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'I WAS NOT SOMEONE WHO WOULD HAVE A MENTAL HEALTH PROBLEM. I'VE ALWAYS BEEN VERY SYMPATHETIC AND UNDERSTANDING OF ALL THESE THINGS, BUT I STILL DIDN'T THINK IT APPLIED TO ME'

EXPLORING INDIVIDUALS' EXPERIENCES OF ACCESSING SUPPORT FOR ANXIETY AND DEPRESSION: A THEMATIC ANALYSIS

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A thesis submitted to the University of Huddersfield in partial fulfilment of the requirements for the degree of Master by Research

The University of Huddersfield

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Abstract

The prevalence of mental ill health and severity of its impact across society highlights the importance of further research to extend our understanding of this pressing issue. The current study utilises a qualitative, critical realist approach to gain in-depth understanding of individuals' experiences of accessing support for anxiety and depression. Eleven participants, who have accessed support for anxiety or depression within the last five years, took part in semi-structured interviews regarding their experiences. The interview transcripts formed the data set, which was analysed using Braun & Clarke's (2006) guidelines for thematic analysis. From the analysis four main themes were created to represent the experiences described by participants. These were '*Reluctance to Access Support and Delaying until Crisis*', '*Concerns About Medication*', '*Sharing and Vulnerability*' and '*Having to Fight for Support*'. The findings emphasise the challenges individuals face while attempting to access support and bring to life the struggles involved. Based on these findings areas for change and further research are explored.

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Dedications and Acknowledgements

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Introduction

Mental health issues are common across all countries and cultures affecting millions of people worldwide (World Health Organisation, 2017). In England among people aged under 65 years, mental illness makes up almost half of all ill health; nearly as much as all physical illness put together (The Centre for Economic Performance's (CEP) Mental Health Policy Group, 2012). Mental health or psychological wellbeing is a vital component in individuals' capacity to live fulfilling lives. The detrimental effects of mental ill health can impact many meaningful aspects of life; including individuals' ability to work, study, pursue interests and participate in social and family life. Mental health explains more variance in a population's overall life-satisfaction than physical health, unemployment or income (Flèche & Layard, 2017).

Through its effects on individuals' ability to work, or work to their full potential, mental ill health has dramatic economic implications, which cost the government and businesses billions of pounds every year (Black, 2008). For instance, mental illness accounts for at least 40% of absenteeism in the workplace (McManus, Meltzer, Brugha, Bebbington & Jenkins, 2009) and 52% of all people on incapacity benefits (Centre for Mental Health, 2007). Mental health has been found to be the single most important predictor of individual life-satisfaction and happiness (Flèche & Layard, 2017). The prevalence of mental health issues and the serious implications, not only for individuals personally affected, but also for their families, friends and society as a whole, makes this a hugely important issue.

Depression and anxiety disorders, which are the focus of this study, are by far the most common forms of mental illness (NICE, 2011). Depression is characterised by persistent low-mood, feelings of hopelessness and helplessness with loss of interest and pleasure derived from living (American Psychiatric Association, 2013). Anxiety disorders are a category of mental health issues which are characterised by feelings of anxiety and fear. The most common anxiety disorders include phobias, panic disorder, Obsessive Compulsive Disorder, Post-Traumatic Stress Disorder and Generalised Anxiety Disorder (GAD) (Mental Health Foundation, 2014). GAD can cause difficulties in many different situations and areas of life for sufferers. It accounts for over 30% of the mental health problems seen by GPs (Mental Health Foundation, 2014). In the United Kingdom one in every six adults has a common mental health issue, with mixed depression and anxiety being the most prevalent (McManus, Bebbington, Jenkins & Brugha, 2016).

The scale of this issue and its debilitating consequences for those affected shows the importance of access to effective mental health support and treatment. Services within the

NHS have been reported as struggling to cope with provision inconsistent across the country (CEP's Mental Health Policy Group, 2012; QualityWatch, 2014). A report by The CEP's Mental Health Policy group (2012) describes the under-treatment of 'people with crippling mental illnesses as the most glaring case of health inequality in the country': only a quarter of those with mental illness receive any treatment, compared to the vast majority with physical conditions. The QualityWatch (2014) report identified failings in service delivery; such as long waiting times for treatments, declining accessibility and reduced numbers of staff and available hospital beds. A survey of people who had attempted to access talking therapies in the last two years by the mental health charity Mind (2014) found that one in ten people had to wait over a year for assessment and half of those who received therapy felt they had insufficient sessions to help with recovery. The survey also showed disastrous effects for many people left waiting for therapy; with 67% of people's conditions worsening, 40% of people harming themselves and one in six attempting suicide. A report commissioned by the Department of Health (Allen, Carr, Linde & Sewell, 2016) states that mental health services remain under-resourced compared with other areas of healthcare and much change is required to address issues within services.

Through the research aim of in-depth exploration of individuals' experiences of accessing support for anxiety or depression, the present study intended to explore the topic from service users' perspectives. However, experiences of accessing support were not limited to NHS services alone and participants were encouraged to discuss experiences of accessing support for anxiety or depression from any relevant organisation. As discussed, anxiety and depression are extremely prevalent and a significant source of distress for individuals affected and for those around them (McManus, Meltzer, Brugha, Bebbington & Jenkins, 2009). A qualitative approach was adopted due to its suitability for obtaining and analysing rich, detailed accounts (Coolican, 2009). Individuals' own experiences of accessing support are vital sources of knowledge for mental health research and extremely relevant when considering provision of support, as it is for these individuals' needs and wellbeing that services serve (Crawford *et al.*, 2011; Lasalvia *et al.*, 2012; Mavaddat, Lester & Tait, 2009; Patterson, Trite & Weaver, 2014; Wylie, Fitter & Bragg, 2009).

Literature Review

Literature pertaining to approaches and attitudes towards common mental health disorders is considered. This section considers the complexities in defining clinical depression and anxiety and the role of human experience and individuals' life events. An overview of existing support services and their access routes follows; including findings leading to the launch of the government's Increasing Access to Psychological Therapies (IAPT) programme and subsequent literature evaluating the programme's approach and level of success. Finally previous findings relating to help-seeking behaviour and accessing support for anxiety and depression is examined.

Attitudes and Approaches towards Mental Health

The differing approaches towards mental health presented in previous literature can vary considerably in the way disorders, such as depression and anxiety, are understood. This section will consider the relevance of bio-medical, environmental and social factors relating to common mental health problems and the difficulties encountered negotiating these complex influences. Literature concerning approaches to treatment and the role of health professionals and service-users within this process will also be explored.

Previous research suggests different etiological explanations of common mental health issues affect attitudes towards treatment, personal empowerment and stigma (Lee, Farrell, McKibbin & Deacon, 2016; Goldstein & Rosselli, 2003). Describing anxiety and depression in terms of biologically based brain disorders, such as chemical imbalance and genetic vulnerability explanations, has been a way of attempting to combat stigma by reducing blame or personal responsibility. Although some research has suggested biological explanations do help to reduce blame and self-stigma for those diagnosed with depression; it can also encourage a more pessimistic and hopeless attitude towards the likelihood of recovery and potential benefits of therapy, life-style interventions and self-help (Deacon & Baird, 2009). Feelings of hopelessness and lack of personal control can have detrimental effects in relation to individuals' motivation to access support and engage with therapeutic treatments and self-help.

The relevance and effectiveness of bio-medical or pharmacological approaches to anxiety and depression has been criticised (Blease, 2014; Moncrieff & Kirsch, 2015). The importance of social and environmental factors such as, personal history, life events and challenging circumstances, in the development of mental health issues is widely recognised. This has influenced the process of medical diagnosis of depression and anxiety, which utilises specific measurable criteria from the DSM-IV (APA, 2013) to rate symptoms and prescribe

corresponding recommended treatments, including medication and therapeutic interventions. NICE (2009) acknowledge a wide range of factors influencing the course of depression and its treatment are not well captured by current diagnostic systems. To combat this, guidelines for NHS practitioners also emphasise the importance of taking into account patients' personal history, circumstances and preferences when considering care options (NICE, 2009; NICE, 2011).

The combination of influences involved makes diagnosing and categorising the severity of individual presentations of anxiety and depression extremely difficult. Previous research has raised a variety of concerns regarding defining and identifying depression and anxiety. For instance, evidence suggesting inconsistent diagnosis and under-treatment of common mental health issues (Thornicroft *et al.*, 2017). Alongside this, contrasting reports endorse the dangers of medicalising 'normal' experiences of sadness and fear (Dowrick & Frances, 2013). There is no clear consensus in research or practitioner fields regarding the distinctions and over-lap with clinical anxiety and depression, experiences of wellbeing and negative emotions, such as of despair, grief and hopelessness.

Moncrieff (2008) suggests treatments which take into account a more holistic view of mental health can combat the passive patient role in medication-only treatment; by encouraging individuals to evaluate their lifestyle, find new perspectives and learn new skills. Psychosocial interventions can offer practical ways of tackling problems and empower patients to feel more able to make changes, which could be beneficial in their recovery. Acknowledging the difficulties people have faced and seeing anxiety and depression as rational reactions to adversity is another way this approach could promote wellbeing and reduce stigma. Movements towards more holistic consideration of anxiety and depression may allow service-users to become active collaborators in their treatment and recovery by identifying issues and implementing change.

Focusing on recovery through self-directed emotional and behavioural changes is a dramatically different approach compared with treatment by medication alone. The conflicting expectations of patients' role in their recovery have been identified as a source of confusion and an unfair burden on those who are seeking help and are often in crisis (Donahue, 2000). Therapeutic interventions have also received criticism regarding the potential to have a negative impact; framing personal internal factors as sources of mental health difficulties and individuals as central in controlling their own wellness could elicit feelings of guilt, shame and weakness (Layton, 2009).

Plans to improve NHS mental health services have included aims to become equivalent to physical health services with greater integration (Department of Health, 2014). Emphasis on

patient choice and empowerment within mental health services attracts diverse positions and opinion. Department of Health (2011) literature reports the benefits of patient choice and of providing clear information, enabling service-users greater autonomy in their healthcare decision-making. However, approaches emphasising individuals' empowerment and self-directed choices have also faced criticism for denying the feelings of psychological frailty, vulnerability and dependence (Rizq, 2012a). Rizq (2012a) argues there is a shift from 'patient' to 'consumer', with healthcare services attempting to change illness and suffering into a satisfying activity where individuals decide which treatments suit them and choose with confidence from proven options. She asserts this approach loses the ability to acknowledge and meaningfully engage with the pain and fragility which are part of mental health problems.

Presenting anxiety and depression treatments as proven options, equivalent to physical healthcare, has been challenged by some researchers. Literature evaluating the efficacy of medication to treat disorders such as anxiety and depression has been mixed, with many studies finding antidepressants to be no more effective than placebos and even when statistically significant results are obtained this does not necessarily translate into significant clinical improvement (Bloom, 2010; Moncrieff & Kirsch, 2015). Side effects of medication can cause unwanted complications and have serious negative impacts on quality of life. Research has also suggested potential risk factors from therapeutic treatments, with a recent study suggesting one in twenty patients experience 'lasting bad effects' following treatment (Crawford *et al.*, 2016). In addition to the varied evaluations of more mainstream treatments for anxiety and depression, there are an increasing number of alternative approaches to improve mental wellbeing. Literature has shown undertaking pursuits such as mindfulness, meditation, exercise and leisure activities can alleviate mental health problems and help individuals deal with the challenges they face more easily (Iwasaki, Coyle & Shank, 2010; Strauss, Cavanagh, Oliver & Pettman, 2014).

These diverse approaches to treatment, alongside previously discussed ambiguities regarding mental health, can lead to confusion in what course of action to take and how to make sense of experiences of anxiety or depression. Donahue (2000) summarises some of the contradictions and dimensions of mental health those seeking support may need to navigate:

'The environmental versus the neurobiochemical; self-empowerment versus provision of care; recovery without limits versus rehabilitation with limits; and nurture versus nature, all contribute opposing themes that help shape the debate. And they are indeed frequently presented as opposing and opposite ends of a spectrum, with little potential for balance.' (Donahue, 2000, pg. 428)

The complex backdrop to mental health, including depression and anxiety, is important when considering people's experiences of accessing support. The vast array of differing professional

and lay opinions when it comes to defining mental illness, its causes, preferable treatments or courses of action and what to expect for the future have been considered. How these mixed messages and opposing ideas may influence individuals experiencing anxiety or depression and attempting to access support is an important and under-researched area of investigation. This confusing landscape is likely to affect how individuals view mental health, sources of support and themselves; including self-esteem, resilience and personal responsibility. Qualitative enquiry is flexible enough to deal with these complex issues and potentially identify links between theory and participants' material.

Sources of Support for Anxiety and Depression

This section provides an overview of the variety of services individuals seeking support for anxiety and depression may access. These include private therapy, work-based counselling, schemes and support groups run by mental health charities or community projects, online resources, telephone helplines and NHS services. Access routes are likely to vary considerably depending on the course individuals take. Literature pertaining to the Increasing Access to Psychological (IAPT) programme will be reviewed. This is relevant to the current study, as the programme is the NHS' frontline treatment for anxiety and depression disorders in combination, where necessary, with medication (Clark, 2011).

Access to therapy through private agencies or work-based services is likely to come through self-referrals, recommendations by employers or sign-posting from other services. These services are usually funded privately by the individuals seeking support or their employers. These routes may not be feasible for many people due to the financial investment required, limitations in workplace provisions or for those not in employment. However, for those that can access private and work-based therapy waiting times are generally considerably shorter and the process of assessment and commencing therapy more straightforward, compared with talking therapies offered through the NHS.

Therapies for anxiety and depression, available through NHS provision, can be accessed through referrals from GPs and other health professions and self-referrals to services such as IAPT. A stepped-care model is adopted by health professionals and services for mental health issues, such as anxiety and depression. This means low-intensity interventions are often prescribed initially, then moving to higher intensity interventions in circumstances where initial treatment has not been sufficient. The severity of symptoms and impact on individuals' everyday functioning is an important factor in determining the course of support recommended. In cases of persistent sub-threshold or mild to moderate depression and anxiety, patients are encouraged to try low-intensity interventions first, such as computerised

CBT, group-based peer support programmes, psychoeducational groups and non-facilitated and facilitated self-help (NICE, 2011). These interventions can also provide interim support for individuals who would benefit from high-intensity therapies, but are on waiting lists to access them. These types of routes to accessing services can lead to a more complex and lengthy process.

Support offered through mental health charities and organisations can include a wide variety of services, for instance be-friending or mentoring schemes, help with specific difficulties relating to anxiety and depression such as employment and finance, peer-support groups and individual counselling via online, telephone or face-to-face meetings. The availability and ease of access for these methods of support can depend on location, demand and individuals' awareness of the services. These types of service are often accessed through self-referrals. Referrals may also come from more official sources such as health professionals, social workers or recommendations from friends and family. Free and subsidised counselling services can be in high demand and result in long waiting lists and delays to accessing support. Delivery of support for anxiety and depression through these types of organisation is offered through diverse methods. Programmes can be based around exercise, meditation or artistic pursuits, for example. Community based projects can help to bring people with common mental health disorders together, facilitating supportive peer relationships and networks.

Online resources are another way individuals may access support for anxiety or depression. The NHS Choices Moodzone (2016) website is one example of the many sites that offer advice and support regarding stress, depression and anxiety. The site offers tips for boosting mental health, information around self-help, online assessment tools, audio guides, recommended apps and sign-posting to other relevant services. Online methods of support will be discussed further in the '*Help-Seeking Behaviours and Accessing Support*' section.

Increasing Access to Psychological Therapies (IAPT)

The IAPT programme began in 2006 to address issues with NHS mental health care provision in England. The initiative's purpose is to increase access to evidence-based therapies recommended by the National Institute for Health and Clinical Excellence (NICE) for people with anxiety and depression. IAPT aims to increase availability of talking therapies, such as Cognitive Behavioural Therapy (CBT), through: investing in services, training new psychological therapists, introducing target waiting times for assessments and referrals, and adopting a stepped-care treatment model (Department of Health, 2011). Large numbers of people who would not previously have been able to access psychological therapies have done so through IAPT services. Another important feature of the IAPT programme is a focus on

evidence-based treatments, including session-by-session outcome measurements to monitor clinical progress and change (Department of Health, 2012).

The Department of Health (2012) has described the high levels of data completeness in pre-treatment and post-treatment outcomes measures in IAPT services as important in improving mental health service transparency and identifying areas which are working well and areas for improvement. However, the programme's focus on numerical outcome data and randomised controlled trial methodology has also attracted criticism. Williams (2015) argues this positivist approach could bias services towards a narrow view of recovery, which overlooks service users' subjective experiences. Adopting a qualitative paradigm, which includes individuals' perspectives, could offer a richer understanding and more meaningful view of accessing support, as symptom reduction outcomes are only one part of a person's 'lived experience narrative' (Packer & Goicoechea, 2000). The current study aims to utilise a qualitative approach with emphasis on understanding how accessing support is experienced from individuals' perspectives. This method allows for the complexities and contexts involved in seeking and receiving support to be explored in a way that some previous studies relating to IAPT services may not. Many researchers have stressed the importance of qualitative enquiry to ensure mental health literature and support services focus on wider domains of recovery, rather than more abstract, numerical measures of quality of life (Scanlon & Adlam, 2010).

Department of Health literature regarding performance of the IAPT programme has also received criticism. The annual IAPT reports evaluating the programme's success typically show recovery rates near the target levels set, at around 45% for patients receiving a full course of therapy (Health and Social Care Information Centre (HSCIC), 2015). However, these figures have been described as misleading because the same HSCIC data, when represented in another way, also shows only around 6% of patients receiving referrals to IAPT services moved to 'reliable recovery' (Atkinson, 2014). These apparent contradictions in the statistics seem to demonstrate how numerical data, such as patient health questionnaires and specific disorder outcomes, can be manipulated to suggest very different levels of success in tackling anxiety and depression. Omitting data relating to individuals who were referred for therapy, but did not receive any or who did not complete the full course, allows the HSCIC report to present a figure of recovery which appears more favourable than when including the data for all individuals who attempted to access support. Figures from mental health charity Mind (2013) also seem to challenge IAPT's own assessments and suggest the programme has not yet adequately addressed problems with the accessibility of talking therapies, with 10% of referrals still on waiting lists after a year and 50% waiting more than 90 days.

Political motivations to report positive outcomes from government initiatives and show value for money in investment need to be taken into account when considering IAPT reports

(Griffiths & Steen, 2013). The problems with positive reporting bias and issues around quantitative measures' suitability in meaningfully describing outcomes and experiences of accessing support show a need for a different kind of investigation. Concerns raised regarding the IAPT programme's and related literature's focus on generating positive public perception and political gains, whilst disregarding the inner emotional realities of those experiencing psychological distress, suggest a vital area for further research (Rizq, 2012b).

In addition to contributing towards the need for further qualitative research concerning IAPT services, the current study will explore experiences of access more broadly by including other organisations and services. Inclusion of a variety of services and pathways to accessing support may allow insight into shared strengths and struggles across different settings, potentially offering new perspectives and alternative ways of working.

Help-Seeking Behaviour and Accessing Support

Despite the distress and serious consequences anxiety and depression can cause for those affected, it is estimated that only half of those experiencing depression and a third with anxiety seek professional help (Gulliver, Griffiths, Christensen & Brewer, 2012). Seeking support for mental health issues has been shown not to be a simple process of experiencing psychological symptoms and then seeking help (Rickwood, Deane & Wilson, 2007). Instead many factors seem to play a role in this process. Barriers and deterrents to accessing support identified in previous studies will first be explored, followed by alternative models and perspectives. Finally, literature regarding ways to increase help-seeking behaviour and access to services will be considered.

Concerns about whether services and treatments would be able to help and are suitable to approach for anxiety and depression issues have been identified in previous research, as a cause of reluctance or avoidance to access support. An American study found participants were unsure if general doctors were suitable to approach regarding mental health concerns and expressed worries about competence and knowledge (Kravitz, *et al*, 2011). A mistrust of mental health professionals and the efficacy of treatments has also been reported, which has been found to be particularly relevant for young adults. This may be due to feelings of vulnerability or perceived power imbalance especially pertinent for young adults (Martínez-Hernández, DiGiacomo, Carceller-Maicas, Correa-Urquiza & Martorell-Poveda, 2014). Mixed messages about the benefits of treatments for anxiety and depression discussed in the previous section, also contribute to a recurrent theme of a lack of clarity in services suitability to help. Findings in previous research have suggested lay understandings of emotional

difficulties are not always thought of as appropriate reasons to access formal support. For instance, participants in Pill, Prior & Wood's (2001) study were unsure if emotional distress constituted as 'legitimate' illness and spoke about preferences to deal with these kinds of problems themselves or with the help of friends and family. If individuals do not recognise their experiences of anxiety and depression as illness they could be unlikely to access support services.

Public attitudes and behaviours regarding anxiety, depression and mental health support are likely to impact on access to care. This could be at an institutional level by influencing legislation, funding and availability of services (Henderson, Evans-Lacko & Thornicroft, 2013). Also, through stigma which can exist around common mental health issues, whether this is actual or perceived prejudice and discrimination (Anderson, Jeon, Blenner, Wiener & Hope, 2015;). Anxiety and depression are arguably more widely understood and accepted than in the past, with efforts to improve mental health literacy and encourage more open discussion. However, research suggests there are still issues surrounding stigmatised attitudes towards anxiety, depression and seeking support. For instance, some findings suggest fears of detrimental effects on career opportunities reduce willingness to seek medical assistance (Chew-Graham, Rogers & Yassin, 2003). Also, self-stigmatising views and fear of judgement from others that difficulties are caused by personal weakness or failure, have been suggested as a cause of reluctance to acknowledge or report issues (Talebi, Matheson & Anisman, 2016). Seeking help can be seen as an admission that problems faced are too much for the individual to cope with. Prior (2011) suggests that courage to seek help may be the most significant challenge in contending with mental illness. The current study hopes to gain further, detailed insight into how these issues may be experienced and understood from the perspective of individuals accessing support.

Biddle, Donovan, Sharp & Gunnell (2007) criticise dominant approaches to understanding help-seeking for being too simplistic and static by framing non-help-seeking behaviour in terms of 'barriers' to care. They assert a more dynamic approach is required to meaningfully represent these complex issues. An alternative interpretative perspective to seeking support for mental health issues is the 'Cycle of Avoidance' model, which explains help-seeking as a circular process driven by attempts to negotiate personal and social meanings of illness and 'being helped'. The model proposes that individuals attempt to avoid meanings of being in 'real' illness through repeated efforts to normalise or cope with increasingly severe distress and shifting the threshold between what they believe constitutes 'normal' stress and 'real' distress or illness (Biddle, Donovan, Sharp & Gunnell, 2007). This previous study focuses on young people's help-seeking behaviour and further investigation into the model's applicability for other age groups and wider relevance is required. However, the model is an example of the non-linear journeys seeking support may take and the importance of individuals' own

interpretations of 'real' illness. These insights could be relevant to participants' personal experiences of accessing services and the need for flexible methodologies to combat reported issues of simplistic or superficial representations.

The complex and personal nature of individuals' journeys to access support for anxiety and depression has been highlighted in previous research; along with the need to avoid assumptions those experiencing difficulties actively seek help and make explicit decisions about access. Pescosolido, Gardner & Lubell (1998) found that participants own 'stories' and self-reports of initial contact with mental health services often involved themes of choice, coercion and 'muddling through.' Rational decision-making, in combination with influence from social networks was found to be important in the process of contacting support services. Coercion relates to instances where individuals actively did not want to access support, but were forced, pressured or encouraged to do so from other sources, such as friends and family members, employers, police or social workers. Although Pescosolido, Gardner & Lubell's (1998) study included other mental health disorders, in addition to anxiety and depression, where coercion from authorities and other sources may play a greater role, the significance in considering the intricacies of real life experiences of accessing support is still relevant. Personal accounts are likely to include convoluted, often chaotic descriptions, rather than linear rational choices and implicit decision-making to seek help. 'Muddling through' is another way individuals may experience accessing support, which involves neither actively resisting nor seeking treatment. People may be unclear how they initially became involved with support services or have experienced ambivalence to accessing services. A qualitative methodology allows these important elements of experience to be explored without trying to define or limit findings to more isolated, individualistic decision-making views of mental health care.

Previous literature has also focused on evaluating ways to improve access to support for anxiety and depression and increase help-seeking behaviour. Utilising online resources and guidance is one approach to increasing accessibility of support. These alternative mediums for support can potentially be more convenient, flexible, offer greater privacy and anonymity, appeal to those who prefer self-help strategies and lower costs of treatment (Choi, Andrews, Sharpe & Hunt, 2015). Titov *et al.* (2011) found cognitive behavioural therapy delivered over the internet (iCBT) to be effective for patients with anxiety and/or depression, who reported significantly reduced symptoms following a ten week course. Participants also rated the procedure as 'highly acceptable.' Many empirical studies of online and telephone-based guided support have advocated the benefits and reduced resources required of these methods (Berger, Boettcher & Caspar, 2014; Dear *et al.*, 2015). The NHS has utilised this approach in some of its low-intensity interventions within the stepped-care model (Department of Health, 2011). Further qualitative enquiry into alternative mediums of support could help to elaborate on the experience of these approaches for the individuals receiving support.

Another avenue, explored in previous research, to improve access to depression and anxiety support services are ways of reducing stigma (Quinn *et al.*, 2013). The impact of public health programs and other initiatives to reduce stigma is difficult to gauge due to the complexities of this challenge. Previous research suggests unanticipated, subtle effects can result from these initiatives and may have long-term implications on perceptions and behaviours (Talebi, Matheson & Anisman, 2016). Interventions which focus on improving mental health literacy have been found to positively affect attitudes regarding seeking help (Gulliver, Griffiths, Christensen & Brewer, 2012). However, much of the research into reducing stigma has focussed on changing attitudes and beliefs, which has been shown to have limited effects in changing behaviour and increasing help-seeking (Han, Chen, Hwang & Wei, 2006). For instance, Wimsatt, Schwenk & Sen (2015) found that even medical students, who are very well informed about depression and its potential causes, continue to show reluctance to access support themselves and hold negative attitudes towards those with mental illness. Stigmatised views of depression and anxiety indicating personal weakness or failure may be particularly relevant for specific groups. For instance, research has suggested masculinity norms can heighten self-stigma for men experiencing depression and inhibit help-seeking behaviour (Seidler, Dawes, Rice, Oliffe & Dhillon, 2016). Understanding and reducing stigma may be particularly complex in regard to anxiety and depression, where it can be more subtle compared with other mental disorders; patronising attitudes, feelings of stigma, rather than overt discrimination have been reported (Dinos, 2004).

It is important to continue up to date investigation of experiences of accessing support for anxiety and depression, as this is a constantly changing landscape. Literature needs to continue to assess attitudes, behaviours and experiences relating to mental health, and monitor how new approaches to treatment and initiatives to reduce stigma and improve knowledge of anxiety and depression are affecting the situation. The diverse issues relating to help-seeking previously discussed, show how complex this area of research can be. The following quote summarises some of these considerations and emphasises the need for adaptive, holistic approaches to investigate this topic.

'Although awareness of a problem (by self or others) is a starting point, the symptoms of mental health problems and mental disorders play a smaller role than might be expected in prompting help-seeking. A wide range of other factors are involved, including appraisal of a problem as something to seek help for, willingness to seek help and social norms that encourage such behaviour, access to appropriate services, and choosing a source of help.'
(Rickwood, Deane & Wilson, 2007, pg. S35)

The current study's aim is to address these concerns through the use of open and flexible research methodologies, suitable for exploring experiences of access and placing participants' material as a central source of knowledge.

Methodology

Epistemological Position

The current study adopts a critical realist position. Similarly to interpretative and phenomenological approaches, this position asserts that the world is not passively understood by individuals and values subjective perception and experience as a valid and vital source of knowledge (Green & Thorogood, 2009). However, critical realism is a more suitable position for the current study, as exploring individuals' subjective experience remains integral, whilst also acknowledging that these experiences relate in some way to an objective reality outside of language and other human constructs (Seale, 1999; Roberts, 2014). This position means that by working critically and reflexively researchers are able to achieve 'qualified objectivity', giving research the potential to meaningfully investigate wider contexts, relationships and phenomena beyond subjective perceptions (Manicas, 2009).

In the case of this study, a critical realist position means participants' accounts are thought to represent subjective constructs and interpretations of accessing support, but also that the accounts can provide insight into the outside world of how mental health services are working, which exists separately from individuals' experiencing. This is an important part of valuing participants' experiences and can be both a positive and practical position. Personal accounts are acknowledged as not only providing valuable insights into individuals' views, but having the potential to offer greater understanding more broadly, for example how mental health services are working to support people living with anxiety and depression and potential areas for improvement.

Design

Qualitative methodologies have been underutilised in past mental health research, despite their potential benefits in addressing complex, multifaceted issues (Kuntz *et al.*, 2014; Crowe, Inder & Porter, 2015; Fossey, Harvey, McDermott & Davidson, 2002; Peter, 2010). The development, diagnosis, treatment and consequences of mental health issues, such as anxiety and depression, involve numerous and varied factors. By generating rich, detailed data qualitative research is better able to recognise participants' full experience and avoid losing meaning (Coolican, 2009). Rather than attempting to isolate or quantify specific relationships between factors, a qualitative approach offers a more holistic way of studying people's

experiences. Qualitative enquiry is vital to the study's aim of in-depth exploration of individuals' unique, personal experiences of accessing (or attempting to access) support for anxiety or depression.

Adopting qualitative methods in mental health research offers a way of empowering participants and service-users, as their subjective experiences and meanings are recognised as relevant and meaningful sources of knowledge, with the potential to provide valuable insights into mental health issues and the provision of support. By acknowledging the importance of participants' subjective experiences and giving them a voice, qualitative enquiry can help combat problems of scepticism and disengagement with mental health services; instead service users can be more actively involved in evaluating and improving support (Peter, 2010). This study recognises the value of exploring individuals' accounts of what is often an extremely difficult time, attempting to get support for depression and anxiety, and allowing them to express their views more freely and fully than is typically offered through quantitative research, such as tick box questionnaires and rating scales. This qualitative approach allows participants' perspectives to be represented in a more authentic form, staying as close as possible to their described experiences. The focus on fuller understanding of participants' perspectives is intended to shed light on the issues that are relevant and important for them.

Semi-structured interviews were used to gather detailed accounts of participants' experiences. This flexible method of enquiry ensured the research aims were addressed within the interviews, while also allowing the participant to guide the direction taken depending on what was important and relevant for them (Punch, 2005). This structure also maintained the freedom to explore interesting elements that emerged, which may not have been anticipated by the researcher (Evans, 2007). A flexible interview structure was especially important considering the current topic, as participants' history of mental health issues and experiences of accessing support were extremely varied and specific to each individual. For instance, some participants' histories of accessing support for anxiety and depression go back over many years involving numerous organisations. Therefore an adaptable interview guide was essential to successfully explore these diverse experiences and complex narratives.

Development of the Interview Topic Guide

The interview topic guide (*Appendix 1.*) was developed after consulting relevant literature and defining the research aims. The topic guide intended to meet these aims by posing questions which break down the wider experience of 'accessing support' into more specific elements for participants to consider. The interview guide could be thought of as taking a somewhat chronological route to explore participants' experiences of accessing support, as the first two

questions concerned the circumstances leading up to seeking support and the preceding expectations and feelings. The next two questions also related to participants' experiences leading up to accessing support. They explored factors participants felt had influenced their decision to seek support. Questions five and six moved on to what happened once the participant accessed or attempted to access support. This point in the interviews usually diverged most from the interview topic guide; additional questions specific to the unique circumstances and experiences presented by the participant were used when necessary to clarify and explore material further. The next two questions from the interview guide continued to explore the experience of accessing and receiving support by asking participants to identify aspects they found particularly helpful or unhelpful. By this point the interview topic guide and additional questions aimed to have elicited a rich account of participants' experiences of accessing support. The next questions asked participants to reflect on their experiences further, by comparing the expectations of accessing support with what actually occurred, then to consider the impact of their experiences on what they would do in future if they themselves or a friend was experiencing anxiety or depression. The final question was added to the interview schedule following the pilot interview, which highlighted the need for a very open question to give participants the opportunity to add anything they felt was relevant. This was especially important to capture issues which may not have been anticipated or previously discussed within the interview and to explore areas of participants' choosing in more depth.

Pilot Interview

A pilot interview was undertaken to assess the suitability of the topic guide (*Appendix 1.*) in meeting the research aims. The interview was conducted at the researcher's home with a 47 year old, female participant known to the researcher. The interview briefing (*Appendix 2.*) reiterated the nature of the research and the participant's rights, which had been provided previously in the information sheet emailed to the participant in advance of the interview. The participant was encouraged to ask any questions they might have regarding the project and sign the consent form when they were ready, which was witnessed by the researcher. The interview lasted around thirty-four minutes in total and roughly followed the pre-devised interview guide.

The pilot interview highlighted how inter-linked previous or on-going experiences of receiving support and accessing support can be. In this case, the anticipated focus of the interview was a specific occasion the participant went to her GP for support for anxiety and depression in 2011, but this particular incidence of accessing support is part of the participant's wider experience of receiving support and treatment from a variety of services intermittently over many years. During the interview the participant talked about the issues she had experienced

at other times during treatment and when participating in various support groups. This aspect of the interview emphasised the complex histories participants can have in accessing support, also the required time and flexibility of the topic guide to explore these experiences in depth.

Following the pilot interview I decided to highlight within the interview briefing (*Appendix 2.*) that the timeframe of accessing support specified in the participant criteria does not mean participants are restricted to speaking only about events which occurred in the last five years. This criterion was a measure intended to recruit participants who were able to remember their experiences of accessing support clearly. This issue came up several times during the pilot interview, as the participant was unsure if she should talk about experiences of accessing support before the five year timeframe. Mentioning this within the interview briefing aimed to encourage participants to discuss any experiences and thoughts they felt were relevant to the research topic whenever they occurred.

Initial reflections after completing the pilot interview included concerns regarding the difficulty in differentiating between 'accessing' support and receiving or evaluating support. However, following transcription and further reflection it became clear that the participant's discourse regarding previous encounters with a variety mental health services and treatments were relevant to the current topic of access, as past experiences and issues have contributed to the participant's broader attitudes and reservations around accessing support.

The pilot study also highlighted the likelihood that many people who have accessed support for anxiety and depression will have strong views regarding their experiences and issues that are important to them, which they will want to talk about. Although this can be an asset which may mean participants were more motivated to share in-depth, personal material, it also meant extra attention may be required to ensure material was relevant to the research question, which specially relates to 'accessing' support. The addition of the final question interview question following the pilot interview aimed to give participants an opportunity to talk about the issues that they felt were important and either had not come up within the interview or which they wanted like to discuss further.

Sampling and Recruitment

Eleven participants were recruited through opportunity and snowball sampling. The participants included four males and seven females, whose ages ranged from 23 to 65 years. Most participants were White British, except for participant 6, Amira, who identified as Black British. A letter of invitation (*Appendix 3.*) was shared via email and social media posts to people known to the researcher, some of these individuals then shared the letter of invitation with their colleagues, friends and family members and so on. The letter included the aims of

the project, participant eligibility criteria and contact details of the researcher should individuals wish to express their interest in taking part or request further information.

All participants met the study's inclusion criteria of being eighteen years or above in age and accessing or attempting to access support for depression and/or anxiety from mental health organisations within the last five years. The five year timeframe was set to try to ensure participants could remember their experiences in detail. Also, by concentrating on experiences of accessing support within the last few years it means findings are likely to be more relevant to current services. The five year timeframe also means potential participants may be able to have some time between their experiences of accessing support and taking part in the study. This gap could be important for some individuals, for recovery and coming to terms with often difficult and traumatic periods. Having some distance between these events could mean some individuals feel they are in a better position to talk openly and in depth about their experiences and reduces the likelihood of causing distress.

Participants

This section provides brief introductions of participants and their journeys of attempting to access support for anxiety and/or depression, to help bring the findings to life and add context.

Participant 1 – Heather is 47 years old and has been receiving support and treatment for depression and anxiety from a range of mental health services intermittently since her early twenties. Services include NHS counselling, following referral from her GP, support groups through the charity Mind and a variety of artistic and practical courses and programmes for people with mental health issues. Heather is single, has grown up children and currently works as a carer and shop assistant.

Participant 2 – Jo is a 23 year old, postgraduate student studying psychology and is in a long-term relationship living with her partner. Jo first contacted her GP for support with anxiety and depression five years ago. She then completed a course of Cognitive Behavioural Therapy (CBT) based group sessions. Three years later Jo returned to her GP for further support for depression and was prescribed medication.

Participant 3 – Chantelle is 26 years old and has been in touch with various mental health services for support with anxiety and depression since she was 17 years of age. After the breakdown of her relationship several months ago Chantelle was admitted to hospital for a short period of time due to increasing difficulties with coping and attempts to take her own life.

She is now in a more stable position and continuing to run her own business with ongoing contact with mental health services.

Participant 4 – Rhys is a 39 year old musician and music teacher. He is a father of three from previous relationships and is currently single. Rhys attempted to access support for anxiety and depression through his GP on two occasions. The first time he was referred for counselling and spent several months on the waiting list before receiving a letter requesting he confirm he still required the treatment. Rhys mistakenly did not reply within the specified timescale, which meant he was taken off the waiting list and did not receive any counselling. Four years later when Rhys returned to his GP for support with depression. He was prescribed medication and referred for CBT. While on the waiting list he completed a course of interim therapy and further assessment with a mental health worker, who confirmed he would benefit from individual CBT with a fully qualified counsellor. After remaining on the waiting list for several more months, he was offered another course to complete in the meantime. This was a group workshop, which Rhys did not feel was particularly helpful and was repeating material from the earlier course. As he did not attend all of the group sessions, Rhys was again removed from the treatment waiting list and did not receive CBT.

Participant 5 – Ken is a 65 year old retired teacher. He first got in touch with mental health services for support with depression and what he describes as a 'complete mental breakdown' after separating from his wife six years ago. He visited his GP initially and was referred to the Mental Health Crisis Team and prescribed medication. Ken stopped taking the medication after a short time due to unpleasant side effects. He maintained contact with NHS mental health services over a period of around two years. This time included ongoing support from the Crisis Team, GP, and a year of psychotherapy.

Participant 6 – Amira is a single, 24 year old graduate and is currently working as a support worker for adults with learning difficulties and severe mental health issues. Amira received counselling as a child to help her come to terms with traumatic experiences that occurred in childhood. Amira sought support for depression four years ago, while studying for her degree, through her university's welfare services. This led to the offer of individual counselling sessions and group workshops from the university.

Participant 7 – Matt is 32 years old and married. He works as a music producer. Matt first contacted his GP for support with depression 5 years ago after experiencing problems in his workplace. Matt was then referred to a counselling service with sessions initially taking place over the phone. However, this changed to face-to-face sessions at Matt's request, as he found it difficult to open up and engage with the counsellor over the phone. While going through

relationship difficulties last year Matt returned to his GP for further support. He was prescribed medication and offered support through online and telephone based counselling.

Participant 8 – Eva is 28 years old, single and working as an illustrator. Eva experienced a traumatic event in 2013 when she was at home during a burglary. It was almost a year later, following the death of her friend that Eva attempted to access support for anxiety and depression from her workplace's counselling service. However, following telephone assessments Eva was advised this service was not suitable for her and she needed to contact her GP. Eva's GP referred her to a Cognitive Behavioural Therapy counselling service for a twelve week course of individual therapy.

Participant 9 – Collette is 27 years old, single and currently working as an English as a foreign language teacher. She first attempted to access support for depression while studying at university around five years ago through the university's welfare service. She was offered individual counselling, but after an assessment and initial session Collette decided not to continue due to issues with the counsellor. Around two years ago Collette was experiencing difficulties at work and again sought support for depression. She was recommended a counselling practice through a colleague. After contacting them and discovering the fees were too high for her to afford, they put her in touch with another counselling practice that offer a subsidised service. Collette has since been having weekly sessions for about 18 months.

Participant 10 – Charles is a 63 year old, married, father of two. He is a self-employed shop owner and jeweller. He went to his GP three years ago to access support for depression. Charles was prescribed medication and referred for counselling. However, after several months on the waiting list for NHS counselling he decided to seek alternative support from a private wellbeing and Mindfulness course.

Participant 11 – Theresa is 61 years old, married and previously worked as a senior level, social worker. Theresa encountered difficulties in the workplace, after promotion to a new job role. Theresa was later signed off work with anxiety by her GP and prescribed medication. However, after experiencing adverse effects from the antidepressants Theresa decided not to continue taking them. She received twelve weeks of counselling, which was arranged and funded by her employer. Theresa now uses alternative ways of managing her anxiety including reading on self-help, meditation and Pilates.

Procedure

After recruitment fully informed consent was sought from participants and documented via signed Participant Consent Forms (*Appendix 4.*). Interviews took place either at private rooms booked at University of Huddersfield or York Library or the home of the participant or researcher, depending on the location which was most convenient and appropriate for the participant. Participants were briefed before the interview began on the research aims, interview process and their rights as participants. The interviews began with participants being invited to briefly introduce themselves and describe the circumstances surrounding their decision to seek support for anxiety or depression. The interview topic guide then continued to provide the direction of the interviews, however the semi-structured format allowed flexibility in the way the interviews progressed with additional questions included where appropriate and participants given the freedom to speak about experiences they felt were relevant. The researcher made brief notes during the interviews to record points to go back to for clarification or more detail later in the interview, to avoid disrupting the participants' dialogue. The interviews were audio-recorded and transcribed afterwards by the researcher.

Ethical Considerations

The study adheres to the British Psychological Society's (BPS) Code of Ethics and Conduct (2009) and was approved by the School Research Ethics Panel at the University of Huddersfield. Please see *Appendix 5.* for a copy of the ethical approval and risk assessment form.

To ensure researcher and participant safety when conducting the interviews I informed someone of the planned location and times of the interviews, then called them once the interview had finished. The interviews took place on the University of Huddersfield campus where possible, unless this was not possible for the participant to travel to when an alternative location was agreed. The alternative locations were participants' own homes, private room at York library and researcher's home. The two interviews conducted at the home of the researcher were participants known to the researcher previously.

Participants were made fully aware of what taking part in the project would involve and their rights as a participant through the provision of a 'Participant Information Sheet' (*Appendix 6.*) and 'Participant Consent Form' (*Appendix 4.*). The information sheet (*Appendix 6.*) was supplied to potential participants in electronic format after they expressed interest in taking part. A hard copy was also supplied for participants to read through again before the interview began. The participant information sheet (*Appendix 6.*) made participants aware of the limits

of confidentiality, which were that if they mentioned anything within the interview that suggested there was a risk of harm to themselves or someone else I would have to pass the information on to appropriate persons. Participants were given the opportunity to seek clarification and have their questions answered before they agreed to take part in the study and also encouraged to ask any further questions of the researcher throughout the study. Participants were supplied with the contact details of the researcher to get in touch with any queries they may have or if they wished to withdraw from the study after the interview. The research process aimed to be as transparent as possible. These measures ensured individuals had a clear idea of purpose of the study and understood their rights, thus were able to give fully informed consent to participate. This was documented by a signature on the consent form (*Appendix 4.*).

To ensure confidentiality was maintained, all participant data was stored safely and securely. Physical documents and recordings were kept in a locked cabinet, which only the researcher had access to. Digital recordings and electronic documents were only available to the researcher and supervision team and stored on a password protected computer. The interview recordings were destroyed after transcription and analysis was completed. Any physical copies of transcripts were shredded on completion of the project and electronic data stored in password protected files.

In order to protect participants' identity pseudonyms were used and other identifying details removed from the interview transcripts and final report. Any real names of individuals and organisations that came up within the interviews were also changed in the research report.

Participants were given contact details of relevant organisations on the Participant Information sheet (*Appendix 6.*), should they experience any distress or require support. However, precautions were taken to minimise this risk as far as possible, for instance, by ensuring participants were fully aware of the research topic before choosing to take part and that they felt comfortable talking about their experiences. The researcher also reminded participants in the interview briefing of the purpose of the interview being a research project, rather than a therapeutic or counselling process. The steps planned to protect participants in the event they became distressed during the interview were: for the researcher to reassure them, reiterate there was no obligation to continue with the interview, as previously set out in the participant information sheet and consent form, and offer to take a break or terminate the interview depending on the preference of the participant. The researcher would have stayed and talked with the participant until they were calm, then provided details of sources of support which may be helpful.

There was one instance during the interviews when a participant became upset. The steps outlined above were followed; however on this occasion the participant asserted that she was happy to continue the interview and declined the offer of a break. I tried to reassure the participant as much as possible. Very quickly the participant became much calmer and seemed more comfortable as she began to continue describing her experiences. The participant was made aware of the relevant organisations to contact should she wish.

Although the research aims and process were fully disclosed to participants from the outset, participants were debriefed on completion of the interview in line with the BPS guidelines (2009). The debriefing recapped the intended outcomes of the research, highlighted relevant organisations to contact for support if required and reminded participants' of the right to withdraw their data from the final analysis if they wished, up to one month from the interview date.

Reflexivity

Reflexivity in qualitative study refers to the researcher's active involvement in the research process and recognition of the researcher's influence in shaping and interpreting the data produced (Fine, 1992). This active role means it is crucial for the researcher to reflect on how their own values, experiences, interests and beliefs have affected the research (Evans, 2007). For this reason a break in the usual academic style and use of first person is appropriate within the report to allow for personal reflection and critical thinking regarding my involvement and influence within the study (Banister, 1994). Reflexivity is important for qualitative research to improve transparency in the research process and ensure good quality data (Alvesson & Sköldberg, 2009).

Reflexive procedures included in the study have involved conscious efforts to be self-aware and reflect on my role in the research process, such as how I interacted with participants during the interviews, my skills and concerns regarding conducting the interviews, my role in analysis and interpretation of the data. I made notes on these reflections throughout the study in a journal, including writing up a reflexive account of each interview, with the aim of increasing awareness of my role and gaining insights into how this affected the research process and outcomes. Reflections on my position and interest in the topic are discussed in a reflexive account (*Appendix 7*). Further details of my role as an interviewer and conducting the analysis are covered within the *Discussion* chapter, including consideration of sample and sampling strategy in the '*Limitations of Study*' section.

Analytic Strategy

Transcriptions of participants' interviews formed the data set and were analysed using Braun & Clarke's (2006) six stage method of thematic analysis. Thematic analysis is not tied to a specific theoretical position and can be applied across a range of epistemological approaches, unlike other more rigid analytic strategies. This flexibility in application made the method more suitable than other approaches, which are not compatible with the critical realist position of this study, such as interpretative phenomenological analysis (IPA) bound with a phenomenological stance (Braun & Clarke, 2006; Smith & Osbourne, 2003). Thematic analysis is also an appropriate tool to usefully summarise large bodies of complex data, in this case detailed interview transcripts. This method of analysis' suitability in providing rich description fits well with the research aim of in-depth exploration of participants' experiences of accessing support. Braun & Clarke's (2006) 'inductive' approach was adopted, meaning the themes identified are strongly linked to the data and produced in a way that is data driven rather than trying to fit data into a pre-existing theoretical framework (Patton, 1990). This approach aimed to keep findings as close as possible to participants' described experience, limiting potential distortion from expectations and biases.

The first phase of thematic analysis involves familiarising yourself with the data. This was achieved through firstly listening to the recordings during the transcription process. Followed by repeated listening and reading through the transcriptions to ensure the interviews were captured accurately in the transcripts and to familiarise myself with the data. Throughout this stage I noted down reflections of my role as interviewer and researcher in a reflexive journal. I also began jotting down interesting features and potential meanings, patterns and codes within the data, as Braun & Clarke (2006) emphasise the importance of writing occurring from the beginning and throughout analysis.

Phase two encompasses the generation of initial codes from the data. Initial coding stays very close to the material participants provide. Codes were created to represent the data and identify features by reading through the interview transcripts and noting down brief summaries of what participants said in the margin of the page. After working systematically through the data a long list of codes were produced.

The next phase involves developing broader themes from initial coding by collating relevant coded extracts under potential themes. This process considers how different codes may connect to each other and combine to form overarching themes. This was achieved by reviewing the initial coding and notes I had kept, then grouping together codes and extracts that seemed to fit together in separate word documents. At this point an initial thematic map

was developed (Figure 1) to help to identify the candidate themes and connections between them.

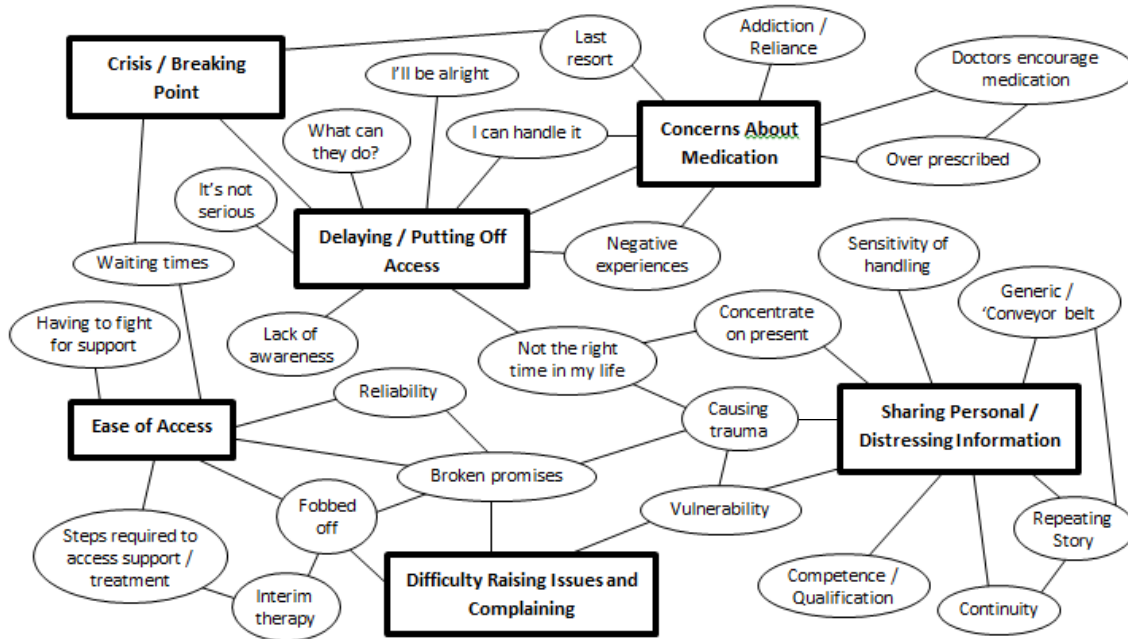


Figure 1. Initial thematic map developed during phase three containing six potential main themes.

Phase four concerns reviewing candidate themes and sub-themes in order to refine the categories and ensure they are distinct and supported with evidence from the interviews. This stage is important for ensuring data within themes cohere together meaningfully while also having clear distinctions between themes (Braun & Clarke, 2006). This was achieved through removing or adjusting problematic themes, which were less relevant when reconsidering the research aims or not sufficiently supported in the data. Also, reworking and creating new themes to better fit and encompass the data extracts helped to refine analysis further. As part of this process a systematic review of the data set was conducted highlighting relevant extracts and noting main themes in the margins. In conjunction with this process I continued to edit and add relevant interview extracts to the word documents, which represented potential themes. After this process of reviewing and refining coding a developed thematic map (Figure 2.) was created with a clearer idea of the main themes and how they fit together as a whole.

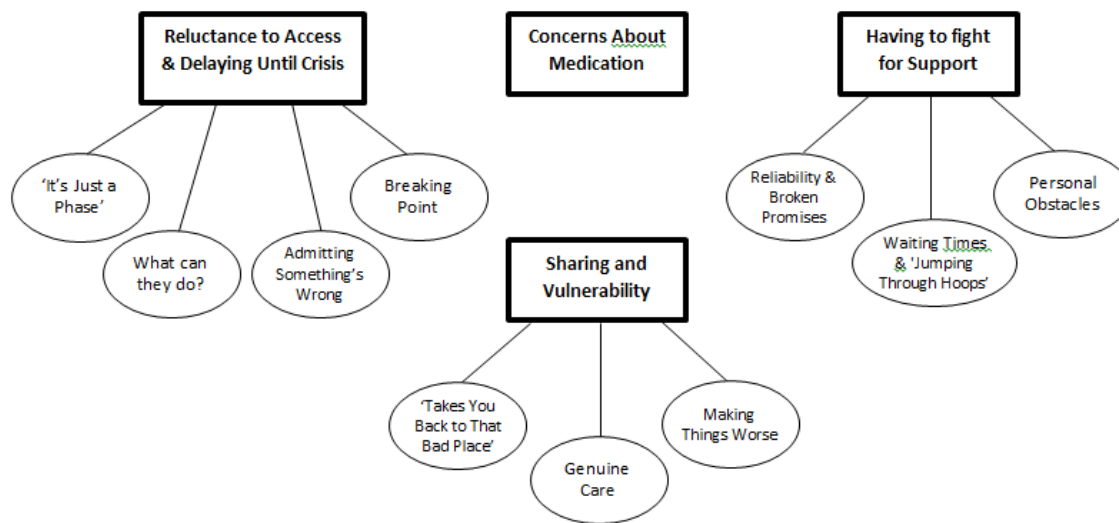


Figure 2. – Developed thematic map from phase five of analysis displaying four main themes and the sub-themes within.

Phases five and six are dealt with in the *Findings and Discussion* chapter of the report and comprise final definition of the four main themes, which aim to identify the essence of the data and provide a coherent and consistent account. Compelling extracts from the data are provided to evidence the themes, demonstrating fulfilment of the research aims and relating findings to previous literature.

Findings

The analysis identified four main themes: *'Reluctance to Access Support and Delaying until Crisis'*, *'Concerns about Medication'*, *'Sharing and Vulnerability'* and *'Having to Fight for Support'*, including the sub-themes within (see *Figure 2.* for themes overview). These themes represent my interpretation of the essence of participants' dialogue about their experiences of accessing or attempting to access support for anxiety or depression.

Due to the space limitations of this report, I have selected three of the main themes, which I felt were most relevant to the research aim, to discuss in detail. These themes are: *'Reluctance to Access Support and Delaying until Crisis'*, *'Concerns about Medication'* and *'Sharing and Vulnerability'*. These selected themes created using Braun & Clarke's (2006) method of thematic analysis, will now follow including quotations from participants' interviews to illustrate the findings and bring the themes to life. The *'Having to Fight for Support'* theme is referred to within the discussion of other main themes and the connections between them explored. A summary of *'Having to Fight for Support'* is also provided at the start of the chapter to give context to the findings and how the themes fit together. Findings will then be considered in relation to previous research and what the study can add to our current understanding of people's experiences of accessing mental health support.

Having to Fight for Support

Due to space constraints of this report only a summary of the content of the '*Having to Fight for Support*' theme and the relevant sub-themes has been provided. This summary gives context to findings as a whole and the links with other main themes, which are discussed in the following sections covering the three remaining themes.

All participants spoke about having to overcome difficulties of some kind in order to seek help and access support for anxiety or depression. The first sub-theme, '*Reliability & Broken Promises*', relates to barriers created through service providers' and practitioners' failings. '*Waiting Lists & Jumping Through Hoops*' is the next sub-theme, which relates to some participants' experiences of having to overcome long waiting times, assessments and unhelpful interim care in order to gain access to support. The final sub-theme includes participants' experiences of '*Personal Obstacles*', which they faced as part of their battle to access support. This main theme highlights the struggle participants described in accessing support and the bravery and persistence they often needed to demonstrate to get help. Also, how these barriers became too much for participants at times, preventing them from accessing treatments or causing them to take alternative routes. These obstacles and experiences affected the way participants view the organisations and support available and influenced how they dealt with their anxiety or depression on further occasions.

Reliability & Broken Promises

This sub-theme encompasses participants' experiences of services and treatments failing to be delivered reliably and as indicated by the providers. Issues with services' reliability included: difficulties for participants when trying to contact services and unclear or incorrect information provided regarding meeting times and locations. Some participants were affected by broken promises and poor communication while attempting to access support. For instance, promises made by professionals about the care provisions that would be in place to support a participant following a hospital admission, which were neglected once the participant was discharged. Other serious incidents described included conflicting advice and lack of communication between health professionals. Participants described how these failings had been barriers to access and rather than support being freely offered and carried out as promised, participants felt they needed to 'fight' to get access to treatments and services. The distressing and frustrating experiences described by some participants led them to feel disillusioned and distrusting of support services. This sub-theme highlights how participants' negative interactions with support services can instil a lack of faith or hope in the services available and feed reluctance to engage with services or seek help in the future. Issues around participants'

reluctance to access support are discussed further within the '*Reluctance to Access Support and Delaying until Crisis*' theme.

Waiting Lists & 'Jumping Through Hoops'

Participants all spoke about the time it took to access support services and treatments, highlighting the importance of timely provision in what are often critical and highly stressful periods. Long waiting lists affected some participants, in one instance a participant waited over a year for individual therapy. Some participants' access to support was affected by the steps in place in-between requesting support and receiving treatment, such as assessments and interim interventions, as part of the stepped-care treatment model. For some participants the assessments before undertaking therapy were distressing and a difficult hurdle to overcome in order to access counselling. For other participants the 'low-intensity' therapeutic interventions, which they were required to complete while waiting to access a course of individual therapy, were described as 'pointless', repetitive and as though they were being 'fobbed off'. Both Rhys and Matt described leaving interim therapeutic treatments as they found them to be so unhelpful. Leaving these interventions early meant further support was withheld and they were not able to access individual therapy with fully qualified counsellors, which they had both wanted. The waiting times and steps in place before individuals can access some treatments were described by nearly all participants as difficulties they felt they had to fight to overcome or barriers which prevented them from getting the support they required. Some of the detrimental effects described by participants are related to the '*Making Things Worse*' sub-theme within '*Sharing & Vulnerability*' and are explored further, later in the chapter.

Personal Obstacles

Personal obstacles which participants described having to overcome in order to access support included: raising the funds to pay for private counselling, contending with perceived judgements of friends and family members for seeking help for a mental health problem, and the personal difficulties caused by anxiety and depression which can make accessing support challenging. For instance, attending group sessions which involve meeting new people and sharing sensitive material can be incredibly daunting for those with anxiety, characteristics of depression such as low energy, lack of motivation and feeling hopeless also made seeking help and accessing treatment a struggle for many participants. These difficulties are again linked with the theme of '*Reluctance to Access Support and Delaying until Crisis*', which is discussed in detail in the following section.

Reluctance to Access Support and Delaying until Crisis

This main theme includes participants' experiences of putting off accessing support often until they felt they had no other choice and could not cope any longer. The idea of putting off contacting mental health services and accessing support being a last resort featured in all participants' transcripts. The four sub-themes within this theme relate to the different aspects of reluctance in seeking support participants described. Concerns about services, practitioners and other aspects of support's ability to help are explored in the first sub-theme, '*What can they do?*'. The next sub-theme captures a more fearful side of delaying access to support, due to feelings that seeking help would be admitting weakness and make problems 'real' by '*Admitting Something's Wrong*'. The following sub-theme, '*It's Just a Phase*', explores participants' tendencies to dismiss or trivialise problems they experienced and deem seeking help unnecessary. The final sub-theme, '*Breaking Point*', relates to the crisis or breaking point participants described, which finally led them to overcome previous reluctance to access support.

'What can they do?'

This sub-theme explores beliefs that services will not be able to help or could make the situation worse, contributing to participants' disinclination to access support. Doubts about support services' ability to help were sometimes linked to: a lack of knowledge about treatment options, reservations about services' approach and previous negative experiences. A further aspect of this sub-theme includes worries services would not be helpful due to participants' issues not being understood or taken seriously.

Many participants discussed putting off or rejecting completely the idea of accessing support because of doubts about the services' ability to help with anxiety or depression. Matt spoke about having these types of concerns regarding counselling before he accessed services, as illustrated in the following quotation.

Matt: "I think if I'd have known what it was the therapy, or whatever you want to call it, was gonna be like I would probably gone for it sooner, but erm at the time I thought it was literally going in laying on a couch and start talking about your life and not really understanding how that was going to help and that sort of thing erm, which yea it sounds stupid when I think back to it now. When it first crossed my mind [to seek support] I was just like 'Aww well they're just going to send me to someone that's just gonna make me talk about my life and how's that gonna help me? You know, like right now sort of thing.'

Matt articulates how his preconceived ideas about what therapy would be like may have stopped him from accessing support sooner. His worries about counselling focusing on the past and how talking about it could alleviate the current problems he was facing seems to have held Matt back from seeing counselling as a viable option.

Current findings suggest reservations around accessing support are not only a result of misinformation or lacking knowledge of treatment options, but can also be based on previous bad experiences. Heather talked about concerns regarding services' ability to help, including major reservations about counselling and the counselling relationship. In the following extract, Heather describes how her negative past experiences have led to a distrust of counsellors and serious misgivings about this approach to treatment for depression.

Heather: "I would only, only go [to the GP] if I was in crisis and if I was offered counselling I would have the same reservations that, this sounds very arrogant to say, that the counsellor wouldn't be skilful enough to be helpful. Erm.. and that it's erm, it just doesn't feel an equal relationship, it feels like yea this particular counsellor and previous ones before the five year period we're talking about, have seemed to me to be very judgemental and that they elicit information and then condemn you for sharing that."

Heather talks about her previous experiences of counselling relationships as unequal and judgemental. This quote is an example of how some participants not only felt services would not help them, but may actively cause further problems. The potential for accessing support to have detrimental effects for participants is discussed further in the '*Making Things Worse*' sub-theme within '*Sharing and Vulnerability*'. Unhelpful and difficult experiences with mental health services, which made individuals reluctant to contact them again, were shared by several participants.

Feelings of indifference towards some services and examples of support for anxiety and depression not seeming relevant were expressed by most participants. Theresa describes not being particularly unhappy with her experiences of accessing support for anxiety from the GP, but viewing the 'medical model' as having little to offer her in her current situation. The quotation below also describes Theresa's belief in other, self-directed approaches offering more value.

Theresa: "There are ways that you can heal yourself if you know about them and you're open to them. I suppose what I'm saying about the doctor is, I'm quite happy with them. I'm not 'Oh I'd never go back to them', all or nothing sort of thing. That's not that the case. I don't think they have anything to offer me because I, I believe in the power of healing yourself, as long as you've got the right teachers and the right tools, I believe you can."

This extract illustrates Theresa's view that the medical approach and the support her GP can offer are not appropriate for her situation. Theresa went on to explain further what other forms

of anxiety support, such as meditation, positive thinking and self-help offer her compared with medical approaches, as shown in the next quotation.

Theresa: "It's just a completely 100% different way of looking at life; completely different way of looking at my life. The doctor's gonna look at malfunction of the body. He's gonna diagnose some problem that would need medication. That's what the doctor's gonna do. That's what doctors do. That's the biological model. That's the medical model, whereas I know it's our thinking that's what screws our heads up, our thinking and I've learnt that and I know even in the most direst of circumstances we've got to hold on to what's good in life and that yea I wouldn't go back cos I won't need to."

Theresa speaks about doctors focusing on 'malfunction of the body' and prescribing medication. This view of the 'medical approach' does not feel relevant to Theresa, with her emphasis being on her thinking and 'holding on to what's good in life.' Theresa described her self-help approach to tackling anxiety using meditation, Pilates and positive thinking techniques, as giving her a completely new way of looking at her life. However, Theresa went on to say she felt the course of counselling she completed when initially accessing support 'set me on the right path' and helped 'start to put a lot of my demons to bed', and having reached this point of her 'journey' support from sources, such as the GP, no longer feel like they have anything to offer her. This account is an example of the way individuals' views around accessing support may alter over time with their needs or preferences changing at different stages.

Another aspect of this sub-theme, are concerns that services would not be able to offer helpful support because participants' difficulties may not be recognised or taken seriously. When asked about reasons which might have held Jo back from accessing support sooner, she talked about worries the doctor might trivialise the issues she faced with depression, as illustrated in the following quotation.

Jo: "Before I went to the doctors I thought that, I'm not sure what I thought. Probably I'd just be told that I was just down and I'd get over it. That's what I thought honestly would be what the doctor would say. My sister had been before [to the GP] and she went and the doctor pretty much told her, 'Aww well, this has happened so no wonder you're sad. You'll get over it.' So I kind of assumed that would be what they'd say to me."

This extract describes Jo feeling unsure of being understood and her issues potentially being dismissed by the GP, if she approached them for support with depression. Jo also mentions the role her sister's negative experiences played in these concerns, believing she would receive similar, unsympathetic treatment. Several participants also talked about worries doctors may view issues as not serious or warranting medical assistance. This seems to correspond with participants' own feelings of uncertainty, as to whether they were 'really' ill and whether problems may pass. This link ties into the sub-theme '*It's Just a Phase*', which deals with

participants' doubts and reasoning, which contributed to reluctance to access support, in more detail.

Theresa's difficulties in believing that she was 'really ill' contributed to reluctance to seek support and serious concerns about being treated sympathetically. The following quote describes fears that going to the doctor or occupational therapist would not have a supportive function, instead would result in her being 'discovered' as a fraud.

Theresa: "[The GP] might see through me and think 'Ahh she's putting all this on. She just doesn't want to go to work.' It's crazy, crazy stuff I used to think. "You're not depressed. You're not anxious. You just can't do your job. You're a fraud." That was my real fear. I felt a total fraud and I kept thinking someone would see through me. I kept thinking somebody would go 'Why are you doing this? Just leave if you don't want to do the job.'"

The extract describes Theresa's fears that accessing services might result in her 'being found out', which seems to relate to her own self-doubt regarding her mental health. The quote is an example of several instances where Theresa spoke of a fear of 'being found out' as not really ill and feeling 'terrified' of being made to return to work. Theresa described being extremely reluctant and fearful about appointments with an occupational therapist she felt, at the time, was going to try 'trip her up' and reveal that the difficulties she was experiencing were not symptoms of anxiety disorder, but inability to do her job. These kinds of concerns, which may stem from personal doubts, were also discussed by Heather and Chantelle. They described reluctance to access or fully engaging with services due to the role they had in assessing fitness to work and control over benefits and sick leave. These fears are an additional facet of the '*What can they do?*' sub-theme, where participants described concerns services might involve judgemental or evaluative treatment.

This sub-theme has explored doubts expressed by participants about services ability to help and how these concerns act as a deterrent to accessing support. Current findings suggest fear may play a role in reluctance to access support for anxiety and depression. The fearful attitudes held by some participants regarding accessing support included worries doing so could make their situation worse and concerns about not being taken seriously or being blamed for the issues they were experiencing. However, an additional important aspect of the '*What can they do?*' sub-theme identified other motivations for participants' reluctance, uncertainty and scepticism of what services had to offer. For some participants rather than fear, feelings seemed to centre around a sense of hopelessness or despondency. Participants described feeling resigned to the idea of their anxiety or depression as insuperable at times with services unable to offer relevant support or treatment. Several participants spoke about their perception of mental health services as having nothing to offer due to a preference for self-help and dealing with issues in their own way.

Admitting Something's Wrong

This sub-theme deals with participants' often complex relationship with accessing support. The decision to seek support can be seen by participants to signal that problems have become more than they can cope with and admitting something is really wrong. Participants talked about being reluctant to access support, as they did not want to admit or did not believe they could have a mental health problem.

Most participants spoke at some point about feeling reluctant to access support, due to the difficulty in acknowledging themselves as having a mental health problem. The following extract is an example of the aversion Chantelle felt to going to her doctor and therefore admitting there was 'something wrong with me'.

Chantelle: "I didn't want to go to the doctors then, no cos I didn't think I had owt wrong with me. Cos I didn't really know much about mental health then. I just thought mental health was just.. psycho people. I just didn't want to believe I had something wrong with me."

This quote also includes an insight into the stigma that can surround identifying as a person with a mental health issue. The challenge participants described, in negotiating what it would mean about themselves and who they were, if they were someone who required support for anxiety or depression, is a vital element of the sub-theme. Accessing support for many participants was described in terms of admitting a personal weakness and in conflict with aspirations of self-reliance and strength. The following quote from Amira relates to this issue and talks about her pride acting as a barrier to accessing support for depression.

Amira: "I think what held me back [from seeking support], I have a lot of pride (laughs) I think sometimes my pride gets in the way like.. I think when you're brought up in a family where you're very prideful about themselves and they don't like to admit.. 'Help!'"

The previous extract is an example of how accessing support for some participants can feel like admitting weakness by asking for help. Amira describes finding it difficult to ask for help, as contributing to reluctance to access support. The desire to cope with the issues they faced without professional help was a recurrent theme in participants' dialogue and seems to be a major motivation to delay or avoid accessing support. The next quotation explores the tension acknowledging mental health issues and accessing support can cause with participants' view of themselves.

Theresa: "Looking back at it now I can see how ill I was, but at the time 'Am I really ill?' because I didn't really believe I could be, you know the stigma of mental health! It's not going to happen to me. I'm very tough. I've had to be tough all my life. I'm not.. nothing sinks me. So it was a real tension going on in terms of that."

This excerpt explores some of the difficulties Theresa had in recognising and accepting she could have a mental health issue. Also, how coming to terms with this was challenging and seemed to be at odds with her view of herself as a strong person. Theresa went on to discuss how pervasive these feelings were, despite being well informed and experienced regarding the nature of mental illness, she still felt it could not apply to her personally.

Theresa: "Well I think in our society we all see mental health issues potentially as a weakness, unless we are enlightened people, unless we're tolerant people, unless we're trained people. The majority of people who don't know, do think that and even if you know it, as I knew it and you know I've worked closely with mental health services for years, I still felt that I was not someone who would have a mental health problem because I'm too strong for that. So it's quite a humbling experience actually, you know yea. You know I've always been very sympathetic and understanding and tolerant of all these things, but I still didn't think it applied to me because I was like tough as old boots."

Theresa's quote highlights the extent of difficulties that can be involved in identifying as someone who has anxiety or depression. Despite her understanding regarding mental health issues generally, and the severity of problems she was facing herself, Theresa still found the idea of being affected personally impossible to reconcile with her view of herself as tough and self-reliant.

The following quote explores Jo's experiences of returning to her GP a second time, for further support with depression, two years following her initial contact. Although she described her first experience as largely very positive describing the CBT workshops as: 'giving me more confidence' and 'helped me make the practical changes I needed to', rather than providing a source of hope or encouragement when accessing services again she felt disheartened to be returning.

Jo: "I was kind of thinking 'We're here again so it obviously didn't work the first time.' But I think then that's just... me thinking that well, there's like this magic cure and I will eventually not have to go back. Still, even though I know that is not true I still want to.. you still want to believe that you're not going to have to go back and that they're going to figure out how to help you this time and you'll come out of this and you'll be fine and you'll be back to normal and erm so... I went thinking, like 'Yea, I'm here again.'"

This quote illustrates the emotional impact accessing support can involve. In this case, how returning to her GP negatively affected Jo's outlook on the therapy previously undertaken, which she now described as having 'not worked', and her outlook on the situation as a whole. Accessing support again seems to feel like a step backwards, with recovery or being 'back to normal' appearing less likely. This demonstrates how individuals' experience of accessing support for anxiety or depression can be framed, not as 'accessing support' or a positive step, but instead as '*Admitting Something's Wrong*' with the associated negative connotations.

The findings included in this sub-theme of '*Reluctance to Access Support and Delaying until Crisis*' suggest stigmatised views towards mental health issues and seeking support play a role in individuals' reluctance to seek help. The current findings demonstrate powerful emotional challenges for participants in coming to terms with the symptoms or effects of anxiety and depression, and also in accepting engagement with support services as a potentially on-going and long term commitment. Reluctance to '*Admit Something's Wrong*' is not only affected by stigmatised views of mental health and the self, although these also seem to be important factors, also difficulties in acknowledging ways anxiety or depression may continue to affect participants' quality of life in the future. The theme shows how participants can see returning to access support as an indication permanent recovery and 'being back to normal' is less likely.

'It's Just a Phase'

This sub-theme explores issues discussed by most participants, regarding the belief that their difficulties could be overcome without accessing support, as problems were seen as just a temporary phase or reaction to current circumstances. The sub-theme considers how these experiences led participants to delay seeking support, despite the difficulties they were facing. Issues with anxiety and depression were dismissed by many participants as not warranting support. Participants spoke about previously downplaying and trivialising the issues they were struggling with. By framing issues as temporary, manageable or not serious enough, participants did not view seeking support as a suitable option. Participants' expectations of themselves to cope without accessing support are also explored within this sub-theme, in relation to frequently described experiences of trying to manage alone until the difficulties passed.

The following response from Amira after being asked what she thought might be behind her hesitation to seek support, is an example of how persistent mental health issues with serious effects on quality of life can be downplayed and dismissed as not warranting support.

Amira: "I think I thought I could deal with it really. I just felt like I could handle it on my own, but when I look back now I think I was in that funk for a while, but I didn't realise how bad it was until it got to that stage where I wasn't able to get out of my bed.. Yea I just felt like I could handle it myself like it's just a phase I'll get over it kind of thing. It's that thing that you tell yourself that it's just a phase you need to have some down days and then you'll get back up, but it wasn't the case for me. It was just never-ending."

The extract highlights difficulties Amira experienced in recognising the severity of issues she faced at the time, instead dismissing them as something she could handle alone. When reflecting on her situation later Amira talks about realising how long the difficulties lasted and 'how bad things really were.' This was a view also expressed by other participants. The

implications of this finding and how it affects participants' decision to delay accessing support is a crucial aspect of the *'It's Just a Phase'* sub-theme. Amira also discusses difficulties in distinguishing between 'normal, down days' and when problems had become more serious. This kind of experience was discussed by all participants and links to the following sub-theme *'Breaking Point'*, which deals with participants' realisations that issues were not just a passing phase.

The next extract from Matt's transcript also discusses his struggle to really believe the problems with depression he was experiencing could be serious or long lasting and how this affected his decision to delay accessing support.

Matt: "...I think there was [something holding me back from seeking support], but it was kind of in my head like telling myself 'Aww it's not as bad as it actually is' and that sort of thing and just sort of blocking it out for a while I think I was really. Yea because like I say it's like is it actually as bad as it seems or am I er, you know being a drama queen about all this sort of thing in my own head and it's just like 'No, no, no it will all be fine and it's just a blip' and er.. that blip just didn't ever go away."

Matt talks about 'blocking out' the problems he faced and disbelief in the 'realness' of his difficulties, instead questioning and doubting his feelings. This quote is an example of many instances where participants spoke about internal conflicts in acknowledging anxiety and depression, with part of themselves downplaying or denying the issues they were facing. The extract again highlights participants' dismissal of issues as temporary phases and 'just a blip'.

The next extract is another example of doubts participants experienced in relation to recognising symptoms of anxiety and depression, in this case Jo talks about her depression not being justified as she had 'nothing to be sad about'.

Jo: "When you are at your worst, you don't, you basically think to yourself, well I thought to myself, 'You're being stupid. You've got nothing to be sad about. Stop being sad. Just get over it.' Erm and even though, cos obviously with knowing a bit more about depression with studying it and stuff and even though you know all that and you know all these things like ways that it could be chemicals in your brain and things like that, my brain was still telling me 'You're being an idiot. There's nothing to be sad about. You'll get over it. It'll just pass.' I don't think there were any other barriers really other than me! Just thinking, 'You don't really need to. You'll be fine soon,. You'll get better.' "

Jo's dialogue suggests how dismissal of issues she faced as stupid and irrational can create further difficulties by contributing to judgemental, self-critical appraisals. The extract seems to show Jo's attempts to use will to 'stop being sad' and frustration in not being able to control her emotions. Jo talks about gaining knowledge of mental health issues through her studies in psychology; but despite this still struggling to understand and come to terms with her own experiences and ongoing symptoms of depression. Jo describes herself as the biggest barrier

to seeking support, due to her belief she 'had no reason to be sad' so the difficulties would pass. The need to justify or validate symptoms of anxiety and depression with an outside cause or 'valid reason' was mentioned in some way by all participants. Jo and other participants' reluctance in recognising the severity of issues they faced seemed to be related to perceptions of their anxiety or depression not making sense or being logical reactions.

Participants' descriptions of becoming used to symptoms of anxiety and depression unable to distinguish them from everyday difficulties and low mood are another aspect of the '*It's Just a Phase*' sub-theme. Participants described not recognising difficulties as mental health disorders, but passing phases or part of 'normal' life not warranting support from services. Eva talks about this issue in the following quotation.

Eva: "I think cos when shit sort of happens you don't always know what they are inside your head, if that makes sense? Cos sometimes you can feel these things and they're really horrible, but you don't necessarily know that they're.. like something wrong? Like so for example, I used to have panic attacks, but I didn't actually know what they were. The same with depression cos you're gonna have all these horrible feelings, but you don't think.. you just get used to it and then you forget that it's not normal until it just kind of escalates."

Eva talks about not always understanding or really appreciating the severity of problems she was experiencing, such as panic attacks and 'horrible feelings'. Other participants also talked about not recognising the significance of anxiety or depression on some levels, despite the negative impact they were also aware of at the same time.

This sub-theme encompasses the tendencies participants spoke about to reject or downplay the severity of difficulties they were experiencing with mental ill health. Desires to resolve issues themselves and cope without help were also described by participants within this theme as contributing to reluctance to access support. Denying and trivialising problems seems to be an approach many participants described in attempting to get back to 'normal' and overcome anxiety and depression. Participants' appraisals of difficulties not making sense or being logical reactions also seemed to contribute to ideas that problems were not real or valid, so could not last for long. Participants described struggling without seeking help; in the hope issues were '*Just a Phase*'. The following sub-theme follows on from these experiences and covers what happened for participants when this way of thinking about their anxiety and depression was challenged when they reached '*Breaking Point*' and problems became too much to 'block out' or downplay as a phase.

'Breaking Point'

Participants described putting off seeking support, until they reached a breaking point where they felt they had no choice but to ask for help. Participants explained they did not necessarily recognise the problems they were contending with as a mental health problem or warranting seeking support. The '*Breaking Point*' sub-theme covers this common experience expressed by most participants of not recognising their experiences as mental health disorders or issues requiring support until they reached a crisis. At this point some participants talked about being desperate and willing to try anything, as they felt they could not carry on any longer without seeking help.

The following extract concerns Collette's reflections of how she wished she had accessed support much earlier, instead of dealing with things alone until she reached 'breaking point.'

Collette: "Oh God [I waited] ages, I mean I should have been speaking to someone for like all my life! (Laughs) You know what I mean! I think I just got to a point where I just literally just felt like 'Ok I need some help like right now.' It was breaking point when I contacted them. Yea it should have been much earlier. I think you don't realise.. you don't realise what's a big deal. You're just given a situation and you deal with it and.. if you start thinking 'Oh I should get some support.', whatever it's kind of admitting the situation's maybe abnormal or something.. You deal with things and you just kind of get on with stuff until you can't cope."

Collette talks about the urgency she felt in needing help 'right now', after dealing with things without support for a long time, until she reached a point where she felt she could not cope. Theresa also spoke about not accessing support until she reached a crisis point, where she could no longer ignore problems that had been building up.

Theresa: "I just carried on and then one morning I woke up and couldn't move my head and I went to a physio and just got completely distressed and crying and sobbing just hysterically sobbing. It was building up to this. There were sleepless nights. There were night sweats. There were things that I didn't realise at the time, but were classic signs of anxiety. I couldn't get out of bed, very distraught, very erm.. I didn't only feel unwell and closed off from everything, I felt like a complete and utter failure. I'd fallen apart."

In this extract Theresa describes there being signs of anxiety building up, but not accessing support until she could not get out of bed and 'fell apart'. It was after a visit to a physiotherapist with pain from her 'neck going into spasm because of anxiety and stress' that Theresa contacted her GP about her mental health.

Describing a crisis or breaking point was a common theme in the transcripts. For three participants plans or attempts to take their own life were a trigger to finally accessing services or returning for further support. Charles spoke about waiting around a year before going to his

GP for support with depression. In the following extract he describes how things became worse and worse and the desperate situation he was in when he sought help.

Charles: "I got in touch with the doctor because I was very, very low, very, very tearful all the time, suicidal erm... wishing you know that it was all over with. Looking back and thinking that.. thinking that everything.. I'd ever done was for nothing. I was really in a state, really I was in pieces by the time I did go. I couldn't hardly cope with anything. It just went deeper and deeper and deeper and so that my sleep patterns were destroyed, my erm self-esteem completely had gone. I felt terribly, just worthless really.."

Charles' experience is another example where participants put off accessing support until reaching crisis. The next quotation from Eva's account reflects back on how she would do things differently in light of her experiences and seek support sooner in future.

Eva: "I would seek support sooner now just because I know that they take like a lot of, I dunno, I think there's a misconception that you have to feel like suicidal or something terrible has to happen in order for you to seek help and actually.. Yea you've got to justify, 'Oh I'm only stressed about this.' or 'I'm only worried about that.' or you know and I think another thing that sort of prevented me from seeing anyone is I sort of had this idea that what had happened to me wasn't bad enough... just cos you're not like crazy or you know the fact that you're struggling with life is a good enough reason to get therapy."

Eva's comments highlight that on reflection she feels she waited too long to access services and her awareness that support is appropriate before individuals' reach desperate circumstances and breaking point. Looking back on their experiences, many participants spoke about regretting not accessing support sooner.

However, reaching 'breaking point' may have been necessary in order for some participants to access support and overcome the reluctance they felt. The previous sub-themes covered within '*Reluctance to Access Support and Delaying until Crisis*' have explored participants' motivations and other factors in putting off and rejecting seeking help. Several participants spoke about considering or actually cancelling appointments with mental health services and backing out of planned interventions once they made some improvement and were no longer at 'breaking point.' For example, in the two months Eva had to wait between referral for therapy and starting CBT she describes questioning whether she should still attend the therapy due to the progress she'd made after making some lifestyle changes and utilising self-help strategies.

Eva: "I actually worked quite hard cos of how I felt after the telephone interviews. I started to actually feel a lot better. Well quite a bit better when I actually started the counselling anyway. Just because I'd like stopped drinking and just going for pathetic runs cos I was just like 'Right that's it!' So I'd been doing like casual runs but not like very far, so I was feeling a bit better already and I was almost like 'Do I even need to see a counsellor?', but everyone was like 'Yea obviously.' I nearly cancelled it cos I thought you know I'm alright now, but then I went. I was nervous when went to see him cos I didn't want to go back to how I felt before if you know, cos I felt like I'd made a bit of progress with my depression. I thought it might set me back."

Eva describes the improvement she made from while she was on the waiting list causing her to question 'Do I even need to see a counsellor?'. This extract shows how for Eva nerves about the counselling process and potential of feeling worse again were nearly enough for her to change her mind about accessing support when she was no longer in crisis. The decision to access support for many participants seems to have been taken only once they find themselves in such a difficult place they are willing to accept any help and try anything in order to get better. The severity of crisis or 'breaking points' described by participants within this sub-theme seem to indicate how powerful reluctance can be towards accessing support for anxiety and depression and the significant distress often needed to surmount it.

Concerns About Medication

All participants spoke about having concerns regarding medication as a treatment for their anxiety or depression. Worries often related to the potential for medication to have a negative impact on participants' wellbeing, including concerns drugs would alter their personality, cause undesirable side effects and result in reliance or addiction. The idea that medication does not really tackle anxiety or depression and its 'root causes' was also discussed by many participants and it was seen as an unsatisfactory or less preferable solution compared with talking therapies and other strategies. Another aspect of this theme were views expressed by several participants that mental health services will mainly or only offer medication as treatment for anxiety or depression and that they may be encouraged or pressured to take this route. The combination of these concerns relates to the previous theme and seems to be a factor in participants' reluctance to access support and doubts about services' ability to help.

The following quote illustrates Amira's concerns regarding the potential for addiction or reliance upon medication, and how her friends and family have influenced her view of medication.

Amira: "Seeing some of my friends who had, who had the same like, well suffering from depression the same as me and they were all on the medication and I saw how it was like getting them hooked onto it and it was.. well not necessarily hooked, but like it felt to me that they were relying on the medication instead of finding ways to make themselves feel better and when you're relying on the medication that becomes a problem because you're not going to be happy unless you've got a medication in your system situation and I felt also my Mum had the same thing. I think she kind of scared me a little bit, about medication and saying that she never takes it, she doesn't believe in that kind of stuff. She was saying 'Aww don't take the medication you'll rely on it. You'll get addicted.' "

In this extract Amira talks about her feelings that finding other ways to help yourself is a more preferable method of combatting depression than medication, which you could become reliant on. Ideas relating to medication use as a sign of weakness or unsuitable method to be avoided where ever possible were expressed by many participants and are shown in the following quotes.

Charles: "I mean one of the reasons I hadn't gone [to the GP] initially was because I don't know if I agree with people taking drugs to alleviate problems like depression cos I sort of looked upon it as just.. it's a personal problem and should you need to take drugs or medication to alleviate an external, just something, an external thing coming into to you just because you're fed up cos I just looked upon it as being fed up. Erm and it seemed a bit excessive."

Jo: "That's probably just me cos I'd rather try anything before I'd try putting drugs into my body for it. I was already swayed towards not having.. if there was a way they [GP] could help me without having the medication that's what I'd, I'd go that route yea."

The previous extracts suggest reluctance to 'rely on' medication and negative connotations of 'putting drugs into my body' affects participants' decision-making when considering whether to seek support and also what they want or do not want from services. Participants spoke about concerns alluding to medication being a less holistic or healthy method for tackling their mental health issues. In the following extracts participants discuss their concerns about the negative ways medication could work to alleviate symptoms, such as sedation and altering their personality, also the perceived inability to address crucial issues they feel have led to their difficulties.

Charles: "I did have reservations because I thought 'Oh they'll put you on these drugs that will be.. They'll make you into a zombie' and make you sort of mindless and just sort of dull your senses to calm you down."

Theresa: "I would never take medication. I don't believe I would need to have medication. I think some people desperately do if they're going to harm themselves or you know, I'm not saying I'm anti-medication, but for where I was, my depression was a reactive depression. It was depression to an issue, to an incident, to an event in my life, a circumstance and in my situation I didn't need it. I'm not critical of it across the board, but for me I would be fearful that it would take away who I am and stop me from being able to concentrate on what would make me right."

Theresa and Charles talk about fears medication may suppress the 'real me', instead making them 'mindless' and taking 'who I am.' Theresa's quote also shows the importance of addressing the issues and life events she feels the difficulties are a reaction too. The following extract similarly refers to medication as an inappropriate treatment method for the participant, due to it not addressing the causes of depression. Eva also talks about the resulting anxiety when she thought this might be the only treatment offered by her GP.

Eva: "I was actually really worried that she [GP] was just gonna give me antidepressants and I knew I didn't really want that. I think.. it just feels like a make do situation, rather than a let's get this sorted type of thing and I know that's not true and they work for a lot of people, but for me I felt like if I was just given antidepressants.. I knew what was wrong with me, like I haven't had depression where it's like throughout my whole life I've only felt like shit because of x, y and z has happened in a really short space of time. I think that's probably why I didn't want them cos.. I'd got a very clear idea of what's made me feel like this."

This extract again highlights participants' views around medication being unsuitable for them, as they need to address the causes and 'real issues' they believe are behind their anxiety and depression. Reservations about medication as a treatment are particularly relevant to experiences of accessing support, as many participants spoke about concerns of being encouraged or pressured into using medication if they visited their doctor for support with anxiety or depression. The following quote by Amira is an example of some participants' worries that medication is the most likely treatment offered by the GP.

Amira: "I kind of felt like if I had to go to counselling that means that [the university counselling service] would need me to go to the doctors, which I didn't like the idea of because it's always the story of if you're depressed you've got to take some medication for it, which I definitely didn't want. They never suggest counselling at first. I think it's usually they think 'Well take the pills and how you feel.' "

This extracts illustrates how Amira's belief doctors use medication as the first response for depression contributed to her hesitance to access support and fears that her preferences for other treatment routes may not be taken into account. This was a concern many participants also described.

An additional way concerns about medication affected participants' decisions around accessing support was through their past experiences. The following quotes describe how previous difficult responses to antidepressants contribute to participants' reluctance to access further support. Jo and Rhys talk about their complex relationships with medication, involving serious reservations and uncertainty around trying drug treatments again.

Jo: "I don't know cos I supposed that's kind of like where I've been at recently and I haven't gone back, but I think that's because.. I came off because at the end of medication I felt like numb, like for that last, although I got better it was like I didn't feel happy and I didn't feel sad I literally just felt like I was walking around in a bubble. Erm, so then I came off it. I was, I was a lot better in myself and I thought it's done its job, now I'm just numb.. erm so I came off it, so I think that's put me off going back on it cos I felt numb."

Rhys: "Then it was like offering of antidepressants, which I didn't want to take because I'd taken them before err.. and not great effects and stuff and I'd rather have sorted it out myself. I had had it when I was a lot younger, er it was that Seroxat. It was a sort of sister drug to what's it called, the big one? Prozac? Prozac, but it ended up, I don't know if you can still get it now, but it was.. there was a programme about it on the telly about people murdering their, all their families and all sorts er of crazy effects. It really affected me. I felt very different when I was on it. Really different like, like a bit mental really, like hyper erm, whereas the stuff I've had now, Citalopram, was a lot more, it didn't really change me that much so yea.. but it took me a long time to make the decision, to make the decision to try that route again."

The previous extracts describe Jo and Rhys' mixed experiences of medication and the effects that has when considering to try this route of treatment again. Jo talks about getting better, but at the same time feeling 'numb', neither happy or sad anymore, which has now left her reluctant to try medication again. Rhys describes taking a long time before trying medication again following negative side-effects he had in combination in the past with hearing about 'crazy effects' of Prozac.

Participants spoke of holding very different ideas about the suitability of medication for themselves at different stages of their journey in experiencing difficulties with anxiety and

depression and accessing support. The following quotes are examples of participants' evolving medication concerns and priorities.

Heather: "I was quite resistant then to taking [antidepressants] anyway because.. I had been resistant previously, but I felt so awful then that I would have done anything to feel better... and erm... I think I'd been resistant to taking drugs because of the idea that the drugs would alter my personality. Whereas I'd sort of by that time learnt that they, that they're actually intended to erm support you while the brain repairs its connections.. and kind of like how the, I think the illustration is having your leg in plaster while your broken bones repair."

Matt: "I went down [the counselling] route instead, which I'm glad for in that instance I think really because the less tablets I'm taking the better I think so yea...[The second time] was literally like 'Yes I'd rather not take tablets, but to be quite honest I'm literally so sad.. whatever basically.' Yea just ended up taking them. They actually said the first time about it being an option, to take antidepressants, but I'd sort of edged away from it, but when they said about it this time it was just like, 'That's fine I'll just go for it.' Erm, yea.. I do still think it was the tablets that helped me sort of get better the second time round as opposed to the counselling."

These extracts describe Heather and Matt's different positions towards medication treatment on separate occasions of accessing support. They both describe becoming more open to medication than they were in previously. With Heather explaining, learning more about how drugs work to 'support you' like 'having your leg in plaster while the bones repair' had helped her to overcome previous fears antidepressants might alter her personality and affect the 'real me'. She also talks about her difficulties becoming worse and leading her to be more willing to try 'anything to feel better.' This experience is also described by Matt who accepted antidepressants when he returned to his GP the second time despite his reservations. Matt's quote includes both statements 'the less tablets I'm taking the better' and 'it was the tablets that helped me.' This is an example of numerous conflicting views and feelings expressed by participants regarding medication for anxiety or depression.

The '*Concerns About Medication*' theme reveals a complex picture of participants' mixed experiences and conflicting ideas around medication. Participants' reservations about taking medication to treat anxiety or depression seemed to relate to concerns it may suppress or alter the 'real me.' Many participants also spoke about the desire to address issues, such as past experiences, which they felt were the root causes of their difficulties, with preference towards therapeutic interventions and self-help in achieving more meaningful support. Ideas around medication being a mask, rather than cure for 'real' causes and issues, alongside concerns about the potential to become reliant or addicted are an important part of participants' concerns. The theme also encompasses individuals' accounts of distressing side-effects from taking medication and how this affects views of medication's suitability as a treatment option. Participants' concerns about medication seemed to create doubts around

services' ability to provide support which was appropriate and took into account their personal preferences. Hesitance to access support seemed additionally affected by some participants' view that services offer medication as the first or only treatment method, with concerns they may be pressured to take this treatment route.

Sharing and Vulnerability

This theme covers the importance of how participants' personal stories and sensitive information is obtained and handled by support services and practitioners. Accessing support for anxiety and depression often involves individuals sharing intimate details of their personal lives and emotional states. This type of sensitive disclosure is usually necessary in order to understand service users' needs, assess the suitability of the support offered and diagnose mental health difficulties. Therapeutic interventions also rely on clients' openness to discussing their difficulties and past experiences. Talking about difficult circumstances and potentially traumatic experiences can be extremely challenging and stressful, requiring sensitive and skilled handling by the practitioners and services involved. The '*Sharing and Vulnerability*' theme explores the potentially negative outcomes of seeking help and psychological interventions. Participants' perspectives on how the process of sharing their personal stories with support services has been difficult, even traumatic and in some instances led to further problems. This theme comprises three sub-themes: 'Takes You Back to that Bad Place', 'Genuine Care' and 'Making Things Worse.' The first sub-theme, 'Takes You Back to that Bad Place', explores participants' experiences of going over their past, repeating sensitive issues multiple times with multiple people. All participants spoke about the value of competent, caring, trustworthy practitioners when sharing their stories or the damage caused when they felt this was not the case. These crucial attributes are represented within the 'Genuine Care' sub-theme. Participants' vulnerability pervades the theme and is especially relevant to the 'Making Things Worse' sub-theme, which refers to the potential for accessing support or attempting access to cause further trauma and leave participants feeling worse than before.

'Takes You Back to that Bad Place'

This sub-theme explores the challenges participants' can face when sharing their story while accessing and receiving support. Specifically how talking about their past, often on multiple occasions, can feel as though it keeps participants from moving on and causes distress through re-living traumatic memories. In the following quote Eva describes the impact of talking about a traumatic past event during an initial assessment for therapy conducted over the telephone.

Eva: "The incident where I got assaulted in the burglary that was like a year ago. That kind of felt like it was in my past, even though it was really affecting me today. It all felt like quite a while ago. I hadn't talked or thought about it, well no actually that's a lie I had thought about it every day, but I hadn't talked about it. Cos when something bad happens you talk about it to everyone for a month and then you never talk about it again and I think it was sort of like re-hashing old.. Even though I thought about it every day, saying the words out loud I found quite upsetting."

As suggested in this quote and throughout Eva's interview she found the process of explaining events leading up to her accessing support very distressing. However, the context of sharing information was important for Eva as she described the benefits that came from opening up with her counsellor and exploring events from her past, however the telephone assessment the previous extract relates to was extremely difficult and Eva spoke about how the thought of having another assessment was nearly enough to stop her from pursuing support a second time. Eva emphasised that even though past events may have been on her mind and causing her distress that there was something particularly upsetting about '...saying the words out loud.' This issue is extremely important to consider when looking at provision of support for anxiety and depression, as individuals are in a vulnerable position and seeking help, but may actually find they experience further trauma as a result. Accessing support for some individuals becomes a painful and emotionally challenging experience, rather than a supportive one. This issue also relates to the theme, *'Having to Fight for Support'*.

In addition to causing distress, participants spoke about the frustration they felt as a result of providing detailed accounts of their past. Some participants described a sense of wanting to move on from the problems they had faced and repeating their story was seen as holding them back. Amira talks about this in the following extracts.

Amira: "It's just having to tell your story over and over again, which is quite frustrating at times if you're not really gonna get any feeling from it or you're not gonna get help from it because it's going to keep coming up all the time, people are gonna keep asking the same questions. It's gonna take you to that bad place again."

Amira goes on to talk about the difficulties of having to explain her background on multiple occasions with different people.

Amira: "With the GP I was just seeing too many different people in and out and they're having to ask about my background every time erm.. I just feel, should I say?! Bored! I just think 'Gosh I'm sick of hearing my own story' kind of thing and it's like you know no one wants to hear this story over and over again, but you just literally you're just bored of hearing your own voice and hearing your own story about your life. You're telling yourself you need to move on now like you've told your story plenty of times, now's the time to stand up and get on with it."

This sub-theme highlights the importance of communication within and between mental health organisations and continuity in support provision, so that service-users' are not required to repeat their background on numerous occasions. This issue is also important for services to recognise when initial contact or assessments occur, as for the individuals accessing support rather than the first step it may be part of a lengthier journey seeking help, which may involve the repeated retelling of their histories to other agencies and individuals.

Most participants spoke about timing as an important factor in accessing support and whether they wanted and felt able to talk about issues from the past. In the following extract Chantelle explains how the combination of personal events and examining past issues led to her discontinuing support.

Chantelle: "I went to that psychotherapy place, but I hated that, so I didn't go again. [The therapist] got into your head and made you like realise things that you wouldn't have realised on your own. They said you can only go there if you're like erm... sort of like level headed, like sane or whatever so you could cope with it. And obviously I wasn't right in the head then, so I couldn't cope with it. I think me and Tom had only just broken up as well. Talking about things from the past and it like made you remember stuff and like see it a different way and made you realise that that would have had an effect on your life and how you are and stuff. (Pause) Don't know, just very clever and got in your head. It felt like too much, too intense."

When accessing support individuals can be in a very vulnerable position: struggling with anxiety and/or depression, the burden of personal difficulties and often in crisis. Chantelle's experience shows the distress that can be caused when tackling issues from the past, especially during a difficult time when she felt she was not ready; in this case resulting in disengagement from the support and feeling she could not cope or continue with the therapy. Collette also spoke about the time needing to be right to feel able to cope with the challenges of talking about the past and able to engage with talking therapies.

Collette: "I knew it wasn't a good time for me to be going into any like childhood stuff, anything that might affect the relationship with my Mum, basically I knew at that time I had to be strong for her and what was going on for her and it wasn't a time for me to be going into that relationship and dissecting it and pulling it apart and going into the past because that wasn't the appropriate time for it. It wasn't the time to be going into that. I just needed someone to kind of off load onto about the burden that I was taking on."

For Collette, at that time, the difficulties she was facing with her family and needing to support her mother meant she did not want or feel able to talk about childhood issues and go into problems from the past. The support Collette wanted was to help cope with her current situation and she felt that rather than alleviate problems discussing the past would make things more difficult. This aspect of the theme highlights the necessity for services and practitioners to adapt to the different needs of individuals, along with the changes of these needs over time. Collette talks about a later point when she felt more equipped to address issues from her past and the stress this process can cause, due to having less demands professionally at that time.

Collette: "I was quite lucky to have counselling at a time when I was doing an internship that wasn't very demanding. I was doing charity fundraising which wasn't too demanding, so I was able to go through all these like personal up and downs with the counselling, bringing up a lot of stuff from the past and

not have too much demands on me professionally at that point. I do appreciate that that's made it easier for me to go through this process."

This quote is an example of how dealing with issues from the past and sharing personal history in counselling can be a challenging as well as a therapeutic process. Several participants described experiences of therapy as emotionally draining and disruptive to other areas of life. Collette suggested that she and others in a similar position may have found it difficult or impossible to cope with the demands of counselling alongside other employment. This aspect of the theme defines counselling as not simply a therapeutic treatment, but also an intensive demanding process, which requires investment of time and energy from recipients. The difficulties of sharing personal material during counselling could affect access issues in a number of ways, such as individuals feeling unable to continue treatments or reluctant to access support in the future following negative experiences.

The '*Takes You Back to that Bad Place*' sub-theme describes how challenging it can be for individuals accessing support to talk about the issues they are facing and their circumstances. Articulating their stories and feelings about the past is often a significant process, rather than simply conveying information to someone else, saying the words out loud can cause individuals to realise new perspectives, re-live past trauma and experience powerful emotional responses. Services and practitioners must recognise this significance in sharing personal stories and the demands it can place upon those seeking help, in order to handle these situations as sensitively and ethically as possible. The following sub-theme, '*Genuine Care*', pertains to this issue and explores the effects of the professionals who are requesting information from service users.

Genuine Care

This sub-theme explores the importance of a practitioners' role in handling sensitive disclosure from those attempting to access support for anxiety or depression. Participants spoke about beneficial attributes of practitioners that had helped them to share their stories and put them at ease. Incidences where participants felt professionals' behaviours and attitudes made sharing more distressing and had negative outcomes were also discussed. The need for practitioners' to show genuine care and interest in participants' stories and wellbeing was a recurrent theme in the data. Being suitably qualified to handle participants' disclosure and showing professionalism and skill is another part of the '*Genuine Care*' sub-theme with all participants touching on the importance of these kinds of attributes when interacting with practitioners and sharing personal material.

Ken spoke at length about the positive experiences he had when accessing support, due to the skill and kindness of the mental health nurses, his GP and other professionals involved. The way he felt their approach was tailored to his needs and responded to changes in his personal circumstances was also something Ken found helpful at an exceptionally difficult time, which he described himself as 'not functioning', 'suicidal' and 'frightened'. The following extract is an example of how important genuine care can be in assisting individuals accessing support who are often vulnerable and in crisis. Here Ken is describing how he felt after contacting his GP for support with depression.

Ken: "I was really erm, I can only put it as cocooned. I was surrounded by people immediately who knew what they were doing. They were trying their best to be supportive to my needs and not to get into too much depth you know, 'Let's go swimming. Let's go for a coffee.' That sort of light-hearted approach, light touch, but with a constant monitoring and constant erm.. that really, really helped and I am really very grateful to the whole team for what they did. It was genuine support that I needed and well organised."

This quote also mentions the benefits of a 'lighter approach', which could be seen as a way of reducing the potential of causing harm or distress from sharing in-depth material. A preference for this type of support was mentioned by several participants, as seen in the extract below in which Charles talks about a Mindfulness course he attended and the organiser's approach.

Charles: "[The group tasks] weren't too invasive into your life or their lives. It allowed people to talk about what they wanted to talk about, rather than saying 'Right well tell me why are you..' you know cos that can be aggressive and quite intimidating. I was worried I'd be intimidated, but I wasn't at all. It was done in such a gentle way, it didn't matter you know, you were alright. You gave as much or as little as you wanted to give."

Through a gentle approach services can support individuals towards recovery without pressure to share sensitive material unless they feel comfortable. Charles went on to describe how the group organiser's experience and gentle approach helped to facilitate a supportive atmosphere.

Charles: "Huge inspiration from him and he offered [support] completely without.. he was completely non-judgemental. He listened. He'd seen it all before. He'd been doing it for years. [The course] did help. It did help me and made me want to help others to be honest. There was just so much kindness being offered around. The air was thick with kindness and it just rubs off."

The previous quotes demonstrate the positive outcomes professionals showing sensitivity and genuine care can achieve, for instance by alleviating feelings of vulnerability experienced by individuals seeking support and combatting issues around sharing sensitive information. Through demonstrating genuine care practitioners can help put individuals at ease and create calming and caring environments where people feel safe to share personal and difficult material.

However, some participants described encounters with practitioners where they felt they were treated impersonally, like a 'conveyor belt' and responses felt scripted and generic. In the following extract Eva talks about her experience of a telephone assessment for a work-based counselling service, which she describes as 'the grilling'.

Eva: "I think it's like telling your story from beginning to end, in quite a lot of detail about each individual shit thing, but not being offered anything back. With the grilling [assessment] it's like let's go through it all and then they're like 'Next!'. You know go through the next shit thing and you go through it again all in massive detail and you're crying and then 'Out of ten how shit do you feel now?' You know.. it's like everything feels like it's out of ten and it's like, I don't know it just pissed me off."

Eva's experience illustrates the distress and frustration sharing sensitive information and details of difficulties can cause when mental health professionals do not seem to show genuine care. The insensitive, impersonal assessment Eva describes seems to be conducted in a way that prioritises obtaining the required information and completion of the assessment itself; disregarding the wellbeing and vulnerability of the individual. Eva goes on to explain further how she found the assessor unhelpful and indifferent to her distress.

Eva: "They weren't supportive! They were just like 'Understandable, I understand you feel like shit' something like that, you know generic, like not useful things you can go away and take. It's just.. yea it's just like a bit of a conveyor belt just this, this, this, next!"

Eva contrasted these impersonal and generic encounters with her experiences of the counselling she went on to have. Unlike the assessments, where she felt distressing material was elicited without the benefit of useful insight or support, she found her counsellor to be supportive, caring and skilled in dealing with sensitive issues, as described in the following excerpt.

Eva: "I was really, really lucky cos the guy that I saw was just, we just really got on. He was really experienced and really, really like patient and kind and explained things really easily. He was like a really caring man, so you could tell he gave a shit, which made a big difference, but yea so the actual counselling experience I would say was really positive. He was also qualified in lots of other different types of therapy [as well as CBT]. I feel really lucky cos it was sort of like he kind of worked around me and what I needed. He had the knowledge or the skill set to adapt to fit what I needed. So that was so good."

Eva describes her therapist qualities of patience, kindness and his expertise in a variety of therapies leading to a 'really positive' counselling experience. This extract is an example of many instances in the data where participants emphasised the importance of practitioners showing genuine care and concern for their wellbeing, along with feeling valued and treated as individuals.

Matt also spoke about experiencing difficulties when sharing personal details of the issues with depression he faced. In this instance, through a course of counselling delivered over the telephone. As the following quote explains, Matt struggled to open up over the phone and describes the service as 'impersonal' and 'scripted'.

Matt: "Well a big part of it was probably just me, erm feeling awkward talking about it over the phone*, but again a lot of it felt like she'd been.. it's kind of like ringing up a call centre and trying to explain your depression and what's going on in your life to somebody in a call centre. In my head I think have they just been trained for four weeks and you know, if somebody says this then here's what you need to respond with sort of thing, rather than actually listening. Erm, that's how it kind of felt like, like I was literally ringing a call centre somehow. It was bizarre really and it just felt very impersonal, almost like reading it from a script."

Matt's experience is another example of practitioners failing to convey attributes of 'genuine care', instead seeming as though they are not really listening, giving impersonal script-like responses. On this occasion it led to the participant becoming frustrated and disillusioned, before discontinuing counselling. Another incidence of a practitioner seeming uncaring is given in the extract below.

Ken: "I like to be friendly with people and I got to know Jade and James from the Crisis Team very well, the mental health nurses. But with [the psychotherapist] he wouldn't even shake hands. There was a wall between us and he wouldn't cross that wall. He wouldn't give me any answers to questions I gave him about him, you know. So that's what I didn't like really. I wanted to be a bit more erm, a bit more human and erm.. a bit more equal."

For Ken, the lack of warmth he experienced in interactions with a therapist was problematic. He describes the lack of friendly conversation or gestures usual outside therapeutic settings, making sharing personal details difficult and their relationship feel unequal. This component of the '*Genuine Care*' theme is included throughout the previous extracts, with participants talking about the importance of having an understanding and trusting connection with practitioners. The following quote from Matt also emphasises the importance of understanding practitioners and building a rapport. In this case, how Matt's relationship with his GP made the initial steps of accessing support feel easier and less daunting.

Matt: "You get on better with some doctors don't you? As hard as it was still to go in [to the GP practice for support], knowing that I was with a good doctor that I got on with and I did know that by seeing that particular doctor it would be easier for me to explain what was going on and it was literally just go in, this is what's happening and no sort of questions or looking at me like I'm an idiot or whatever you know? It was good yea, erm yea that, the GP that I saw definitely a big part of it I think. There was already that foundation of being able to talk to him easily and be comfortable."

Matt went on to talk about previous discussions with his GP about shared interests, such as music and films. This background and comfortable foundation Matt talks about seems to be an important factor for making the experience of accessing support and sharing sensitive

information an easier process. The above quote suggests a friendly relationship can help to ease concerns about how practitioners might react to personal material shared and alleviate vulnerability that can be felt when asking for help.

Valuing friendly, more 'human' (as Ken describes it) interactions, such as conversations outside treatment, common acts of kindness and sharing personal information arguably goes beyond some current notions of professionalism in mental health care. The importance of genuineness and friendly rapport with practitioners seems to be emphasised in this sub-theme helping to reduce participants' feeling of vulnerability and put them at ease.

Sharing sensitive, personal details of life experiences and emotional and mental difficulties can make accessing support for anxiety and depression challenging, placing people in a position of vulnerability. This vulnerability arguably makes trusting and supportive relationships with practitioners involved in providing support extremely important. In the following excerpt Collette talks about the importance of the relationship she has with her counsellor.

Collette: "I know that you can get counselling wherever you want and I know that, but I've built up.. I've told this person.. everything, well not everything, but things I've never told anybody, things that I didn't even realise I hadn't told anybody, you know what I mean and I built up a very important relationship there. I think it's a really big deal when you tell someone a lot of your stuff. It's been life changing, that's why I've stuck at it."

This quote is an example of how important and intense exploring personal issues and disclosure while accessing support can be. The special bond Collette talks about was mentioned by several other participants, who also emphasised the need to feel warmth and understanding from practitioners, especially due to the personal and sensitive nature of anxiety or depression. In the following extract Rhys discussed how he prefers to see a particular GP regarding support for depression, even if this means he has to wait longer for an appointment.

Rhys: "If I wanted an appointment with [my GP] I'd have to wait like two or three weeks. So usually if it's anything that's just physical or whatever I'll just see whoever I can. But yea he knows my history and stuff so it's quite nice, I think that's quite important to have a doctor that you kind of have history with."

The particular importance of the relationship with practitioners when dealing with mental, rather than physical health issues is highlighted by Rhys in the previous quote and on numerous occasions by other participants. This aspect of the '*Genuine Care*' sub-theme again focussed on how accessing support for anxiety or depression necessarily involves sharing personal and intimate material and the importance of practitioners' role in this process.

The sub-theme highlights practitioners' significant influence in exacerbating or alleviating problems of vulnerability and distress for individuals accessing support. Current findings highlight the importance of professionals showing genuine care and developing trusting relationships all along the journey to seeking support. Also, how these qualities can affect areas other than treatment success, such as assessments conducted in a way which acts as a barrier to accessing treatment or good relationships with GPs making seeking support less daunting. The current findings also suggest that important practitioner qualities may differ from some traditional approaches to mental health professionalism with most participants valuing a friendly, more 'light-hearted' approach.

Making Things Worse

The sub-theme, '*Making Things Worse*' explores participants' experiences of negative, often distressing outcomes of disclosure while accessing or attempting to access support for anxiety or depression. The sub-theme encompasses problems of support being withdrawn or denied following participants sharing details of the issues they were experiencing. This was for a variety of reasons, including for some participants that issues were deemed too serious or specialist to be dealt with by services or conversely that individuals issues were not serious enough to require any support or treatment. Experiences of feeling practitioners were acting unprofessionally, by blaming participants in vulnerable positions for their problems and making them feel worse will also be explored.

Throughout Chantelle's interview she spoke about feeling let down by the services she had been in contact with and that sharing the issues she faced with mental health professionals had not largely been helpful or supportive. In the following extract Chantelle explains how after completing six sessions of counselling, she was told that accessing the service again was not a viable option for her.

Chantelle: "The last counsellor I had she said she wasn't qualified enough to be able to help me. I think it was about 6 sessions you can have and then you have to go back on to the waiting list again, but I didn't I just went to see a mental health nurse. She said there was no point going back on the waiting list with her again cos she won't make much difference.. (Laughs) I thought I was a psycho! I thought they can't help me."

This is an example of a participant feeling accessing support made things worse. Instead of feeling better following the course of therapy, Chantelle talked about her frustration, feeling hopeless and like she must be a 'psycho'. Other participants also spoke about incidences where telling mental health professionals details of the issues they faced had led to recommendations

for specialist or 'high intensity' interventions. The impact these statements may have needs to be recognised with an emphasis on sensitive handling due to the potentially damaging effects.

Heather describes a similar incident during counselling in the following quotation, where after revealing sensitive material at her therapist's request, therapy was terminated and she felt 'ditched'.

Heather: "I only really wanted to focus on current things, but on, I think I had four sessions with her, on the fourth session she... I want to say lured me into revealing a lot of personal stuff from a long, long, long time back and erm.. and then and then she just ditched me. Said she wouldn't continue with the counselling and scrawled out a couple of places I could go to for more, for long term counselling because the issues were more than could be covered in the.. in the five sessions, of which only one of them was left. But she'd kind of encouraged me to, to go back into my childhood. I really had lost faith in counselling at that stage. I know, I knew I should complain about what happened but I was just too upset to, to do that."

Heather's description of this experience really highlights the vulnerable position people can be in when seeking support and the emotionally demanding nature of sharing potentially distressing and traumatic material. Heather also talks about feeling coerced into talking about her past by the counsellor, rather than the issues she wanted to focus on. After reluctantly sharing details of her past, Heather felt she was abandoned by her counsellor who cut short the course of treatment and described the issues as too much to be covered in the remaining sessions. Heather then describes 'losing faith in counselling' at that point, which she talks about further in the extract below.

Heather: "I think there's a great mystique attached to counsellors. And I mean it's not just my personal experience, I've heard from other people that the counsellors have blamed them for their own problems and made them feel much worse.. I do think that... with mental health I think, I think if anybody left a consultation with their condition worse, if it was a physical condition, I think that the practitioner would be accountable, but I think in mental health they're just not. I think it's just blamed on the patient."

The concerns raised within this extract, and sub-theme as a whole, are extremely worrying. Further examples of the harmful consequences experienced by participants accessing or attempting to access support make up the the '*Reliability and Broken Promises*' sub-theme summarised at the start of the chapter.

For support and treatment to not only fail to benefit participants' mental health, but cause additional suffering and significant problems in themselves is an imperative ethical issue to be investigated and addressed. The current findings suggest insensitive handling and negative consequences following disclosure of sensitive material, as part of accessing support and therapy, is an important, specific issue which has made some participants' situations much worse. These negative experiences can also feed into a distrust of practitioners and services

and reluctance to seek help, as discussed within the '*Reluctance to Access Support and Delaying until Crisis*' theme. Failure to acknowledge the vulnerability of those seeking help and the potential for interventions to cause further problems is an area needing urgent investigation and improvement.

The '*Sharing and Vulnerability*' theme has highlighted the sensitive nature of accessing support and the care that is needed to help people at what is often an extremely difficult time. The theme has covered: problems with participants having to re-live or re-tell their stories on multiple occasions, inappropriate and insensitive handling of their disclosure, and negative consequences resulting from therapy and attempts to access support. The theme has also explored participants' experiences of some mental health practitioners who: have helped to make seeking support less daunting and have been sources of comfort and inspiration through the perceived genuine care and support they offered. The findings emphasise the importance of sensitivity from practitioners regarding the handling of participants' personal stories. Also, seeming to raise the question as to whether discussing sensitive material and past events is always the best approach for those seeking support, as many participants valued more 'light-hearted', friendly and practical approaches from mental health practitioners.

Discussion

In the following section the current findings will be considered in relation to previous literature and how they may expand on these findings.

Reluctance to Access Support and Delaying until Crisis

Previous literature has also identified individuals' tendencies to avoid or delay accessing support for anxiety and depression. However, qualitative enquiry allows investigation of this topic from the perspective of service users by gaining in-depth personal accounts.

'What can they do?'

Findings support aforementioned research, which has found doubts about treatment efficacy and mistrust of health professionals to be a factor in avoiding help-seeking (Martínez-Hernández, DiGiacomo, Carceller-Maicas, Correa-Urquiza & Martorell-Poveda, 2014). Previous literature has focussed in particular on young people's reluctance to access support, however the current findings suggest doubts about mental health services and practitioners may affect adults' in similar ways.

A recent study by Sweeney, Gillard, Wykes & Rose (2015) which involved participants affected by other mental health disorders, such as bi-polar and schizophrenia, identifies fear as a motivating force behind interaction with mental health services, which can act as a deterrent to help-seeking. Current findings also suggest fear can play a role in reluctance to access support for anxiety and depression. Fears stemming from previous negative experiences of accessing support were discussed by some participants, in addition to concerns around accessing or fully engaging with services that also had a role in judging fitness to work and qualification for benefits. The fearful attitudes held by some participants regarding accessing support included worries doing so could make their situation worse and concerns about not being taken seriously or being blamed for the issues they were experiencing.

Although there are similarities, current findings also suggest rather than fear, uncertainty and scepticism of what services had to offer seemed to be the motivations of some participants' reluctance to access support. The '*What can they do?*' sub-theme explored these doubts expressed by participants regarding services ability to help and how these concerns can act as a deterrent to accessing support. The qualitative approach allowed a variety of individual

explanations to be explored. Some participants described feeling resigned to the idea of their anxiety or depression as insuperable at times with services unable to offer relevant support or treatment. Others spoke about their perception of mental health services as having nothing to offer them personally, due to preferences for alternative approaches and self-help.

Admitting Somethings Wrong

This sub-theme relates to previous literature on stigma around mental illness and in seeking support itself. Research on self-stigmatised views is especially relevant in relation to current findings. Previous findings from a survey of four European countries suggest that the majority of people believed there was something admirable about a person willing to deal with conflicts and fear without professional help (Coppens *et al.*, 2013). This prizing of self-reliance as the most preferable way to tackle problems is thought to contribute to stigma surrounding mental health issues and accessing support (Griffiths, Crisp, Jorm & Christensen, 2011). Current findings offer further understanding into this area by exploring the issues through personal, in-depth accounts. Rather than simply identifying correlations between quantitative measures of attitudes on stigma, self-reliance and accessing support, the '*Admitting Something's Wrong*' sub-theme explores the intricacies of how these issues can affect participants in their own words. A main finding seems to be how these issues can challenge participants' self-concept and accessing support can be seen as impacting negatively on their view of themselves, suggesting personal weakness.

Another way findings add to the literature is by highlighting other factors which can make admitting something is wrong and accessing support challenging. The findings included in this sub-theme of '*Reluctance to Access Support and Delaying until Crisis*' suggest stigmatised views of mental health do not tell the whole story of individuals' reluctance to seek help. This corresponds with Prior, Wood, Lewis & Pill's (2003) study, which highlights the inadequacy of the majority of literature's reliance on 'stigma' as an answer to widespread reluctance to disclose 'emotional problems.' The current findings demonstrate powerful emotional challenges for participants in coming to terms the potentially on-going and long term effects of mental health issues, in this case anxiety and depression, and continued engagement with support services. Many participants' experiences included cycles of improvement and returning to access services for support. Accessing support was described in terms of signalling something was still wrong and made the likelihood of 'a magic cure' or being 'back to normal' less likely. Sometimes research focusing on stigma and the need to educate and challenge these views can lose site of the ways depression and anxiety negatively affects individuals' lives. The '*Admitting Something's Wrong*' sub-theme acts as a reminder of the severity of real life effects for those struggling with these disorders and, as highlighted in the literature review, the less than clear or reliable routes to recovery to contend with.

'It's Just a Phase' and 'Breaking Point'

These sub-themes encompass participants' experiences of delaying accessing support, often for long periods of time until they reach crisis or 'breaking point'. These findings support previous research that a lack of public 'mental health literacy' contributes to slow recognition of mental ill-health with increasing severity eventually facilitating problem recognition and prompting individuals to seek help (Thompson, Hunt, Issakidis, 2004). Participants' accounts give some understanding of why only a minority of those suffering anxiety and depression seek help. Current findings support literature suggesting seeking support for mental health issues is not a simple process of experiencing psychological symptoms, then seeking help (Gulliver, Griffiths, Christensen & Brewer, 2012; Rickwood, Deane & Wilson, 2007). The 'Cycle of Avoidance' model proposes that individuals attempt to avoid meanings of being in 'real' illness through repeated efforts to normalise or cope with increasingly severe distress and shifting the threshold between what they believe constitutes 'normal' stress and 'real' distress or illness (Biddle, Donovan, Sharp & Gunnell, 2007). Participants experiences of trivialising or denying the difficulties they faced seem to support previous findings and could suggest 'The Cycle of Avoidance' model, developed with young people experiencing mental health difficulties, may also be relevant when considering how adults conceptualise anxiety and depression and make the decision to seek support.

Research into mental health support often focuses on how to encourage people with anxiety and depression to access support sooner or strategies to combat mental ill-health before it becomes more severe. Current findings seem to support this approach, as many participants described how they felt they would have benefited from accessing support much earlier and avoided further distress and deteriorating mental health. However, participants' experiences may suggest that reaching a crisis or 'breaking point' where individuals can no longer ignore the issues they are experiencing and are forced to recognise the seriousness of their situation may be a painful, but unavoidable component in their decision to access support. Participants often described themselves in a place where they are willing to accept any help and try anything in order to get better before they will commit to accessing and continuing to engage with support.

Concerns About Medication

Negative attitudes towards medication as a treatment for mental health issues have been well documented in previous literature. One of the main concerns found is fear of becoming reliant

or addicted to medication for anxiety and depression (Gibson, Cartwright & Read, 2014). Although antidepressants are not known to cause chemical dependency many individuals worry they would be unable to stop medication once they have started (Kessing, Hansen, Demyttenaere & Bech, 2005). Previous research also suggests medication use for depression and anxiety can be viewed as an indicator of not being able to self-regulate and cope with the demands of daily life (Malpass, Shaw, Sharp, Walter, Feder, Ridd, 2009). Current findings support the literature in these regards with participants expressing similar concerns. Participants also voiced concerns regarding medication treatment's inability to address the root cause of anxiety and depression, such as traumatic life events. Instead medication was described as masking or dulling symptoms, rather than solving problems (Priest, Vize, Roberts, Roberts & Tylee, 1996).

Previous literature has also found participants often have mixed and negative reactions to drug treatment for anxiety and depression (Liebert & Gavey, 2008; Price, Cole & Godwin, 2009). Participants' personal experiences of medication, the process of recommendation, prescription, taking the medication and its effects, alter how they view the treatment and how they are likely to approach support in the future (Gibson, Cartwright & Read, 2014). Views on medication have been found to change over time and be influenced by the different stages of treatment (Karp, 1993). The current study also found participants described different points of view regarding medication at different times in their journey of accessing support. Complex, mixed past experiences and the many other factors involved in concerns about taking medication, such as stigma, dependency, and authenticity of wellness can result in shifting and conflicting views (Malpass, Shaw, Sharp, Walter, Feder, Ridd, 2009).

The current study has been able to build on previous findings due to the qualitative approach adopted, which is able to explore the complexities of the concerns participants felt. For instance, statements by Matt describe simultaneously feeling 'the less tablets I'm taking the better' and 'it was the tablets that helped me.' This is an example of numerous conflicting views and feelings expressed by participants regarding medication for anxiety or depression. Rather than seeking to simplify or resolve inconsistencies in participants' dialogue, the '*Concerns About Medication*' theme reveals a truer picture of these complex experiences and the many conflicting ideas held simultaneously. Unlike research which focuses almost exclusively on stigmatised views and misinformation about medication as the source of concerns, although these undoubtedly play a significant role; this study also reveals individuals' accounts of serious and distressing side-effects from taking medication, such as emotional numbness, time off work due to vomiting and nausea, and feeling frightened by 'hallucinogenic' effects. The role these experiences play in affecting people's attitudes and reluctance towards medication seems to be lacking in the literature. Although the negative effects of medication are documented in previous research, quantitative numeric descriptions

can fail to convey the significance these experiences have for those who go through them and often do not consider how side-effects could affect attitudes towards medication and accessing support.

Sharing and Vulnerability

Previous research has largely overlooked the potentially negative outcomes of seeking help and psychological interventions, leading to a scarcity in reliable information for both practitioners and patients (Jonsson, Johanson, Nilsson & Lindblad, 2015; Crawford *et al.*, 2016). The '*Sharing and Vulnerability*' theme explores this neglected area from participants' perspectives and how the process of sharing their personal stories with support services can be difficult, even traumatic and led to further problems. Evaluations of support services by the NHS and other mental health organisations (Department of Health, 2014) mainly focus on how improvements can better tackle anxiety and depression themselves, without specifically considering problems that can be caused by the process of accessing services.

'Takes You Back to that Bad Place'

Findings within this sub-theme and in previous research investigating service users' experiences have identified the need for improvements in communication and continuity in care provision to reduce the potential for frustration and distress from re-telling personal histories and traumatic events. However, the recent report from the Department of Health (2015) and NHS initiative focusses on ways to address problems in repeated explanations of individuals' past in children and young people's mental health services. For instance, through the creation of mental health passports, which young people can give new practitioners to alert them to any important information or personal preferences, without needing to speak about potentially distressing or unhelpful topics. The current findings suggest adults also experience difficulties explaining their past to new practitioners and repeating sensitive information, they too may benefit from innovative ways of addressing this issue. Findings suggest more care is required in this area and further research into alternative ways of combatting the issue in adult mental health settings.

Genuine Care

This sub-theme gave detailed accounts from participants regarding the importance perceived 'genuine care' in interactions with practitioners while accessing or attempting to access support. Participants described the value of friendly, more 'human' interactions, such as

conversations outside treatment, common acts of kindness and sharing personal information which may go beyond some current notions of professionalism in mental health care. This issue has also been touched upon in a previous study, exploring patients with psychosis' experiences of treatment. The qualitative study found while patients value expertise and respect in interactions with clinicians, they also appreciate a 'personal touch' (Laugharne, Priebe, McCabe, Garland & Clifford, 2012). Although this earlier research varies considerably from the current project, as it relates to individuals experiencing different mental health issues and mainly within in-patient settings, the importance of genuineness and friendly rapport with practitioners seems to be emphasised in both studies.

The importance of trust, respect and empathy in the therapeutic relationship is central to most counselling theory and has received extensive coverage in the literature, which provides diverse techniques and approaches to achieving them. However, detailed accounts of the traumatic events and difficulties Eva experienced were required during initial assessments before any support or counselling had been offered. The powerful effects talking about the past can provoke need to acknowledged even in the early stages of accessing support, which can involve individuals in extremely vulnerable positions. It is important that the demands of information gathering tools, such as assessments and screenings, on those seeking support are not underestimated. The ethical principles and methods of best practice for counsellors may also be important in other situations which ask individuals to discuss personal, often painful issues. If initial assessments are not dealt with sensitively they may act as a barrier to individuals attempting to access support.

Previous research has found the therapeutic alliance or relationship to be a significant factor in the success of treatment for mental health issues (Arnold *et al.*, 2013; Smith, Thomas & Jackson, 2004). The current study builds on these findings by not only including service users' relationships with therapists and counsellors, and effects on treatment outcomes; but considering the issue more broadly, including participants' experiences with other professionals and at other stages of accessing support, rather than exclusively therapeutic settings. Current findings highlight the importance of professionals showing genuine care and developing trusting relationships all along the journey to seeking support. Also, how these qualities can affect areas other than treatment success, such as assessments conducted in a way which acts as a barrier to accessing treatment or good relationships with GPs making seeking support less daunting. The current findings also suggest that important practitioner qualities may differ from some traditional approaches to mental health professionalism with most participants valuing a friendly, more 'light-hearted' approach.

Making Thing Worse

As previously mentioned, there is an scarcity of research investigating the negative effects of mental health treatment (Crawford *et al.*, 2011). The sub-theme, '*Making Things Worse*', addresses some of these issues through exploring participants' experiences of negative, often distressing outcomes of disclosure while accessing or attempting to access support for anxiety or depression. The theme provides detailed accounts of a variety of worrying occurrences participants shared where they felt let down by support services and professionals. Although disclosing personal material can have powerful therapeutic benefits and is often a crucial part of counselling, current findings within the this theme suggest for some participants this resulted in significant detrimental effects, such feeling blamed, abandoned and beyond help. The distinct lack of research in this area, despite its importance in protecting individuals already vulnerable and experiencing anxiety and depression, from risks in being made to feel worse as a result of seeking help (Crawford *et al.*, 2016).

Reflections on the Research Process

Early in the research process issues around defining experiences which relate to accessing support and closely related material, such as evaluations of mental health services and interventions, became apparent. Retaining focus specifically on issues of accessing support was one of the challenges faced, especially relevant while conducting the interviews and during analysis. The personal and significant nature of the subject matter participants shared necessitated care in ensuring the experiences explored related specifically to accessing support for anxiety or depression. I found this difficult at times during the interviews, as participants spoke about areas outside of the research focus and often interesting related topics and experiences. After reflecting on initial interviews this issue became more apparent to me and I consciously kept this in mind during the following interviews. Where appropriate I asked questions aimed to guide participants back to the research focus and link related material to experiences of accessing support. The thematic analysis phases also presented challenges in keeping the emphasis on access while dealing with vast amounts of data and so much other interesting material. Having an awareness of this issue, allowed me to keep checking throughout analysis that data related to accessing support and was at the centre of the themes I created.

A further issue during the interview process was negotiating the needs of the researcher to gain in-depth spoken accounts, while also conducting the interviews in as sensitive and supportive way as possible. In some instances I found it difficult when asking participants for more details about their experiences, which often regarded emotive and sensitive issues.

Balancing the different aims of the interviews, compared with everyday conversation or a counselling setting, was challenging for me at times. I wanted to ensure participants felt comfortable and understood. In everyday conversation asking questions for clarification and further details can indicate not understanding, with unspoken cues and implicit interpretation allowing individuals to imply meanings. However, within the interview settings I wanted to avoid inferring my own ideas about participants' experiences as much as possible and hear their perspectives. This could be difficult in some instances where I felt participants were implying or briefly speaking about issues and assuming I could tell what this must have been like for them. I was concerned about questions aiming to draw out more details of participants' experiences being perceived as a lack of empathy or not listening. Reflecting on these issues I felt helped in improving my skills as an interviewer and prepared me for further occurrences of these kinds of situations, by carefully considering how best to phrase questions and how I explained the interview process and my role to participants.

Some participants spoke to me following the interviews about how taking part in the study had affected them. Several participants said they had been surprised by how strongly they had felt. Some individuals described negative effects such as feeling raw, becoming upset or feeling down for a few days. These outcomes highlight again the sensitive nature of the research topic and the impact of talking about difficult times, personal struggles and in some cases experiences of injustice and incompetence. Negative feelings following the interviews were even described by some participants whose interviews had seemed largely positive, describing their improvement in wellbeing. This issue emphasised the importance of following ethical guidelines and how talking about past experiences can be more powerful than even participants themselves expect. However, taking part also had the potential to remind participants of positive experiences, including helpful professionals or interventions and their progress in recovery. Two participants shared with me how much they had enjoyed the interviews and how speaking about their experiences had helped them to realise new perspectives and reminded them of how far they had come. The feedback gained informally with participants has encouraged me to consider the potential benefits of providing opportunities to give feedback following participation. Having a more formal mechanism to capture feedback in future studies may help to gain valuable information from participants' perspectives of how taking part felt for them. Also giving participants a more active role in suggesting how the research process could be improved and aspects which worked well.

Participant 1, Heather, initially took part in the pilot interview. After reflecting on the pilot interview and transcript, with the relevant material it covered, I decided to invite Heather to participate in a follow up interview to gain a fuller account of her experiences and combine both interviews as the data for 'Participant 1.' At the start of the follow up interview Heather was given the opportunity to read through the initial interview transcript to refresh herself on

what we had talked about and also to discuss any topics in more detail. I had also come up with some questions and points of interest after reading through the transcript and considering the research aims. After reflection on how this way of collecting the participant's account worked, I think including follow up interviews in the research process could offer benefits in gaining a fuller picture and a more collaborative way of involving participants. Working this way meant the participant had an opportunity to review what they had said previously, reflect on it, offer more detail or clarification of meaning, and address material they found problematic. Meeting a second time also gives both interviewer and participant another chance to pick up on issues they feel are important, points that were unclear or new relevant material they may not have thought of at the time of the initial interview.

Limitations of Study

The constraints of this study meant participants were recruited through opportunity and snowball sampling. This means of recruitment was adopted as a way of reaching participants who had relevant experiences of attempting to access support for anxiety and depression, without the need for NHS Research Ethics Committee (REC) approval. REC approval would have been too lengthier process to undertake within the limits of this Masters study. This method of recruitment may be vulnerable to selection bias and affect the sample in terms of diversity. However, despite these limitations the participants involved in the current study did encompass a variety of interesting backgrounds and experiences. Sampling strategy and diversity could be improved in a future project with more time and resources. This may help to capture a broader understanding of individuals' experiences and how different groups, such as ethnic minorities, might experience accessing support for anxiety or depression differently.

A potential limitation of the study could be issues with the interview method used. For some individuals articulating their personal, often sensitive experiences regarding their mental health and accessing support can be difficult. Participants from different backgrounds also had varying levels of experience regarding research interviews and academic study. For some participants the research process, interview situation and what is 'expected' was much more familiar, especially for those who have conducted research themselves or attended further education. For other participants the situation was completely new, with self-reflection and articulating their experiences this way potentially not something they are comfortable with or experienced at doing. Difficulties in relating to people in professional or academic positions for individuals from certain backgrounds, such as working class, have been documented in previous research and the implications for some participants need to be considered (Rogaly & Taylor, 2016). I felt this was particularly relevant during one interview, which I found more challenging to encourage the participant to talk in-depth about their experiences. This

participant seemed much more uncomfortable to talk at length and seemed to find it difficult to elaborate further and respond to follow up questions. The difficulties I experienced in this interview situation seemed to parallel some of the difficulties participants described in relating to health professionals and engaging with support, particularly discussed within the '*Reluctance to Access Support and Delaying until Crisis*' and '*Sharing and Vulnerability*' themes. This realisation really highlighted the importance of sensitivity when conducting the interviews and gave further understanding into some of the issues involved for those accessing support and talking about their problems.

However, my relationships with some participants prior to conducting the study may have been useful in combatting these kinds of issues. Already having a level of trust and rapport established with participants can aid qualitative research, through encouraging more open, honest and relaxed dialogue (Blichfeldt & Heldbjerg, 2011). Knowing some participants outside of the study may be an unconventional approach within research and could be viewed as a limitation in terms of potential to affect objectivity and researcher bias. The interview topic was not something I had discussed previously, outside of the research process, with the participants I knew directly and I felt this allowed me to approach the material they presented from a fresh perspective. By keeping an awareness of the potential bias I may have from prior knowledge of participants, I tried to maintain vigilance during analysis in keeping directly to the content of the interview transcripts. It is possible that knowing participants personally might make them uncomfortable discussing intimate experiences of anxiety or depression. However, the voluntary nature of participation and clear communication of the research topic meant participants elected to take part knowing the subject matter which would be the focus. I felt the associations I had with some of the participants may have actually assisted the interview process, with participants appearing comfortable from the outset and more at ease discussing personal and difficult times in their lives. Recent literature has challenged existing formalities in academic traditions and begun to investigate the potential benefits of conducting research with acquaintances (Blichfeldt & Heldbjerg, 2011; Yuan, 2014).

Conclusions

Despite some positive experiences shared by participants, the findings really highlight just how difficult and painful the process of seeking and receiving support for anxiety and depression can be. The main themes identified include, '*Reluctance to Access Support and Delaying until Crisis*', with many participants sharing their experiences of strong aversion to seeking help, including views of accessing support being a last resort, only done in times of complete crisis. These findings compliment previous research into avoidance and delaying accessing support. However, the current qualitative approach has allowed a deeper and more personal investigation of this experience from service-users perspectives, which adds to the largely quantitative previous research. The literature has focussed heavily on mental health stigma and fear as main causes of reluctance to access support, and although current findings similarly support these as important issues, other factors and intricacies were discussed by participants within this theme; For instance, participants' feelings that support services were not relevant to them personally, a preference for alternative ways of tackling anxiety and depression, influences of life experiences and previous instances of engaging with support.

The '*Concerns about Medication*' theme covered participants' worries that accessing support may mean they would be encouraged or pressured into taking medication or that medication would be the only option on offer from services. These concerns alongside participants' fears that medication could have detrimental effects or were not the route they wanted to take personally seems to have contributed significantly to doubts about services ability to help and reluctance to access support. These findings add to a wealth of literature relating to individuals concerns about taking medication for anxiety and depression. The qualitative approach adopted has allowed for the complexities and contradictions within participants' accounts to be explored. The ambiguities and presence of multiple, conflicting viewpoints regarding accessing support and medication are intrinsic to people's experiencing and vital in allowing a fuller understanding. Previous literature has also seemed to neglect the seriousness and potentially traumatic nature adverse side-effects can have for the individuals involved. By giving participants the opportunity to talk about their experiences in their own words these experiences and their meanings are shown in a more powerful, relevant way.

The '*Sharing and Vulnerability*' theme encompassed issues regarding how participants' disclosure of sensitive material was handled while attempting to access support. This theme emphasises the vulnerability individuals can feel while seeking help with anxiety and depression. Many participants described the extremely challenging and stressful nature of accessing support with the need for them to share personal struggles and re-tell details of

traumatic experiences with service providers. Participants spoke about the importance of good relationships with skilled professionals and practitioners in these situations. The potential for attempts to access support to have a negative impact for participants' was also covered within this theme. The findings regarding this potential to cause harm and distress to those attempting to access support adds to awareness of this vital, yet under-researched area of mental health.

The final theme, '*Having to Fight for Support*', again emphasises the effort and struggle individuals must navigate in their endeavours to access support. Within this theme, participants talked about the lack of prompt, relevant and easily accessible support, with difficulties in access compounded by personal obstacles and symptoms of anxiety or depression. Due to the constraints of this study the '*Having to Fight for Support*' theme was summarised and then discussed in terms of how it connects to the other main themes, within the relevant sections.

Areas for Further Research

It is clear from these findings and those of previous research that changes need to be made in the provision of support for anxiety and depression. Improvements to existing services and new ways to make accessing support easier and more relevant for those who need it must be found. The field would benefit from further research into how services can be tailored to meet the needs of those seeking support and trialling new methods of tackling the issues highlighted by this study, such as reluctance to ask for support, reservations regarding services abilities to help and the potential to make problems worse.

Current measures to encourage those with anxiety or depression to seek help seem to be failing, with the findings suggesting support services are often viewed as irrelevant or only to be contacted as a very last resort. Accessing support when individuals are already in crisis can mean more pressure is placed on already over-stretched services to provide help urgently and support people who feel they are at breaking point. This study has discussed how reaching 'breaking point' may be an unavoidable component in some individuals' journeys to acknowledging the problems they face and making the decision to seek support. Sources of support for anxiety and depression must take into consideration the desperate situations many people are in at the point of seeking help; by ensuring provisions are adapted to cope with the associated demands of providing urgent assistance to vulnerable individuals at these critical junctures. The NHS' Five Year Forward View (2017) looks to address these issues in mental health support provision, by increasing the availability of talking therapies further and facilitating faster access to digital therapies.

Further research is also needed into effective ways of encouraging individuals to seek help sooner or take other preventative actions before reaching a crisis point. Previous research into mental health and wellbeing has uncovered numerous potentially beneficial strategies to combat anxiety and depression, which can be part of everyday living. Lifestyle choices and habits such as exercise, meditation, diet and job role have been shown to affect mental health. Directing research into how these strategies can practically and helpfully be adopted into everyday living and ways our environments and culture can change to actively promote psychological wellbeing and take into account the endemic of mental health issues, such as anxiety and depression, should be a priority. Greater understanding of how communities, workplaces and other social settings could be better suited to recognise and alleviate mental ill health is an important avenue of research, which could help to protect individuals from suffering the burden of anxiety and depression without support. Improving mental health awareness and fostering caring attitudes in everyday settings seems a vital area of investigation in tackling issues around delaying help-seeking and reaching crisis point. The Mental Health Foundation (MHF) has set out its 'Prevention Revolution', as part the 'A New Way Forward' strategy (2017). MHF's focus is on prevention by funding research and initiatives to help understand and tackle causes behind the development of mental ill health. Targeted community based action, workshops for children and young people, fundraising and leading public movement for mental health are examples of ways they are working towards prevention of mental ill health.

In regards to addressing problems around support being viewed as irrelevant or unhelpful, this study is an example of the wealth of knowledge and expert insight that can be gained from dialogue with people who have lived experience of anxiety or depression and seeking help. Providers of support must have effective feedback mechanisms and actively strive to gain input from service-users to utilise this invaluable source of information. Understanding individuals' experiences and the issues they face when accessing support could help to identify problems with services and suggestions of how to improve. Encouraging individuals to share their experiences and highlight failings is vital to promoting ethical practice with organisations taking these insights on board to improve the relevance and usefulness of support. Current findings suggest participants have found raising complaints and giving feedback extremely difficult. By improving communication, being open to criticism and acting on any discoveries services could gain the opportunity to put problems right and reduce the potential of causing harm to those who access support. Having more collaborative relationships between providers and users of anxiety and depression support could lead to new ideas and meaningful ways for services to adapt and improve.

An interesting area for further research highlighted by the study includes the relationship between how individuals' view themselves and their decision-making regarding seeking support for a mental health issue. Exemplified in the quotation used in the title of the project, participants talked about the difficulties in negotiating seeking support for anxiety or depression with their own identity and what it meant about who they were. Further understanding in this area could provide insights into why education, improving mental health awareness and reducing stigma are often not enough to encourage people to seek support for themselves.

An additional topic, warranting further investigation, discussed by several participants related to their opportunities to offer support and advice to others experiencing similar difficulties to their own and how rewarding they had found this process. Participants who had experienced providing help to others, such as friends, fellow support group members and in more formal positions as mentors and volunteers talked about how beneficial they had found it personally. The potential for these types of supportive relationships to empower those involved to achieve significant positive change for themselves and others is an exciting research prospect. Several participants spoke about how they felt assisting others had improved their own wellbeing and sense of purpose. Acknowledging the value of individuals' personal experiences of coping with mental ill health and facilitating these types of mutually beneficial relationships could provide an important therapeutic strategy for support services. Establishing initiatives which bring people together to collaborate in tackling anxiety and depression, through fostering supportive relationships, networks and communities is an exciting opportunity that merits exploration from future studies.

Appendices

Appendix 1. – Interview Topic Guide

1. Please can you start by explaining a bit about what led you to seek support and which services you got in touch with?
2. What did you hope for or expect from the service?
3. Did you feel there were any barriers to accessing support? / Anything that held you back from seeking support?
4. Was there anything in particular that encouraged you to seek support for the issues you were experiencing?
5. How did you find your experience of accessing support?
6. What resources or therapy were offered?
7. Was there anything you found particularly helpful while accessing support?
8. Was there anything you found particularly unhelpful while accessing support?
9. Were there any differences between your expectations and your experiences?
10. How would you feel about accessing support for anxiety/depression again in the future?
11. In light of your experiences what advice would you give to a friend with anxiety / depression?
12. Is there anything we've not already discussed you like to add about your experiences of accessing support?

Appendix 2. – Interview Briefing

- Introduce myself
- Introduce study
- Allow participants time to read through participant information

After reading Participant Information Sheet re-cap:

- Interview length and format and topic
- Confidentiality: Anonymity and exceptions
- Use of participant data
- Participants' rights to withdraw and omit questions and voluntary participation

**If participant is known to me emphasise – There is no obligation to take part and anything they say or decisions they make regarding participation will not affect our relationship

- Ask participants if they have any questions. After this check questions are answered to participants' satisfaction
- Once participants are happy their questions have been answered, ask them to read Consent Form
- Provide another opportunity for questions before asking participants if they are happy to go ahead with the interview and to sign the consent form if so
- Thank participants for giving their time and if consent has been given begin the interview.

Appendix 3. – Letter of Invitation

Exploring Individuals' Experiences of Accessing Support for Anxiety and Depression.

**Hannah Mitchell, School of Human Health Sciences
University of Huddersfield**

I am a postgraduate student at the University of Huddersfield studying for a Masters by Research in Psychology. My research intends to explore people's experiences of accessing support for anxiety and depression.

I am looking for people who have accessed or attempted to access support for depression and/or anxiety in the last 5 years and would be happy to talk about their experiences in an audio-recorded interview lasting around one hour. Support could come from a variety of organisations, for instance NHS services such as your GP or IAPT, mental health charities such as Mind, Rethink Mental Illness, Relate or Anxiety UK, also occupational and educational counselling services and other organisations.

I would like the project to include participants from a wide variety of backgrounds, cultures and age groups to ensure as much diversity in experience as possible. With this in mind, individuals from ethnic minorities and older age groups are particularly encouraged to take part.

Your participation would be greatly appreciated and contribute towards research which aims to explore personal experiences of accessing support and increase understanding of mental health issues.

If this seems like something you might be interested in taking part in, please get in touch for full details of the project. Please find my contact details below:

Hannah Mitchell

Email: hannah.mitchell@hud.ac.uk

Appendix 4. – Participant Consent Form

University of Huddersfield

Exploring Individuals' Experiences of Accessing Support for Anxiety and Depression.
Hannah Mitchell, School of Human Health Sciences

Participant Interview Consent Form:

Please
tick

I have been fully informed of the nature of the research and have had the opportunity to have my questions answered.

I understand I am taking part voluntarily and have the right to withdraw from the interview at any time without giving a reason and the right to withdraw my data up to one month after the interview.

I understand that the interview will be audio-recorded and the recording kept securely on a password protected computer.

I understand that only the interviewer and her supervision team will have access to the recording and that it will be destroyed after the final analysis is complete.

I understand that my identity will be protected by the use of a pseudonym and that no identifying information will be used in the report.

I give permission to be quoted (by use of a pseudonym) and understand that direct quotes from my interviews may be used in future publications, conference presentations and for teaching purposes.

I am happy to consent to take part in the research project.

Name (Printed)

Participant's Signature

Participant's

Name of person obtaining consent (Printed)

Signature of person obtaining consent

Date

Appendix 5. – Ethical Approval Application

THE UNIVERSITY OF HUDDERSFIELD
School of Human and Health Sciences – School Research Ethics Panel

OUTLINE OF PROPOSAL

Please complete and return via email to:

Kirsty Thomson SREP Administrator: hhs_srep@hud.ac.uk

Name of applicant: Hannah Mitchell

Title of study: Exploring Individuals’ Experiences of Accessing Support for Anxiety and Depression.

Department: Psychology

Date sent: 13/03/15

Issue	Please provide sufficient detail for SREP to assess strategies used to address ethical issues in the research proposal
Researcher(s) details	Hannah Mitchell
Supervisor details	Viv Burr and Chris Bale
Aim / objectives	Exploring Individuals’ Experiences of Accessing Support for Anxiety and Depression.
Brief overview of research methodology	The project plans to explore individuals’ experiences of accessing support for depression and anxiety. The research aims to investigate how participants felt in regard to accessing support, and whether they encountered any barriers or facilitators in attempting to access support. Semi-structured interviews and thematic analysis of the transcripts will be utilised to explore these aims. Please see Appendix 1. for the pilot interview schedule.
Study Start & End Date	Start Date: 01/10/14 End Date: 30/09/15
Permissions for study	N/A
Access to participants	Twelve participants will be recruited through opportunity and snowball sampling of people known to the researcher and also through opportunity sample of Huddersfield University students. I have already received permission from one of my supervisors to access potential participants via his teaching sessions. A letter (Appendix 2.) explaining the project, research aims and eligibility criteria will be distributed to potential participants in a variety of ways, aiming to recruit a suitable and diverse sample. The letter will be distributed by email or in person to people known to the researcher, via email to students at University of Huddersfield and through posting on social media. When recruiting people known to me I will emphasise that our association should not make them feel obliged to participate and that there will be no consequences for them or our relationship should they decide not to take part, or to withdraw. I will reiterate this to participants known to me during the briefing to ensure they do not feel under any pressure to take part and do so voluntarily. Participants will need to meet the eligibility criteria and be happy to take part. Potential participants will be informed of the criteria through a participant information sheet (Appendix 3.). Eligibility criteria for participation include being eighteen years or above in age and attempting to or actually accessing support for depression and/or anxiety s in the last five years. Potential participants may have sought support from a range of services, such as Mind, Anxiety UK, crisis hotlines, self-help groups, counselling services at their workplace or educational institution, or their GP. Because those who access support for anxiety and depression may continue to receive support for several years, the sample may include both individuals who are continuing to access support services and those who are no longer engaged with them. However, the focus of the study will be on participants’ experiences of initially seeking support and attempting to access this, rather than on any treatments or therapies they may have received or be receiving, or any evaluation of support services.
Confidentiality	After collection, all participant data will be kept safely and securely. Any physical documents or recordings will be kept in a locked cabinet which only the researcher has access to. Digital recordings and electronic documents will only be available to the researcher and supervision

	<p>team, and will be stored on a password protected computer. The interview recordings will be destroyed after transcription and analysis are complete. Any physical copies of transcripts will be shredded on completion of the project and electronic data stored in password protected files.</p> <p>The participant information sheet will also make participants aware of the limits of confidentiality, which mean that if they mention anything within the interview which suggests there is a risk of harm to themselves or someone else I may have to pass this information on to appropriate persons.</p>
Anonymity	The interview transcripts will be anonymised with pseudonyms and other identifying details will be removed. Real names of individuals and organisations will also be changed in the research report.. In addition to this I will also ask participants, via the interview briefing, to refrain from using practitioners' names during the interview in order to protect their anonymity as completely as possible.
Psychological support for participants	Participants will be given contact details of relevant organisations on the Participant Information sheet (Appendix 3.), should they require any support. Precautions will be in place to minimise the risk of participants becoming distressed during the interview. For instance, ensuring participants are fully aware of the topic before choosing to take part and feel comfortable talking about their experiences. However, in the event they do experience any distress the interview would be stopped and/or a break taken depending on what is suitable for the participant. I would make it clear they do not have to continue with the interview. I would stay with the participant and talk with them until they were calm, then provide details of sources of support which may be helpful.
Researcher safety / support (attach complete University Risk Analysis and Management form)	To ensure researcher and participant safety when conducting the interviews I will inform someone of the planned location and times of the interviews, then call them when the interview has finished. The interviews will take place on the university campus where possible, unless this is inconvenient for the participant when an alternative location such as the participants' own home will be agreed.
Identify any potential conflicts of interest	None
Please supply copies of all relevant supporting documentation electronically. If this is not available electronically, please provide explanation and supply hard copy	
Information sheet	Appendix 3
Consent form	Appendix 4
Letters	Appendix 2
Questionnaire	N/A
Interview guide	Appendix 1
Dissemination of results	The results will be presented in my thesis, which could potentially be used in lectures, conferences and subsequent publications. The thesis will be placed in the University repository.
Other issues	
Where application is to be made to NHS Research Ethics Committee / External Agencies	N/A
All documentation has been read by supervisor (where applicable)	Please confirm. This proposal will not be considered unless the supervisor has submitted a report confirming that (s)he has read all documents and supports their submission to SREP

All documentation must be submitted to the SREP administrator. All proposals will be reviewed by two members of SREP.

If you have any queries relating to the completion of this form or any other queries relating to SREP's consideration of this proposal

THE UNIVERSITY OF HUDDERSFIELD: RISK ANALYSIS & MANAGEMENT

ACTIVITY: Interviews exploring participants' experience of accessing support for anxiety and depression			Name: Hannah Mitchell	
LOCATION: University campus or where necessary an alternative location agreed with participant and supervisor			Date: 25/02/15	Review Date:
Hazard(s) Identified	Details of Risk(s)	People at Risk	Risk management measures	Other comments
Researcher safety	Potential risk for researcher when meeting participants alone for interviews.	Researcher	I will inform a friend of the planned location and time of the interviews, then call them when the interview has finished. Where possible interviews will take place on the university campus.	
Potential participant distress	Due to the sensitive topic covered by the research it is possible that participants could become distressed as a result of taking part.	Participants	Participants will be informed of the research topic before deciding whether or not they wish to take part. They will also be made aware of their right to omit any interview questions and withdraw from the study without explanation if they wish to. The Participant Information Sheet will provide contact details for relevant organisations to provide participants with support should they need it.	
Potential distress during interview	Due to the topic there is potential for participants to become distressed during the interview.	Participants	Ensuring participants are fully aware of the topic before choosing to take part and they feel comfortable talking about their experiences will reduce the likelihood of any participants becoming distressed during the interview. However, in the event they do experience any distress the interview would be stopped and/or a break taken depending on what is suitable for the participant. I would make it clear they do not have to continue with the interview. I would stay with the participant and talk with them until they were calm, then provide details of sources of support which may be helpful.	

Appendix 6. – Participant Information Sheet

University of Huddersfield
Exploring Individuals' Experiences of Accessing Support for Anxiety & Depression.
Hannah Mitchell, School of Human Health Sciences

Participant Information Sheet:

As part of my Masters by Research degree, I am conducting a research project exploring people's experiences of accessing support for anxiety and/or depression. Support could be through NHS services such as your GP or IAPT. It might also be through mental health charities such as Mind, Rethink Mental Illness, Relate or Anxiety UK, also occupational and educational counselling services and other organisations.

Who can take part?

If you are 18 years of age or above and have accessed or attempted to access support for depression and/or anxiety in the last 5 years your participation in the study would be greatly appreciated.

I would like the project to include participants from a wide variety of backgrounds, cultures and age groups to ensure as much diversity in experience as possible. With this in mind, individuals from ethnic minorities and older age groups are particularly encouraged to take part.

What will I be asked to do?

You would be asked to take part in an audio-recorded interview about your own experiences of accessing support for anxiety and/or depression, which will last around one hour.

You may omit any of the interview questions you wish to (simply state that you do not wish to answer the question) and can decide to withdraw from the study at any time without explanation. You may also request your data to be withdrawn from the study up until one month after the interview, by contacting me using the details below.

Will the information I provide be confidential?

No person other than myself and my supervisors will have access to the interview recording and transcriptions. The recordings and transcripts will be kept on a password-protected computer. The recordings of the interviews and any physical copies of the transcripts will be destroyed once the final analysis is completed.

However, if anything you say in the interview suggesting you are at risk of harming yourself or someone else I may have to pass this on to the relevant persons.

It will not be possible to identify you or the data you provided from the final project report, as false names will be used and any identifying features will not be included.

What should I do if I have any questions?

I would be happy to answer any queries either before or after you take part in the research. Please find contact details below for me and my supervisor:

Hannah Mitchell
School of Human & Health Sciences
University of Huddersfield
Huddersfield
HD1 3DH
Email: hannah.mitchell@hud.ac.uk

Dr. Viv Burr
School of Human & Health Sciences
University of Huddersfield
Huddersfield
HD1 3DH
Email: v.burr@hud.ac.uk
Tel: 01484 472454



Further Support:

The subject of this project may be sensitive for some individuals. If you feel it may cause you any discomfort or distress to take part please feel free to decline. If you feel you need any further support please find details of relevant organisations below:

NHS Choices Moodzone - www.nhs.uk/Conditions/stress-anxiety-depression

NHS Direct - Call: 111

Mind - <http://www.mind.org.uk/>
Call: 0300 123 3393
Text: 86463

Samaritans - <http://www.samaritans.org/>
Call: 08457 90 90 90
Email: jo@samaritans.org

Appendix 7. – Reflexive Account

My Background

My interest in the topic of support for anxiety and depression has been influenced by the experiences of several close friends and family members who have suffered with depression and other mental health issues. Seeing the distress and difficulties people I care about struggle with has made mental health a subject which is very significant for me. Personal relationships have given me an understanding of the real life effects of mental illness, particularly of depression; such as difficulties with employment, financial problems, strains on maintaining relationships, discrimination and stigma. This awareness of how hard it can be to cope with depression and mental ill health has highlighted the importance of effective treatment and support. People I know have had hugely varied experiences when accessing support. The power mental health support has when working with vulnerable people to assist in recovery and create positive change, or potentially cause further difficulties and trauma, is something which is such an important issue for me and a source of both frustration and hope.

My voluntary work at a children's charity involves working with young people and families who have been affected by mental illness, amongst other issues. This role has also given me insight into the detrimental effects depression and anxiety can have on family life, child development and individuals' ability to cope.

Although I have not personally accessed support for anxiety or depression, there have been times when I have been under stress and experienced difficulties with feeling very low and struggled with motivation. These periods of feeling depressed have caused me to consider whether I would benefit from seeking support from my GP for instance. However, I have always decided against this and coped with these difficulties in other ways, such as: talking with friends and family, distracting myself by keeping busy or withdrawing and spending time by myself at home until the feelings pass. My own hesitance to seek more formal support has drawn my attention to the blurred lines between low moods and sadness experienced by people generally and symptoms of depression and anxiety. Personal experiences have inspired my interest in the factors that influence people's decisions to seek support or decide against doing so.

The reflexive issues regarding how my background and experiences have influenced my role as researcher and interviewer are considered further in the *Methodology* and *Findings & Discussion* chapters of the report.

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