between (9 – 5), and a timeframe for general replies (3 days, then maybe send a reminder email to see if they got the email, and are still wanting to take part).
- Ease interviewee in to make them a little more comfortable,
  some starter questions:
  - "How are you?"
  - "So, what course are you doing?"
  - "How do you find your course?" (e.g. difficult, enjoyable, etc.).
  - "What do you want to do after university?"
  - "And, how long have you been at the University?" (*may be answered from initial course question*).
  - "Have you moved away for university? or do you live around the area?"
- After starter questions, explain purpose of interview – would like to talk to them about anxiety. Inform them that they can stop the interview at any point, can avoid answering certain questions if it makes them uncomfortable, and that they can take a break if they need to. Then ask if it's okay to continue. Questions in red are potential questions, depending on answers given.

1. "If you remember from signing up to this study, there was a list of symptoms that you may have experienced (*have list on hand to provide, if necessary*) – can you tell me what symptoms you've experienced from it?"
   "Have you experienced any other symptoms that might not necessarily be on this list, for example, panic attacks or the like? If so, can you tell me what they are, what you consider your symptoms to be?"

2. "Okay, so you said you experienced _____ - can you tell me when you first started to notice them?"
   "And how did you feel when you first experienced them?"
   "was there anything that you think may have triggered it?"

3. "Were you aware of what these things actually were when you first started to experience them?"
   For example, did you recognise the symptoms of a panic attack e.g. feeling sick, trouble breathing? Or did you just want to be somewhere else?"

4. "And, after your first experience, what did you do?"
   - e.g. maybe thought it was a one-time thing, ignored them, talked to someone, etc.

5. "Did you ever speak to anyone about your experiences after these episodes?"
(if they answer yes, start from question 10)
(if they answer no, start from question 6)

6. "Why did you decide not to tell anyone at all?"
e.g. more comfortable dealing with it on your own?
Didn't want to be a burden by telling people?

7. "So, you said_____ - why did you feel _____?" *(^ a follow up question to however the above question is answered)*

8. "You said you've never actually spoken to anyone about your experiences, but have you ever considered talking to someone at all?"
"Why/why not?"
"You said you did consider it, and how did it make you feel?"
"You said you didn't consider this, was there any particular reason why not?"

9. "Do you feel at all, as though there's barriers that affect you from actually seeking help and speaking to some, either professionally or informally?"
"so for example, Stigma? Embarrassment? Judgement? Not being taken seriously?"

10. "Who, besides the people you've already spoke to *(from question 5, if they have)*, have you told about your anxiety?"
"and how did they react to this?"
"were they understanding?"
"how long did it take for you to tell them?"

11. "Can you tell me why you decided to tell this person/these people?"
"so, you felt as though they would be more understanding about it/relate to it more?"

12. "How did telling them about this differ from telling them about something else?"
e.g. telling them about your day/a show/some news you heard, etc.

13. "Was it difficult for you to disclose this information to people?"
"why do you feel as though it was/wasn't?"

14. "What caused you to ask for help?" *(either professionally, or from friends/family/partner, etc.).*
"was there a particular experience/occasion that you felt may have influenced your decision?"
"not necessarily to ask for help, but just to discuss it with someone and discuss how you were feeling?"

15. "Regarding seeking help, what kind of situations do you think would have encouraged you to seek help from a professional?" *(If they already have, maybe inquire about how long it took and whether if there were certain things they knew earlier, they might have sought help earlier).*

being more aware of services, having more knowledge of these services and what they offer, reduction in stigma, etc.

16. "In your opinion, do you think if mental health wasn't so stigmatised and more people understood it, you would have been more inclined to seek help?"
"Why is this?"

17. "Are you familiar with any of the anti-stigma work surrounding mental health?" (e.g. heads together, time to change)
yes - "What are your thoughts on them?"
"Do you yourself have personal experience with stigma?"
no – maybe provide some info on what they do, and then inquire about their thoughts on them?

18. "So, you said at the start that you lived away from home – do you feel as though actually being away from home, and being away from the things you're used to, that your anxiety is more intense?" (if included, can be moved to a better position)
if they live at home: "even though you're living at home, do you feel as though the pressures at uni, etc., make your episodes worse? Or do they have no affect?"

19. "Is there anything that you feel would be helpful to talk about that we might not have covered during this interview?"
"is there any part of your experience that you feel I might be able to use to help other people? Maybe any advice you might have for others that I could pass on?"
e.g. any mechanisms you use to cope? Or any ways you may have found that make it easier to talk to people?

20. "Finally, do you have any other questions?"

- Turn off recording, provide/email debrief sheet and thank the interviewee for coming/emailing and taking part.

Appendix H: Debrief sheet

DEBRIEF SHEET

Thank you for taking the time to take part in this study. The reason for this study was to explore the topic of anxiety, stigma and help-seeking behaviours, looking specifically at the subject of disclosure. Previous research has shown that stigma affects an individual's decision to seek professional help for their mental health illness, choosing instead, to either avoid help altogether or to seek help elsewhere, usually from talking to friends or family members. Martin (2010) discovered that university students tend to not disclose their mental health problems to university staff, and instead go to considerable lengths to hide it, ultimately struggling to meet their university requirements.

The questionnaires you took part in measured your anxiety and helped inform the direction of the interview. The interview you took part in explored questions on mental health and stigma, your decision-making processes surrounding disclosing information to people and your general behaviours surrounding help-seeking. Two types of interviews were carried out, and all participants were given the option to which they would rather undergo. Some participants opted for a face-to-face interview, and others opted a remote, email interview. All information gathered from the interviews will be transcribed and analysed, and then written up in a thesis.

Due to the nature of this topic, and the fact you were asked to talk about your mental health, care was taken to ensure no psychological harm would be caused. However, as stated in the information sheet at the start of the study, some distress may have been caused. If you feel at all distressed from this study, there are contact details available at the bottom and on the back of this sheet for the different support services that are available, which you can contact if you do require them.

If after this study, you decide that you would like to withdraw your data, you have until the 5th June 2018, after which you will be unable to do so. If you have any further questions regarding the study, or any further questions about this topic in general, please don't hesitate to contact me and I will be happy to answer any questions or concerns you may have: Rebecca.Nuttall@hud.ac.uk

Once again, thank you very much for your participation!

Support services:

- University Well-being services:
  - email: studentwellbeing@hud.ac.uk / ipoint@hud.ac.uk
  - telephone: 01484 471001
  - able to book same day appointment or advanced booking appointments from Mon – Fri at the iPoint, Level 4, Student Central.
  - opening hours: 8:00am – 6:00pm during term times and 9:00am – 5:00pm during summer and Christmas holidays.

- MIND:
  - email: info@mind.org.uk
  - telephone: 0300 123 3393 (or text 86463)
  - website: https://www.mind.org.uk/

- Samaritans:
  - email: jo@samaritans.org
  - telephone: 01484 533388 (local call charges apply) or 116 123 (free to call)
  - Huddersfield address: 14 New North Parade,
    - Huddersfield
    - West Yorkshire
    - HD1 5JP

- SANE:
  - support forum: http://www.sane.org.uk/what_we_do/support/supportforum/
  - telephone: 0300 304 7000 (from 4:30pm – 10:30pm every day).
  - website: http://www.sane.org.uk/what_we_do/support/

- S2R Create Space:
  - email: contact@s2r.org.uk
  - telephone: 01484 539531
  - website: https://www.s2r.org.uk/about-us
  - they provide a variety of creative, outdoor, well-being and mindfulness sessions that aim to improve your mental health and help with your well-being.

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