Help-Seeking In University Students Experiencing Suicidal Thoughts And Self-Harm

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature:

Name: Alice Tickell

Date: 17/06/2022

Overview

This thesis explores the topic of mental health help-seeking in university students experiencing suicidal ideation and self-harm. Help-seeking is defined as seeking or accessing care from formal and informal sources of help.

Part 1 is a systematic review, involving a narrative synthesis of 19 studies on the rates and sources of help-seeking, and factors associated with help-seeking in students with a history of suicidal thoughts or self-harm. At least half of students did not seek or receive help for their mental health while at university. Ten factors affecting help-seeking were identified and discussed. There was a paucity of qualitative studies on students who had self-harmed.

Part 2 is an empirical study, examining the help-seeking experiences of students who had self-harmed while at a large London university. This was a joint project with Katalin Hajdú (KH). Qualitative interviews explored students' journeys, facilitators, and barriers to accessing support. A reflexive thematic analysis identified four over-arching themes: "The beginning of university was the hardest part", "My mental health problems needed to be severe", "Escaping judgement, worry, and repercussions from others", and "Choice and flexibility of treatment supported recovery". Implications for mental health service provision and configuration are discussed. This part of the thesis contains accounts of students' views on self-harm which some people may find distressing or triggering.

Part 3 is a critical appraisal of the process of conducting this research, focussing on how the author's various social identities shaped the project and how they approached various methodological challenges.

Impact Statement

A key finding of the systematic review was that at least half of students experiencing suicidal ideation or self-harm did not seek help for their mental health while at university, and this may be considerably less when accounting for response bias towards more help-seeking samples. It also identified a dearth of qualitative studies on the help-seeking experiences of students who had self-harmed. The empirical study endeavoured to fill this research gap. Together, both papers highlighted important priorities for future research, policy, and intervention, to improve the accessibility and quality of informal and formal support for this group of students. The empirical study identified several vulnerability points in students' help-seeking journeys: the beginning of university when support networks have not yet been well established, students' belief that mental health problems need to be severe to warrant support, people's unhelpful responses to help-seeking efforts, and a lack of choice or flexibility in treatment options. These findings were followed by student-led recommendations for how to strengthen pathways to support. These recommendations will be shared with important stakeholders, such as leaders in universities, NHS services, and student mental health charities, so they can effect change in mental health strategy and policy.

The systematic review also highlighted methodological limitations within the extant evidence base on help-seeking in university students. These included, but were not limited to, sampling problems (e.g., response bias towards more help-seeking samples), measurement problems such as inconsistent definitions of suicidality and self-harm and a lack of systematic approach to defining sources of help-seeking, and a need for more qualitative data on students' experiences. In addition, most existing studies were from US samples, highlighting the need for international research to facilitate cross-cultural comparisons. These findings will be disseminated in the academic community by publishing in research journals, to encourage researchers to focus on advancing the quality and breadth of this evidence base. The research will also be presented in academic forums and working groups to inform and direct future

research projects. The data gathered from the present study will be made available to other researchers within the university group, to produce further qualitative publications.

The findings will also be summarised and publicised via social media and blogs to ensure more public engagement with the findings. This will be targeted at students with lived experience of suicidality and self-harm, to make recommendations for how to initiate or persevere with seeking support for their difficulties, based on the facilitators and barriers identified in this thesis. The present findings also highlighted the importance of social networks in supporting students with suicidal ideation and self-harm, so content will also be tailored to these audiences, to advise on how they can better support people in this position.

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Part 1: Literature Review

Help-seeking in university students with suicidal thoughts and self-harm: A systematic review

Abstract

Background

Suicide is a serious problem within university student populations. As suicidal thoughts and self-harm are associated with increased risk of completed suicide, students experiencing these problems are likely to benefit from seeking help for their mental health at university.

Aims

This systematic review aimed to synthesise research on help-seeking at university in students with a history of suicidal thoughts and self-harm, focussing on rates and sources of help-seeking, and factors associated with help-seeking.

Method

Searches were conducted in Medline, PsychINFO, and ERIC (from inception to 15/11/21) for population-based epidemiological or qualitative studies. The 609 identified studies were screened against the inclusion criteria, and 19 studies were included in the review. Due to heterogeneity in the results, a narrative synthesis of the results was carried out.

Results

The majority of studies identified were from US populations. At least half of students with previous suicidal thoughts and self-harm did not seek or receive help for their mental health while at university, with lower rates in men and ethnic minority groups. Ten factors affecting help-seeking were identified and discussed.

Conclusions

The low rates of help-seeking identified in this at-risk group highlight the need for research into interventions to improve help-seeking as part of suicide prevention efforts.

Introduction

Suicide is the fourth leading cause of death in young people aged 15-29 years [World Health Organisation (WHO), 2019]. Increasing numbers of young people are attending post-secondary education, hereafter referred to as university. Global data on university suicide rates suggests that student suicide is a significant public health problem (Schwartz, 2006; Universities UK & Papyrus, 2018). Estimates suggest that approximately 10% of university students consider suicide every year, 3% make suicidal plans, and 1.2% attempt suicide (Mortier et al., 2018). WHO propose that a key intervention for suicide prevention is ensuring that people who are at risk of suicide receive the support that they need (WHO, 2021).

Previous suicidal thoughts or self-harm are associated with increased risk of suicide attempts and completed suicide (Arria, 2009; Hawton & Hariss, 2007; Owens et al., 2002; Ribeiro et al., 2016). Self-harm is defined as any act of self-injury or self-poisoning, irrespective of intent (Hawton et al., 2016). This includes acts intended to result in death (i.e., suicidal behaviour), those without suicidal intent (i.e., non-suicidal self-harm; NSSI), and those with mixed or unclear motivation (Hawton et al., 2016). The notion of categorising suicidal behaviours and NSSI as distinct has gained popularity, especially in the United States (US), although there is debate about the validity and clinical utility of this, given the strong association between NSSI and suicidal behaviour (Hooley et al., 2020; Kapur et al., 2013).

There is limited evidence of effective interventions to reduce suicidal thoughts or self-harm (Barnett et al., 2021; Crawford et al., 2007; Platt & Niederkrotenthaler, 2020). A recent review suggested promising results for certain psychological treatments on reducing frequency and repetition of self-harm, although there were significant methodological limitations in the included trials (Witt et al., 2021). Another review found no clear evidence for the effectiveness of pharmacological treatments in preventing repetition of self-harm (Hawton et al., 2015). In routine clinical practice, service users are more likely to receive interventions to treat associated mental health problems, where the focus may not be exclusively on suicidal thoughts or self-harm (National Collaborating Centre for Mental Health, 2004; 2012).

Research on university students suggests that outcomes for students offered psychological interventions may be as efficacious as interventions provided for adults, with particular benefits identified for anxiety disorders, depression, and eating disorders (Barnett et al., 2021).

However, a large proportion of young people do not seek help from professional sources (Hom et al., 2015; Michelmore & Hindley, 2012; Rowe et al., 2014). Michelmore and Hindley (2012) found that among young people with a history of suicidal ideation or self-harm, rates of mental health service use were consistently below 50%. In addition, there is evidence that many of the young people who do present to services disengage from treatment (Ougrin & Latif, 2011). Young people are more likely to seek help from social networks, most commonly from peers (Michelmore & Hindley, 2012; Rowe et al., 2014). Seeking help from peers may have beneficial impacts such as increased emotional support and encouragement to seek professional help (Simone & Hamza, 2020). However, peers may be poorly equipped to provide helpful responses (Rickwood et al., 2005), which may result in more distress and less professional help-seeking (Simone & Hamza, 2020).

In order to try and address these low rates of professional help-seeking, a number of studies have attempted to understand the relevant facilitators and barriers. In young people, more severe suicidal ideation is associated with less help-seeking, possibly due to 'help-negation' whereby suicidal individuals reject available treatment due to hopelessness, pessimism, or disrupted problem-solving (Hom et al., 2015). Other identified barriers include lack of perceived need, preference for self-reliance, scepticism about treatment effectiveness, fear of consequences (e.g., hospitalisation), and structural barriers (e.g., geography, availability of care; Michelmore & Hindley, 2012). There has been debate regarding whether stigma about help-seeking is an important barrier to care. Stigma can be broken down into self-stigma (one's own stigmatising attitudes) and public stigma (perceived negative attitudes held by others; Corrigan, 2004). In university students, research found that personal stigma was negatively associated with help-seeking, while public stigma was not (Eisenberg et al., 2009). However, these studies have focussed on the general student population; the

experience of stigma may be distinct in students experiencing suicidal thoughts or self-harm and warrants further investigation.

Unique populations of students may face additional barriers to help-seeking. Research suggests that young people who identify as LGBTQIA+ may face additional barriers, such as fear of discrimination (Bachmann & Gooch, 2018). There appear to be gender differences in help-seeking, with young women more likely to seek help from social networks, and young men more likely to seek help from emergency services (Michelmore & Hindley, 2012). This gender difference has been linked to men feeling more shame about help-seeking (Michelmore & Hindley, 2012). In the US and Canada, young people in ethnic minority groups were less likely to use mental health services (Michelmore & Hindley, 2012; Hom et al., 2015). This has been linked to stigma, limited familiarity with mental health professionals, and concerns that providers may not be culturally competent (Hom et al., 2015).

However, much of this research has focussed on adolescents and young people in the general population. University students represent a unique population; they are older than adolescents, face different academic, financial, and social stressors, and have access to different types of social and professional networks and mental health services. These factors may impact uniquely on help-seeking. This systematic review aimed to narratively synthesise research on university students with a history of suicidal thoughts or self-harm, and examine rates and sources of help-seeking, and factors associated with help-seeking while at university. The results could influence university-based interventions to promote help-seeking, to enhance prevention, early detection, and access to effective treatment.

Method

This systematic review was conducted as a narrative synthesis in line with Popay and colleagues (2006) and the Synthesis Without Meta-Analysis (SWIM) guidelines (Campbell et al., 2020). The review followed a prospectively registered protocol on PROSPERO (CRD42022301208) and PRISMA guidelines (Moher et al., 2009).

Search strategy

The search strategy used a combination of keyword and subject heading searches across Medline, PsychINFO, and ERIC (EBSCO), from inception to November 2021. The search terms focussed on three topic areas: university students, self-harm and suicidality, and help-seeking behaviour. Terms relating to these aspects were combined using "AND" as the Boolean operator. Full search strategies are provided in Appendix 1. The search strategy was accompanied by a reference search of relevant reviews.

Selection Criteria

We included published studies meeting the following criteria:

Participants

Studies sampling university students, of any age or educational level (undergraduate, postgraduate), who had suicidal thoughts or self-harmed at least once in their lifetime. Studies using only clinical or help-seeking samples were not included, as these samples would be biased towards help-seeking and may have over-estimated help-seeking behaviour.

Outcomes

Studies reporting on students' rates of help-seeking for their mental health while at university, the sources of this help, and any factors associated with help-seeking. The terms help-seeking and disclosure are often used inter-changeably. Though the purpose of disclosure is often help-seeking, this is not always the case (e.g., disclosing the behaviour to find like-minded peers), and help-seeking does not always involve disclosure (e.g., reading online resources; Simone & Hamza, 2020). In addition, though an individual may seek help, they may not always receive or continue to engage with support. To capture all behaviour relevant to help-seeking, the review included studies examining disclosure, seeking care, or accessing care, from both formal (e.g., professionals who have a recognised role and training in providing help) and informal (e.g., friends and family) sources of help. However, in each

case, clarifying details are provided to specify the exact facet of help-seeking being discussed. Studies not examining students' help-seeking behaviour were excluded (i.e., studies examining help-seeking intentions, attitudes, or styles, help-seeking in hypothetical scenarios, help-seeking on behalf of students by parents or staff). Studies were not included if they only examined people's reactions to other people disclosing suicidal thoughts or self-harm.

Study Design

Study designs included were population-based epidemiological studies or qualitative studies, using self-report accounts of suicidal thoughts, self-harming behaviour, and help-seeking. Only studies published in peer-reviewed journals were included. If studies drew on the same original dataset, the first published study was included, and any subsequent studies were included if they presented novel analyses of the data. This review excluded reviews, commentaries, opinion pieces, conference abstracts, study protocols, experimental studies, case studies, dissertations, and any other studies not published in peer-reviewed journals.

Screening procedure

All records were uploaded to Endnote X9. The primary reviewer independently screened all titles and abstracts and excluded any records that clearly did not meet the eligibility criteria. Any non-English language papers' abstracts were translated using translation software (Google Translate). Then, full-text articles were sought for retrieval, and assessed for eligibility. A reference search was conducted of all eligible studies. A second reviewer reviewed 10% of all references at each stage. Disagreements and unclear cases were resolved through discussion with a senior reviewer.

Data extraction

The primary reviewer extracted the data using an Excel-based form. Data extracted included: study characteristics (design, recruitment/sampling procedures, condition studied, country of origin), demographic composition of the sample (N, age, level of study, gender, ethnicity), and outcome measures (rate of help-seeking, sources of help-seeking, factors

associated with help-seeking). A second reviewer reviewed data extraction in 10% of studies. All disagreements and unclear cases were resolved through discussion with a senior reviewer.

Quality assessment

The quality of studies identified was assessed using the QualSyst assessment tool (Kmet et al., 2004). This tool examines whether the study objectives, design, results, and conclusions are well-described, systematic, and appropriate. It included two separate questionnaires for assessing quantitative (14 items) and qualitative studies (10 items). Items were scored depending on the degree to which the specific criteria were met ("yes" = 2, "partial" = 1, "no" = 0). Some were marked "n/a" if they were not applicable to a particular study design. A summary score was calculated for each study by summing the total score obtained across relevant items and dividing by the total possible score. These scores were calculated as a linear score from 0 to 100 and divided into three categories: low (≤49), moderate (50–74), or high (≥75) quality studies, as has been done in previous studies (Barnett et al., 2019).

One reviewer independently rated the quality of each of the included studies. A second reviewer reviewed 10% of ratings and all disagreements and unclear cases were resolved through discussion with a senior reviewer. The assessments of quality were integrated into decisions about the certainty of the evidence for each outcome.

Data synthesis

Heterogeneity in the study designs, samples, and outcome measures prevented quantitative pooling of results. A narrative synthesis was carried out for all outcomes in line with Popay and colleagues (2006) and the SWIM guidelines (Campbell et al., 2020).

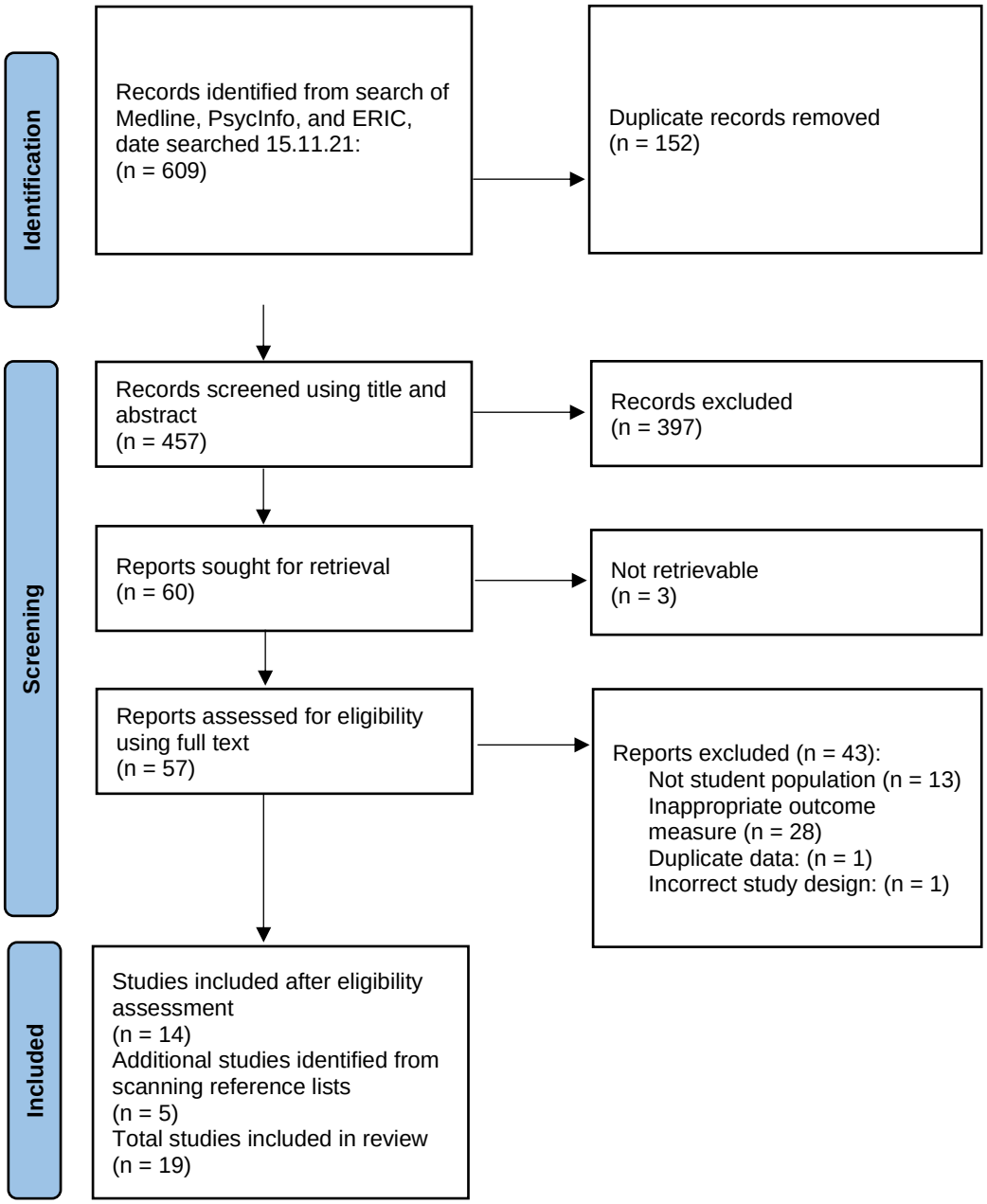
Rates and sources of help-seeking were grouped and tabulated according to condition studied (suicidal thoughts, non-suicidal self-harm, and suicidal self-harm) and timescale of help-seeking. Factors affecting help-seeking were only summarised if they were reported by more than one study. Heterogeneity in study results within these groups was discussed according to study design, sample and study characteristics, and rating of study quality.

Results

The search resulted in 609 records. After removal of duplicates, 457 records were screened, 60 relevant full text articles were reviewed, and 14 studies met the inclusion criteria. A further five studies were identified from scanning their reference lists, resulting in a total of 19 articles included in the review. Figure 1 shows the full search and screening process.

Figure 1

PRISMA diagram to summarise the recruitment process



Study characteristics

The 19 included studies drew on 12 datasets, from at least 210 universities (it was not possible to determine the exact number of universities, due to unspecified overlap between some of the studies). Six studies used data from The Nature of Suicidal Crises in College Students (NSCCS) survey, administered in 2006, by the National Research Consortium of Counseling Centers in Higher Education (original study: Drum et al., 2009; subsequent studies: Brownson et al., 2011; Brownson et al., 2014; Burton Denmark et al., 2012; De Luca et al., 2014; Wong et al., 2014). Two studies used data from the WHO World Mental Health International College Student (WMH-ICS) Initiative, administered between 2014-2017 (original study: Bruffaerts et al., 2019; subsequent study: Bantjes et al., 2020). Samlan and colleagues (2020) extended a study by Downs and Eisenberg (2012) with data from the Healthy Minds Study dataset (2019-2013); both studies were included in the current review.

Eighteen studies were quantitative population-based epidemiological studies, and one was a qualitative study (Burton Denmark et al., 2012). Seventeen studies examined suicidal thoughts and seven studies examined self-harming behaviour (with or without suicidal intent). Table 1 provides a full summary of study characteristics. The majority of the studies used US samples (n=16), with additional studies from Australia (n = 1), South Africa (n = 1), and a multi-national sample (Australia, Belgium, Germany, Mexico, Northern Ireland, South Africa, Spain, and US). Therefore, the studies in this review comprised a sample of majority American and/or Western students, from industrialised, rich, and democratic countries.

Quality Assessment

Fourteen of the studies were of high quality, and five were moderate quality. None were of poor quality. Table 1 notes the QualSyst Score and Category Rating for each study.

Overall, four studies used convenience samples of students (Furr et al., 2001; Nam et al., 2018; Schweitzer et al., 1995; Shannonhouse et al., 2020), which must be interpreted with caution, as they may be unrepresentative of this student population. For example, Nam et al.

(2018) sampled psychology undergraduates, whose help-seeking habits for their mental health may differ to the general student population. In addition, Arria et al. (2011) used a random sample, but purposively over-sampled drug users, and so these results are less generalisable to the target population. Only five out of the 18 studies adjusted for differences between survey respondents and non-respondents (Bantjes et al., 2020; Bruffaerts et al., 2019; Downs & Eisenberg, 2012; Gollust et al., 2008; Samlan et al., 2020). The results of the other studies may be more influenced by the bias between intended and achieved samples. Therefore, where possible the results of these five studies are prioritised in synthesis.

Table 1

Overview of included studies ordered alphabetically.

Authors & Country	Sample source	Design	Condition studied	Outcome(s)	QualSyst Rating
Arria et al., (2011) USA 	Stratified random sample of first-year undergraduate students at one college, purposively oversampling drug users, assessed annually as part of a longitudinal study of health risk behaviours. N = 1253 Mean age: ND[a] Undergrad: 100.0% Women: 51.4% Ethnicity: White 70.8%; Black 9.7%; Asian 9.1%	Cross-sectional interview	Suicidal ideation at college (N = 94)	Sought treatment for episodes of psychological distress while at college	50% MODERATE 
Bantjes et al., (2020) South Africa (SA) 	Purposive sample of first year undergraduates at two universities, drawn from a larger sample (see Bruffaerts et al., 2019). N = 1402 M Age: [92.3% under 21][b] Undergrad: 100.0% Women: 55.0% Ethnicity: White 59.0%	Cross-sectional web-based survey	Suicidal thoughts or behaviours over the past 12 months (N = 491)	Receipt of treatment over the past 12 months for an emotional or substance problem (psychological counselling or medication)	95% HIGH 
Brownson et al., (2014) USA 	Purposive sample of students who were undergraduates and indicated racial affiliation, drawn from a larger sample (see Drum et al., 2009). N = 14,742 M Age: ND Undergrad: 100.0% Women: 62.0% Ethnicity: White 78.9%; Black 4.0%; Multiple Ethnicity 4.0%	Cross-sectional web-based survey	Seriously considered attempting suicide in the past 12 months (N = ND)	Received professional help after recognising they were seriously considering suicide.	81% HIGH 
Brownson et al., (2011) USA 	Same sample source as Drum et al., (2009). Stratified random sample of students from 70 colleges. N = 26,451 M Age: 25.5* Undergrad: 57.0%* Women: 61.0%* Ethnicity: White 76.0%*; Asian 5.1%*; Hispanic 5.0%*	Cross-sectional web-based survey	Seriously considered attempting suicide in the past 12 months (N = 1321)	After recognising that they were seriously considering suicide: (1) How many people told (2) The first person told (3) Received professional help	77% HIGH 

Bruffaerts et al., (2019) Australia, Belgium, Germany, Mexico, Northern Ireland, SA, Spain, USA 	Sample of all incoming first year undergraduate students at 19 colleges. N = 13,984 M Age: 19.3 Undergrad: 100.0% Women: 58.0% Ethnicity: ND	Cross-sectional web-based survey	Suicidal thoughts or behaviours over the past 12 months (N = 4573)	Receipt of treatment over the past 12 months for an emotional or substance problem (psychological counselling or medication)	95% HIGH 
Burton Denmark et al., (2012) USA 	Same sample source as Drum et al., (2009). Stratified random sample of students from 70 colleges. N = 26,451 M Age: 25.5* Undergrad: 57.0%* Women: 61.0%* Ethnicity: White 76.0%*; Asian 5.1%*; Hispanic 5.0%*	Cross-sectional web-based survey	Seriously considered attempting suicide in the past 12 months and did not tell anyone about their suicidal thoughts (N = 558)	Why did you decide not to tell anyone about your thoughts?	90% HIGH 
De Luca et al., (2014) USA 	Same sample source as Drum et al., (2009). Stratified random sample of students from 70 colleges. N = 26,451 M Age: 25.5* Undergrad: 57.0%* Women: 61.0%* Ethnicity: White 76.0%*; Asian 5.1%*; Hispanic 5.0%*	Cross-sectional web-based survey	Seriously considered attempting suicide in the past 12 months (N = 1321)	After recognising that they were seriously considering suicide: (1) How many people told (2) The first person told (3) Received professional help	86% HIGH 
Downs & Eisenberg (2012) USA 	Random sample of students from 15 colleges. N = 8487 M Age: [63.5% 22 years or below] Undergrad: 73.3% Women: 58.9% Ethnicity: White 63.1%; Asian 11.2%; Hispanic: 8.1%	Cross-sectional web-based survey	Seriously thought about suicide in the past 12 months (N = 543)	Engaged in formal treatment for mental or emotional health (counselling/therapy or prescription medications) currently and in the past year Which of the following were important reasons why you received those services? (9 options) Which of the following explain why you have not received medication or therapy for your mental or emotional health? (28 options)	96% HIGH 
Drum et al., (2009) USA 	Stratified random sample of students from 70 colleges. N = 26,451 M Age: 25.5* Undergrad: 57.0%*	Cross-sectional web-based survey	Seriously considered suicide in the past 12 months (N = 1321)	After recognising that they were seriously considering suicide: (1) How many people told (2) The first person told (3) Received professional help	63% MODERATE 

	Women: 61.0%* Ethnicity: White 76.0%*; Asian 5.1%*; Hispanic 5.0%*				
Furr et al., (2001) USA 	Convenience sample of students from four colleges. N = 1455 M Age: [82.0% were 18-24 years] Undergrad: 95.0% Women: 65.0% Ethnicity: ND	Cross-sectional paper-based survey	Had thought about suicide since coming to college (N = 125)	Had sought counselling to assist them when they were in a depressed state.	50% MODERATE 
Garlow et al., (2008) USA 	Convenience sample of students from one college. N = 729 M Age: ND Undergrad: 100% Women: 71.7% Ethnicity: White 67.3%; Asian 13.6%; African American 9.1%	Cross-sectional web-based survey	Suicidal ideation in the past 4 weeks (N = 81) Lifetime deliberate self-harm or suicide attempt (N = 120)	Receiving psychiatric treatment at the time assessment (pharmacotherapy or psychotherapy)	95% HIGH 
Gollust et al., (2008) USA 	Random sample of students from one college. N = 2843 M Age: [All over 18] Undergrad: 66.1% Women: 48.0% Ethnicity: White 60.6%; Asian 13.0%; Black 8%	Cross-sectional web-based survey	Self-harmed without intent to kill themselves in the past 4 weeks (N = 201)	Formal receipt of treatment (psychiatric medication or counselling/therapy visits) in the past year.	100% HIGH 
Han et al., (2016) USA 	Nationally representative data of people aged 18-25 years in the civilian, non-institutionalised population (N = 135,300), including a sub-sample of full-time college students. N = ND M Age: [Range: 18-25] Undergrad: ND Women: ND Ethnicity: ND	Cross-sectional in-person survey	Suicidal ideation and behaviour in the past 12 months (N = ND)	Receipt of mental health treatment (inpatient mental health treatment, outpatient mental health treatment, receipt of prescription medication for mental health problems).	96% HIGH 
Kisch et al., (2005) USA 	Random sample of students from 28 colleges N = 15,977 M Age: [Under 22 years: 62.0%] Undergrad: 88.6% Women: 65.0% Ethnicity: White 68.5%; Asian 10.8%; Hispanic: 8.8%	Cross-sectional paper-based survey	Seriously considered attempting suicide in the past school year (N = 1464) Attempted suicide in the past school year (N = 227)	Currently in therapy. Currently taking medication.	82% HIGH 
Nam et al., (2018) USA	Convenience sample of undergraduate psychology students from one college, who indicated lifetime suicidal ideation.	Cross-sectional, web-based survey	Suicidal ideation (N = 190)	Had an appointment with a psychiatrist, clinical psychologist, or other mental health professional over the past year.	86% HIGH

	N = 190 M Age: ND Undergrad: 100.0% Women: 68.4% Ethnicity: White 69.5%				
Samlan et al., (2020) USA 	Purposive sample of students from Downs & Eisenberg (2012) and the Healthy Minds Survey (2009-2013) from 83 college campuses, who seriously thought about suicide in the past year and did not receive psychiatric medication or psychotherapy during that year. N= 1817 M Age: [18-22: 76%] Undergrad: 81.9% Women: 52.1% Ethnicity: White 65.3%; Asian: 16.5%; Black 9.9%	Cross-sectional web-based survey	Seriously thought about suicide in the past year and did not receive psychiatric medication or psychotherapy during that year (N = 1817).	In the past 12 months, which of the following explain why you have not received medication or therapy for your mental or emotional health? (28 response options)	100% HIGH 
Schweitzer et al., (1995) Australia 	Convenience sample of undergraduate students from one college N = 1678 M Age: 21.9 Undergrad: 100.0% Women: 66.0% Ethnicity: White 92.0%; Asian 6.0%; Aboriginal and Torres Straight Islander <2%	Cross-sectional, paper-based survey	Suicide attempt in the previous year (N = 117*)	Use of mental health services (university counselling or private practitioner) in the previous year.	68% MODERATE 
Shannonhouse et al., (2020) USA 	Convenience sample of undergraduate students at two colleges N = 372 M Age: 21.7 Undergrad: 100.0% Women: 65.0% Ethnicity: White 49.0%	Cross-sectional web-based survey	Suicidal ideation in the past 12 months (N = 189)	After recognising suicidal ideation, how many people told.	73% MODERATE 
Wong et al., (2014) USA 	Purposive sample of Asian American or White American students who seriously considered suicide over the past 12 months, drawn from a larger sample (see Drum et al., 2009). N = 1045 M Age: 23.8 years Undergrad: 69.0% Women: 65.0% Ethnicity: White 94.0%; Asian 6.0%	Cross-sectional, web-based survey	Seriously considered suicide in the past 12 months (N = 1045)	After recognising that they were seriously considering suicide: (1) How many people told (2) The first person told (3) Received professional help	91% HIGH 

[a] = Not determinable from the article; [b] = Square brackets used to denote alternative summary statistics provided; * = Value has been imputed.

Data Synthesis

Rates of help-seeking

Fourteen population-based epidemiological studies reported on rates of help-seeking at university in students with a history of suicidal thoughts or self-harm (Arria et al., 2011; Bantjes et al., 2020; Bruffaerts et al., 2019; Downs & Eisenberg, 2012; Drum et al., 2009; Furr et al., 2001; Garlow et al., 2008; Gollust et al., 2008; Kisch et al., 2005; Han et al., 2016; Nam et al., 2018; Schweitzer et al., 1995; Shannonhouse et al., 2020; Wong et al., 2014). Table 2 summarises the rates of help-seeking reported in each study. Overall, 16.1-56.4% of students with suicidal thoughts or self-harm disclosed, sought, or received help for their mental health while at university (the range was similar when just looking at the nine high quality studies). There were methodological differences between studies, which may have contributed to this wide variation in rates of help-seeking, outlined below.

Studies varied in their definition and timeframe of help-seeking. In terms of disclosure, 39.0-54.0% of students told someone about their difficulties in the past year. In terms of professional help-seeking, 20.0-56.4% sought treatment while at college, 19.9-56.0% received treatment in the past year, and 16.1-31.6% of students were currently receiving treatment. This suggests that students disclosed their difficulties at a higher rate than they sought and received treatment. None of the studies compared rates of informal and formal help-seeking.

Studies also differed in measuring the timeframe of suicidal and/or self-harming experiences, ranging from 4 weeks to over the lifetime. This introduced heterogeneity, as if the timeframe was recent then people may not have had the opportunity to seek help yet, but if the timeframe was long (e.g., over the lifetime) then help-seeking while at university may have not been relevant. In the three high-quality studies looking at students with suicidal ideation only in the past 12 months (excluding those with suicide plans or attempts; Bantjes et al., 2020; Bruffaerts et al., 2019; Han et al., 2016), 19.9-31.3% received mental health treatment in the same timeframe. Receipt of treatment were higher in students with a suicide

plan (37.8-44.0%) or a suicide attempt (45.1-56.0%). The one study that looked at students with recent NSSI found that 26% of students received mental health treatment in the past year (Gollust et al., 2008). Studies typically used a single item with a dichotomous (Yes/No) response option to assess for suicidal thoughts and self-harm, which means there may have been considerable variation in the intensity, duration, and frequency of suicidal and self-harming experiences.

Despite the variation, overall, the results suggest that at least half of students did not seek or receive help for their mental health. However, in reality, rates of help-seeking may be lower than this. In a brief non-response survey, Gollust et al. (2008) found that there was significantly less use of mental health services in non-responders relative to responders. This suggests that students who participated in research were more likely to seek help for their mental health. Only four of these studies adjusted in some way for difference between survey respondents and non-respondents, which means bias may have been introduced between the intended and achieved samples (Bantjes et al., 2020; Bruffaerts et al., 2019; Downs & Eisenberg, 2012; Gollust et al., 2008).

Sources of help

Eight population-based epidemiological studies examined the sources of help sought or received by students (Downs & Eisenberg, 2012; Drum et al., 2009; Garlow et al., 2008; Gollust et al., 2008; Han et al., 2016; Kisch et al., 2005; Schweitzer et al., 1995; Wong et al., 2014). Drum et al. (2009) found that two thirds of students first chose to tell a peer, such as a romantic partner (30-41%), or a friend/roommate (25-36%). The next post popular confidant was a family member (27-30%), followed by a professional (11-20%). They found that almost no undergraduates and no graduate students first confided in an academic staff member. This study looked at who students first spoke to, but none of the studies compared overall rates of informal and formal help-seeking.

The studies measuring professional help-seeking indicated that the majority of students who had treatment received both medication and psychological therapy (Downs & Eisenberg, 2012; Gollust et al., 2008; Han et al., 2016; Kisch et al., 2005; Schweitzer et al., 1995). The largest high-quality study comparing sources of help-seeking found that most students with suicidal thoughts or behaviours reported receiving medication (23.6-44.1%) or other outpatient mental health treatment (21.0-40.9%), while a smaller proportion received inpatient treatment (1.6%-18.2%; Han et al., 2016). The same study found that students who had recently attempted suicide received inpatient treatment at a higher rate (18.2-19.9%) than those who reported suicidal ideation with no suicide attempts (1.6-3.3%).

No qualitative studies were identified in relation to this research question. The population-based epidemiological studies relied on multiple choice options, but there may have been sources of informal and formal support not captured by this approach. Only one study of moderate quality examined the temporality of help-seeking (i.e., who students first chose to speak to; Drum et al., 2009). Studies also did not measure whether students were seeking help for their suicidal thoughts/self-harm, or another concern.

Table 2

Summary of rates of help-seeking and sources of help

Condition studied	Reference	Measure of help-seeking	Timescale of help-seeking	Rate of help-seeking	Sources of help
Lifetime suicidal ideation	Nam et al., 2018 	Appointment with a psychiatrist, clinical psychologist, or other mental health professional	Past year	39.5%	
Suicidal ideation while at college	Aria et al., 2011 	Sought treatment for problems with emotions, nerves, or mental health	At college	56.4%*	
	Furr et al., 2001 	Sought counselling	At college	20.0%	
Suicidal ideation in the past 12 months	Downs & Eisenberg (2012) 	Receipt of treatment for mental or emotional health	Current	31.6%	Medication: 24.1% Therapy: 19.1%
	Kisch et al., 2005 	In therapy or taking medications	Current	18.3%*	Medication: 15.0% Therapy: 13.4% Medication and therapy: 10.1%
	Downs & Eisenberg (2012) 	Receipt of treatment for mental or emotional health	Past year	51.5%	Medication: 35.8% Therapy: 40.9%
	Drum et al., 2009 	Told someone	Past year	Undergrad: 54.0% Grad: 53.0%	*Of those who told others, who was the first person told?* Peer: 66.0% Family: 29.0%* Professional: 14.0%*
	Drum et al., 2009 	Received professional help	Past year	Undergrad: 48.0% Grad: 48.0%	*Of those who sought help, who from:* Counsellor: 66.6%+ Psychiatrist: 33.3%+
	Wong et al., 2014 	Received professional help	Past year	Asian American: 39.0% White American: 49.0%	

	Shannonhouse et al., 2020 	Told someone	Past year	48.8%	
	Wong et al., 2014 	Told someone	Past year	Asian American: 48.0% White American: 54.0%	*Of those who told others, who was the first person told?* For both Asian American and White American college students, the group of people to whom they most frequently disclosed their suicide ideation were their friends.
Suicidal ideation in the past 4 weeks	Garlow et al., 2008 	Psychiatric treatment (pharmacotherapy or psychotherapy)	Current	16.1%	Medication: 13.6% Therapy: 12.4% Medication and therapy: 9.9%
Suicide attempt in the past year/school year	Kisch et al., 2005 	In therapy or taking medications	Current	23.8%*	Medication: 20.7%* Therapy: 19.0%* Medication and therapy: 15.9%
	Schweitzer et al., 1995 	Use of mental health services	Past year	43.0%	Of those who reported suicide attempts in the previous year who used mental health services, 23% used university counselling, 43% utilised services of private practitioners, and 12.8% used both.
Lifetime suicide attempt or self-harm	Garlow et al., 2008 	Psychiatric treatment (pharmacotherapy or psychotherapy)	Current		Medication: 15.0% Therapy: 5.8%

Self-harm without intent to kill themselves in the past 4 weeks	Gollust et al., 2008 	Receipt of treatment or psychotropic medication for mental or emotional health	Past year	26.0%	Medication: 15.7% Therapy: 19.9%
Mixed suicidal thoughts and self-harm over the past 12 months	Bantjes et al., 2020 	Receipt of treatment (psychological counselling or medication)	Past year	Suicidal thoughts or behaviours: 35.0% Suicidal ideation only: 24.5% Suicide plan (no attempt): 41.6% Planned or unplanned suicide attempt: 52.9%	
	Bruffaerts et al., 2019 	Receipt of treatment (psychological counselling or medication)	Past year	Suicidal thoughts or behaviours: 29.5% Suicidal ideation only: 19.9% Suicide plan (no attempt): 37.8% Planned or unplanned suicide attempt: 45.1%	
	Han et al., 2016 	Receipt of mental health treatment (inpatient mental health treatment, outpatient mental health treatment, prescription medication for mental health problems)	Past year	Suicidal ideation only: 31.3% Suicidal ideation and plan: 44.0% Suicide attempt but no plan: 56.0% Suicide attempt with plan: 50.0%	Inpatient: 1.6-18.2% Outpatient: 21.0-40.9% Medication: 23.6-44.1%

* calculated from other values

Factors affecting help-seeking

Eleven studies examined the factors affecting help-seeking in students with suicidal ideation or self-harm. Nine of the studies examined factors that were correlated with help-seeking (Bantjes et al., 2020; Brownson et al., 2011; Brownson et al., 2014; Bruffaerts et al., 2019; De Luca et al., 2014; Downs & Eisenberg, 2012; Drum et al., 2009; Nam et al., 2018; Wong et al., 2014). Two studies asked students why they had not received medication or psychological therapy for their mental health problems, with 28 response options (Downs & Eisenberg, 2012; Samlan et al., 2020). One study was a content analysis of reported reasons for concealing suicidal ideation (Burton Denmark et al., 2012). Ten factors affecting help-seeking were identified in more than one study (see Table 3 for a summary of the studies, including discussion of the strength of the evidence).

Certain sub-groups of students were more likely to seek help than others. Women were more likely to seek help than men, especially more relational types of help-seeking such as telling informal contacts or seeking therapy (Brownson et al., 2011; Bruffaerts et al., 2019; Drum et al., 2009). Men more conclusively reported a preference for dealing with issues on their own (Samlan et al., 2020). There was some evidence of increased help-seeking among White students relative to Asian, Hispanic/Latin, and Black students, with specific barriers reported in each ethnic sub-group (Downs & Eisenberg, 2012; Samlan et al., 2020; Wong et al., 2014). There was not strong evidence for a link between sexuality and help-seeking (Bruffaerts et a., 2019; Downs & Eisenberg, 2012; Nam et al., 2018). Students with more severe suicidal ideation, a suicidal plan, and who had attempted suicide had higher rates of help-seeking (Bantjes et al., 2020; Bruffaerts et al., 2019; Drum et al., 2009; Han et al., 2016; Kisch et al., 2005).

Many studies found that negative attitudes towards mental health treatment were associated with reduced help-seeking. For instance, low perceived need was a commonly reported barrier to treatment among students, including questioning how serious their needs are, the belief that stress is normal in college, that the problem would get better by itself, and

low perceived risk of suicide (Burton Denmark et al., 2012; Downs & Eisenberg, 2012; Samlan et al., 2020). Several studies examined different kinds of stigma and its relationship with help-seeking. There was no evidence that personal stigma relating to having a mental health problem was correlated with service use (Nam et al., 2018). There was more evidence that personal stigma relating to service use was negatively correlated with treatment (Downs and Eisenberg; 2012). Many students self-reported perceived stigma towards using mental health services as a barrier to treatment, in terms of worrying what other people would think about them (Burton Denmark et al., 2012; Downs & Eisenberg; 2012; Samlan et al., 2020). Beliefs about the ineffectiveness of treatment and the unhelpfulness of potential confidants was an important barrier to disclosure and help-seeking (Burton Denmark et al., 2012; Downs & Eisenberg; 2012; Samlan et al., 2020). Finally, students' preference for privacy, and a desire to preserve autonomy was a commonly reported barrier to disclosure and help-seeking (Burton Denmark et al., 2012; Downs & Eisenberg; 2012; Samlan et al., 2020).

Studies also identified a number of social factors that influenced help-seeking. Being encouraged to seek help from others was commonly reported as an important reason for seeking help, and it was associated with increased treatment use (Downs & Eisenberg, 2012; Nam et al., 2018; Wong et al., 2014). However, the presence of informal support was associated with decreased treatment use and vice versa: the loss of informal support (e.g., relationship break-up or family problems) was associated with increased treatment use (De Luca et al., 2014; Downs & Eisenberg; 2012; Samlan et al., 2020).

Table 3

Summary of factors affecting help-seeking

Factor	No. of studies	Summary of findings
Severity of suicidal thoughts and behaviours	7	Drum et al. (2009) found that in students with past-year suicidal ideation, having more intense suicidal thoughts (reporting them to be strong or very strong), or thoughts with a greater impact on academic performance, increased odds of seeking professional help. Bruffaerts et al. (2019) found that past year suicidal ideation was associated with increased odds of receiving treatment relative to no ideation, and odds were even higher in those with a suicidal plan, and a recent suicide attempt. This pattern of increased help-seeking with a suicidal plan and recent suicide attempt was mirrored in other studies (Bantjes et al., 2020; Han et al., 2016; Kisch et al., 2005). Overall, these studies suggest there is strong evidence that more severe suicidal ideation and attempting suicide is linked with increased help-seeking. Only one study of psychology undergraduates found that suicidal ideation severity and intensity were not associated with service use (Nam et al., 2018). Related to this, a qualitative study found that one of the most common reason students gave for concealing suicidal ideation from others was perceiving themselves to be at low risk for attempting suicide (Burton Denmark et al., 2012). They described their suicidal thoughts lacking in intensity or seriousness, anticipating that the thoughts would pass, or that irrespective of the intensity they had decided not to act on them. This suggests that students consider their risk of suicide as a factor when deciding whether to seek help.
Gender	6	All studies conceptualised gender as a binary (men/women). None of the studies reported data on students who identify outside of the gender binary (e.g., non-binary/gender queer). Where differences were identified, this was in the direction of increased help-seeking among women (Brownson et al., 2011; Bruffaerts et al., 2019; Drum et al., 2009). Brownson et al. (2011) found that levels of formal help-seeking before and during periods of suicidal ideation were uniformly higher among women compared to men. An exception to this was medication for ideation: undergraduate men and women were similarly likely to take medication. Regarding informal help-seeking, women were more likely than men to tell someone about their suicidal thoughts. Men and women were similar in their choice of their first confidant, with most choosing to first tell a friend or romantic partner. Two studies found no association between gender and past year service use (Downs & Eisenberg, 2012; Nam et al., 2018). However, Nam et al. (2018) sampled psychology undergraduates, whose help-seeking habits may differ to the general student population; For instance, they may seek help more consistently regardless of their characteristics. Overall, this suggests there is evidence for increased help-seeking among women, especially more relational help-seeking (telling informal contacts or seeking therapy). This is reflected in a study of self-reported barriers to professional help-seeking (Samlan et al., 2020), where men more conclusively reported a preference for dealing with issues on their own.
Ethnicity	6	Two high quality studies identified differences in the direction of increased help-seeking among White students relative to Asian, Hispanic/Latin, and Black students (Downs & Eisenberg, 2012; Wong et al., 2014). Downs and Eisenberg (2012) compared individual ethnic groups and found a lower likelihood of treatment use among Asian and Latin students compared with White peers. Black students had lower rates of treatment use compared to White students,

		but this was not statistically significant. Similarly, Wong et al. (2014) found that Asian American students sought professional psychological help at a significantly lower rate than White American college students. These groups did not differ significantly in the number of people to whom they disclosed their suicidal ideation. However, Asian Americans received less advice from family members to seek professional help compared to White Americans, which was associated with lower rates of professional psychological help seeking. The three studies that found no difference between ethnic groups had methodological problems, which may have accounted for the findings, rather than an actual lack of difference between ethnic groups (Brownson et al., 2014; De Luca et al., 2014; Nam et al., 2018). In Brownson et al.'s (2014) study, there were low numbers of students in each ethnic minority group, which meant there was not enough power to detect significant differences. The other two studies made comparisons between "White" and "Non-White" students, which may have masked important differences within the "Non-White" category (De Luca et al., 2014; Nam et al., 2018). Overall, this suggests that there is evidence that in a US context, there may be increased help-seeking among White students relative to Asian, Hispanic/Latin, and possibly Black students (although this finding was non-significant). Samlan et al. (2020) identified differences in self-reported barriers to help-seeking among different ethnic groups, which could account for these findings. They found that Asian Americans students were more likely than White American students to endorse having no need for services, and less likely to endorse getting support from other sources as a reason for non-treatment. They also found that Asian students were more likely than any other ethnic group to report English language as a barrier to treatment use. Black students were more likely to highlight providers not being culturally sensitive and not thinking anyone can understand their problems, and less likely to endorse getting support from other sources as a reason for non-treatment. Hispanic/Latin students were more likely to report financial barriers than White students. Authors highlighted that free mental health services are offered at 92% of US campuses, so this finding may reflect less awareness of free treatment options. White students were more likely than their peers to report a bad experience with prior treatment as a barrier, although this may reflect higher rates of experiences with previous treatment.
Perceived need for help	4	Downs and Eisenberg (2012) found that respondents who endorsed perceived need for help were almost four times more likely to use treatment compared to those without perceived need. Similarly, reasons relating to low perceived need were some of the most commonly reported barriers to treatment in two studies ("I question how serious my needs are", "stress is normal in college", "the problem will get better by itself"; Downs & Eisenberg, 2012; Samlan et al., 2020). In Burton Denmark et al.'s (2012) qualitative study, the most common reason for concealing suicidal thoughts was low perceived risk of attempting suicide, which students equated with low perceived need for help. These findings across high quality quantitative and qualitative studies suggest that there is strong evidence that perceived need is linked to help-seeking, and that low perceived need was a common reason for students not seeking support. One exception to this pattern was that in a sample of psychology undergraduates with lifetime suicidal ideation, perceived need for mental health services in the past year was not associated with past year service utilisation (Nam et al., 2018).
Stigma	4	Four studies examined how personal (one's own stigmatising attitudes) and perceived stigma (perceived negative attitudes held by others) was related to help-seeking.
Personal stigma		Nam et al. (2018) found that a personal negative attitude towards people with mental health problems was not correlated with past year service utilisation. Burton Denmark et al. (2012) found that seven percent of students said they concealed suicidal ideation from others due to personal beliefs that contemplating suicide is somehow weak or

		wrong, including feelings of embarrassment, shame, or guilt in response to having suicidal thoughts. Downs and Eisenberg (2012) found that a personal negative attitude towards using mental health services was correlated with significantly lower likelihood of service use.
Perceived stigma		Downs and Eisenberg (2012) found that perceived negative attitudes towards using mental health services was correlated with increased likelihood of service use. The authors thought this finding may reflect the fact that use of treatment may make perceived stigma more salient. Conversely, they found that over a third of their sample endorsed "worry about what others will think of me" was a barrier to service use (this finding was replicated in a larger sample; Samlan et al., 2020). Burton Denmark et al. (2012) found around 1 in 10 students mentioned "others' negative reactions" as a reason for concealing suicidal ideation (e.g., rejecting, fearing, blaming, judging, or otherwise treating the student differently for contemplating suicide). Three studies also reported that students commonly feared negative repercussions from others, including academic setbacks or disciplinary action, loss of employment opportunities, and threats to important relationships (Burton Denmark et al., 2012; Downs & Eisenberg, 2012; Samlan et al., 2020).
Encouragement from others	3	Four studies found that being encouraged by others to seek help was a relevant factor in actual help-seeking. Downs and Eisenberg (2012) found that a total of 64% of students endorsed that encouragement from others was an important reason for seeking help; In this sample 42% were encouraged by family, 30% by friends, 9% by other people, and 8% of suicidal respondents reported that they were mandated to treatment by campus staff. Related to this, Wong et al. (2014) showed that in Asian Americans, not being advised to seek professional help was associated with lower rates of professional help seeking. Downs and Eisenberg (2012) also found that in students with past-year suicidal ideation, contact with 3 or more service users was related to therapy use, but not medication use. Nam et al. (2018) found that in psychology undergraduate students with lifetime suicidal ideation, being encouraged to seek help by others was a unique and strong factor related to past-year mental health utilisation. This may be a particularly pertinent factor for psychology undergraduates, who by virtue of their course, may be in contact with more people who would encourage them to seek help. Overall, these studies provide strong evidence that encouragement from others is an important factor in seeking professional help.
Usefulness of seeking help	3	Three studies examined whether beliefs about the usefulness of seeking help were related to actual help-seeking. Two of these studies focussed on professional help-seeking. Downs and Eisenberg (2012) found that in students with past-year suicidal ideation, beliefs in the effectiveness of therapy and medication were each significantly correlated with treatment use. Similarly, one in three students with recent suicidal ideation endorsed "questioning whether medication or therapy is helpful" as a barrier to treatment use (Downs & Eisenberg, 2012; Samlan et al., 2020). This evidence from two large overlapping high-quality studies suggests that beliefs in the effectiveness of treatment impact on treatment use, and that a high number of students may have doubts about treatment effectiveness. One qualitative study focussed on disclosure of suicidal thoughts (Burton Denmark et al., 2012). A key reason for concealing suicidal thoughts from others was beliefs regarding the "pointlessness of help-seeking". Students thought other people would not care, understand, or take them seriously. They highlighted a lack of confidants, due to lack of trust, proximity, comfort, or availability. For some students, this was based on prior, unsuccessful experiences of seeking help. Overall, these studies suggest that students' beliefs about the usefulness of help-seeking are important when they consider seeking informal or formal support.

Sexuality	3	Where differences were identified, this was in the direction of increased treatment use among lesbian, gay, bisexual, and queer students relative to heterosexual students (Bruffaerts et al., 2019), although in one study this was outside the bounds of conventional significance levels (p = 0.07; Downs & Eisenberg, 2012), and one study reported no association between sexuality and treatment use (Nam et al., 2018). Therefore, overall, there was not strong evidence for a link between sexuality and help-seeking among these studies.
Presence of informal support	3	Downs and Eisenberg (2012) and Samlan et al. (2020) reported that at least 1 in 5 students endorsed "I get a lot of support from other sources, such as friends and family" as a barrier to treatment use. Downs and Eisenberg (2012) found that those who endorsed higher levels of "warm and trusting relationships" were significantly less likely to use services. De Luca and colleagues (2014) found that across different ethnic groups, the loss of informal support (e.g., romantic break-up, family problems) was a facilitator for treatment use. Overall, these studies provide evidence that the presence of informal support may reduce perceived need for treatment, while the loss of informal support may increase perceived need for treatment.
Privacy and autonomy	3	In Downs and Eisenberg (2012), and Samlan et al.'s (2020) studies, a preference for dealing with issues on one's own (71.7%) was the most frequently endorsed barrier to treatment use in students with recent suicidal ideation. Similarly, in Burton Denmark et al.'s (2012) study, a common reason for concealing suicidal ideation was students' sense of themselves as a fundamentally private and self-sufficient person. Some responses expressed the student's inability to tolerate the discomfort of talking about feelings, having others know about them, receiving attention or sympathy from others, or a sense of pride in solving personal problems without help from other people. Students also worried that their confidents would feel burdened, overwhelmed, guilty, or feel responsible for having known about the students' suicidal thoughts in advance of their death. Students also feared the loss of autonomy in their life, including being forcibly hospitalised or expelled from their college or university. Seven percent of students also mentioned a desire to preserve their autonomy regarding the decision to attempt suicide. These students indicated that they did not want any type of help and they wanted to avoid any potential for interference with a suicide attempt. The fact that privacy and autonomy was such a commonly reported barrier across three high quality studies, suggests that it is an important factor influencing help-seeking.

Discussion

This review expands on previous research on help-seeking in people with suicidal thoughts and self-harm and focusses on the university student population. Studies identified a wide range in rates of help-seeking. However, the highest rates identified were around 50%. Most studies included data on rates and sources of professional help-seeking in suicidal individuals. This means that at least half of students with suicidal thoughts or self-harm do not disclose, seek, or receive help for their mental health at university. Furthermore, students who participate in research have shown higher rates of help-seeking, which suggests that actual rates of help-seeking may be even lower than this (Gollust et al., 2008). This suggests that interventions to improve professional help-seeking for suicidal thoughts and self-harm in a university context may be valuable.

Only the NSCCS dataset gathered information about informal sources of support. In line with previous research on young people, they found that university students first chose to tell a peer about their suicidal thoughts, followed by a family member. This suggests that friends may be particularly important gatekeepers for suicidal students. Therefore, it would be helpful for universities to prioritise resources into fostering social cohesion among students, to reduce the risk of students becoming socially isolated. This may be of particular relevance during the era of the COVID-19 pandemic, where students are at higher risk of social isolation (Loades et al., 2020). The current findings also showed that the presence of support from family and friends may reduce students' perceived need for mental health treatment. Studies conceptualised this as a barrier to treatment-seeking, but it could be considered a buffer that is protective to students' mental health. It could also be argued that students with suicidal thoughts and self-harm are a high-risk group, for whom professional support is important. There was strong evidence that being encouraged to seek professional support by others increased treatment rates. This highlights the importance of advising peers and families to support suicidal individuals by signposting them to mental health services.

There was very minimal research on support students received from university. One study suggested that very few students first chose to tell academic staff about their difficulties, but this does not indicate that students did not talk to university professionals at a later date. Indeed, research on the experiences of academics suggests that responding to students with complex mental health problems and high level of risk to themselves is an increasingly prominent part of their roles (Hughes et al., 2018). Therefore, it will be important for future research to determine the rates and nature of help-seeking from academic staff, to understand how to support staff to manage these situations effectively and safely. Some studies found that students received university counselling. However, it is unclear whether short-term counselling is an effective treatment for students with suicidal thoughts or self-harm, particularly those with more persistent or severe mental health presentations. As such, there have been calls for university counselling services to ensure effectiveness and safety, by gathering outcome data and student feedback (Hughes & Spanner, 2019).

This review found strong evidence that students with more severe suicidal thoughts and behaviours were more likely to seek or receive help. There were no studies that examined the link between depression or anxiety symptom severity and help-seeking, which may have confounded these findings. Nonetheless, this is in contrast with studies in adolescents, where more severe suicidal ideation has been associated with lower rates of help-seeking behaviours (Hom et al., 2015; Rickwood et al., 2005). University students do not show this pattern of help-negation, which may be due to increased mental health awareness relative to adolescents. Related to this, one of the most commonly reported barriers to disclosing suicidal ideation was perceiving oneself to be at low risk of attempting suicide, due to lack of intensity or seriousness of suicidal thoughts. This suggests that students consider their suicide risk when deciding whether to seek help. However, it also suggests that students experiencing less, or no suicidal ideation may not feel their experiences are serious enough to merit support. This may be pertinent to students engaging in NSSI. This highlights the potential danger of labelling this type of self-harm as “non-suicidal” as it may give the impression of it being less serious

condition, thus reducing help-seeking. Indeed, the majority of studies on self-harm focussed on suicide attempts and excluded students whose motivations were not explicitly suicidal ("NSSI"). However, this means that NSSI while at university was relatively under-researched, despite the fact that the presence of NSSI signals distress, mental health problems, and greatly increases a person's risk of future suicide. From a preventative perspective, it would be preferable to provide students with treatment before suicidal ideation is severe, to prevent escalation of distress and reduce risk of a suicide attempt. In addition, students with suicidal ideation commonly endorsed the belief that "stress is normal in college" as a barrier to treatment use. This suggests that students may benefit from psychoeducation to increase their knowledge that suicidal thoughts or self-harm, of any severity, are a sign that difficulties have escalated beyond "normal stress". Some universities have delivered programmes to educate their students about mental health problems and treatment (e.g., speakers, performances, flyers, newsletters), but few have been assessed for effectiveness in increasing help-seeking (Eisenberg et al., 2012).

Certain sub-groups of students were identified who were less likely to seek help. Previous research suggests that men are generally less likely to seek help for suicidal thoughts and self-harm (Hom et al., 2015), but more likely to seek help from emergency services (Michelmore & Hindley, 2012). The current review found that women were more likely to seek more relational types of help (informal support, therapy), but men were equally likely as women to take psychiatric medication. Men reported a preference for dealing with issues on their own, which may reflect cultural stigma, that men are taught that they should deal with problems alone (Samlan et al., 2020). Taking psychiatric medication may be more acceptable to men for this reason. It could also explain the previous finding that young men were more likely to seek help from emergency services, as they may wait until a crisis point before seeking support (Michelmore & Hindley, 2012). Overall, this suggests that efforts are needed to normalise men sharing their mental health problems with others. Mental health support for men could be enhanced by increasing the availability of self-help resources that can be

accessed independently. In line with previous research, Asian, Black, and Hispanic/Latin students had lower rates of help-seeking than White students. Previous research has highlighted barriers to care such as stigma, limited familiarity with mental health services, and concerns that providers may not be culturally competent (Hom et al., 2015). The current synthesis builds on this by identifying specific barriers to accessing treatment in each ethnic group. This highlights the utility for universities to understand the ethnic diversity in their student populations, and target efforts to improve help-seeking accordingly. Though previous studies have identified that adolescents who identify as LGBTQIA+ encounter more difficulties when getting help for emotional worries, in the current review of university students, there was not conclusive evidence to suggest that sexuality was a factor affecting help-seeking.

Other barriers identified included negative beliefs and attitudes to treatment, including a preference for dealing with issues on one's own, stigma, fear of loss of autonomy, and questioning whether medication or therapy is helpful. In line with previous research, personal stigma was associated with lower rates of help-seeking. Experiences of stigma were also reflected in many of the students' qualitative responses. Supporting findings from the general population, another common concern was fear of forced hospitalisation (Hom et al., 2015). However, results from this review showed that less than 4% of students with suicidal ideation were hospitalised, and some of this may have been voluntary admission. As such, students may benefit from information regarding the symptom severity that warrants inpatient treatment, and the potential benefits of this (Hom et al., 2015). Students also feared being expelled from college or university. This highlights the importance of universities working collaboratively with students in mental health crisis, to ensure that responsive support is provided that does not compromise the students' autonomy. One in three students with recent suicidal ideation reported questioning whether medication or therapy is helpful. This could reflect a lack of knowledge regarding the treatment effectiveness for mental health conditions. On the other hand, qualitative evidence suggests that this attitude may partly reflect students' previous negative experiences of receiving ineffective help. Indeed, recent reviews suggest

that there is limited evidence of effective interventions to reduce suicidal thoughts or self-harm (Barnett et al., 2021; Crawford et al., 2007; Platt & Niederkrotenthaler, 2020). This highlights an urgent need for further research and monitoring of treatment outcomes in this population. This is important because if students engage with treatment that is ineffective, this could reduce their inclination to seek help again in the future.

Methodological challenges

This review identified several sampling issues in the extant literature on help-seeking in university students. The majority of studies identified by this review were based in the US, and so the results of this review may have limited generalisability to other contexts where cultural attitudes, service configuration and provision may differ. Many of the studies in the extant literature base used convenience samples of students, and only a minority adjusted for differences between survey respondents and non-respondents. Students who participate in research showed higher rates of help-seeking (Gollust et al., 2008), so overall the results of these studies may have over-estimated help-seeking. Many of the studies were population-based epidemiological studies on student mental health, where students with suicidal ideation and self-harm were a sub-group. This means that discussion on help-seeking for suicidal thoughts and self-harm was often limited.

This review of the extent literature also highlighted the heterogeneity between studies in the definition and measurement of suicidal thoughts and self-harm. Studies varied in the timeframe of measurement (4 weeks – lifetime), and also typically used a single item with a dichotomous (Yes/No) response option to assess for suicidal thoughts or self-harm. This approach does not capture the intensity, duration, and frequency of suicidal and self-harming experiences. There was also heterogeneity in the measurement of help-seeking and treatment types. No studies compared overall rates of informal and formal help-seeking; only Drum and colleagues (2009) asked students who their first confidant was. There may have been sources of formal and informal support that were not captured by this measurement approach. Studies also did not measure whether students were seeking help for their suicidal thoughts/self-harm,

or another concern. High heterogeneity in the conditions studied and the outcomes chosen meant that meta-analysis was not possible, and the current review relied on narrative synthesis. The SWiM guidance was followed to ensure transparency in reporting in narrative synthesis without meta-analysis (Campbell et al., 2019).

Clinical implications and directions for future research

Given the low rates of students with suicidal thoughts and self-harm who seek help for their mental health, future research should focus on evaluating the effectiveness of interventions designed to target the factors identified in the current review. Other reviews have highlighted promising avenues for intervention, such as stigma reduction and education (e.g., Eisenberg et al., 2012; Hom et al., 2015). However, attitudes such as stigma are formed through an interaction between personal and public attitudes (Vogel et al., 2007), which suggests that one-off interventions may be of limited impact. Research suggests that whole university approaches may be more effective than individual interventions, involving multi-stranded interventions to promote change in attitudes at the systemic level, impacting the culture of the university itself (Hughes & Spanner, 2019).

Improving the evidence base on help-seeking will require multi-site investigations using consistent methods of measurement, to allow for more systematic groupings of conditions and outcomes. Future studies should systematically compare the relative rates of informal and formal disclosure, help-seeking, and receipt of support. Future epidemiological studies would benefit from using random samples of students and adjusting between respondents and non-respondents. Research with larger samples would also support appropriately powered investigations into help-seeking behaviours in different sub-groups of students. The extant help-seeking research mainly focusses on students with suicidal thoughts, and more research is needed on help-seeking in students who have self-harmed. Many studies investigated differences in help-seeking between men and women, and different ethnic groups. Further investigation is needed to understand patterns of help-seeking of LGBTQIA+ students. There were other sociodemographic factors that were not explored by

studies in the current review (e.g., age, religion, social class, disability), which could be usefully explored in future studies.

Help-seeking is likely to be closely linked to social and cultural context, as well as the local service configuration and provision. Therefore, it is crucial to expand the evidence base outside of the US, to understand the facilitators and barriers to help-seeking in other contexts. However, it is questionable whether surveys are an appropriate methodology in relation to the this. Surveys often used multiple choice or short free-text response options, whereas qualitative research generates more open-ended information, situated in its context, and captures the meaning behind students' responses. The current review only identified one qualitative study, investigating the reasons for concealing suicidal ideation. More qualitative research could contribute to a clearer typology of the sources of support sought and received, what students sought help for, their pathways to care, and perceived facilitators and barriers.

One of the key barriers to help-seeking in students was questioning whether medication or therapy is helpful for them. Future research should focus on identifying the most effective psychological treatments for students with these problems. Given the number of students who identified a preference for dealing with issues on one's own, it would be useful to evaluate the effectiveness of self-help resources for suicidal ideation and self-harm.

Conclusion

This review demonstrated that at least half of students with suicidal thoughts and self-harm do not seek help for their mental health while at university. Students' first choice of confidants may be their peers and family members. However, more research is needed into the formal and informal sources of support drawn upon, and students' pathways to care. This review identified a number of factors and self-reported barriers impeding help-seeking. Given the low rates of help-seeking among students with suicidal thoughts and self-harm, future research should focus on identifying effective treatments for this population, and interventions to improve help-seeking at university.

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Part 2: Empirical Paper

“Am I really the priority?”: The help-seeking experiences of students who self-harmed while at university

Abstract

Background

Self-harm is a growing problem in university students, associated with emotional distress, damage to the body, mental health difficulties, and completed suicide. Research suggests that less than half of students who have self-harmed seek any form of professional help while at university, though more may seek help from informal contacts.

Aims

The study aimed to understand the help-seeking experiences of students who had self-harmed while at university, to understand the perceived facilitators and barriers to receiving appropriate support.

Method

Participants were twelve students who had self-harmed while at university. They took part in two semi-structured interviews across the academic year, regarding their help-seeking experiences and suggestions for service improvements. These data were analysed using reflexive thematic analysis, within a critical realist framework (Braun & Clarke, 2006).

Results

Four themes were identified: “The beginning of university was the hardest part”, “My mental health problems needed to be severe”, “Escaping judgement, worry, and repercussions from others”, and “Choice and flexibility of treatment supported recovery”.

Conclusion

This understanding could inform adaptations to the current service model across university and healthcare systems, to respond better to students’ needs.

Introduction

The mental health problems of university students are attracting increasing concern. Epidemiological studies suggest 75% of mental health problems develop by the age of 24 years (Kessler et al., 2005). Most university students are below the age of 24, which means that many will come to university with a history of mental health difficulties or will develop problems while at university (Auerbach et al., 2018; Higher Education Statistics Agency, 2021). Research suggests that in young people, early intervention in mental health plays a crucial role in later outcomes (Kosky & Hardy, 1992). Therefore, university could be an important window of opportunity to prevent and treat mental health problems. However, there is evidence to suggest that many students experience poor mental health that persists throughout university (Bewick et al., 2010).

Self-harm, defined as any act of self-injury or self-poisoning, has been identified as an aspect of student mental health that requires urgent attention. At least 7-23% of students have self-harmed at least once, with high levels of repetition (Croyle & Waltz, 2007; Sivertsen et al., 2019; Whitlock et al., 2006). Self-harm is a behavioural manifestation of emotional distress that tends to be understood as a means for coping with difficult thoughts and feelings (Royal College of Psychiatrists [RCP], 2010). People can self-harm with suicidal intent, with ambivalence towards whether they live or die, or with no suicidal intent (RCP, 2010). Regardless of intent, people with a history of self-harm are at much greater risk of suicide when compared to the general population, and self-harm can also result in unintentional death (Hawton et al., 2003; Cooper et al., 2005). Universities UK and Papyrus (2018) have highlighted student suicide as a priority, and at least 64 university students took their lives in 2017-2022 (Office for National Statistics, 2022). People who have self-harmed often have at least one diagnosable mental health condition, so it is essential that people who have self-harmed receive appropriate support to resolve emotional distress, treat any mental health problems, and reduce risk of completed suicide (RCP, 2010).

Despite these risks, research suggests that less than half of students who have self-harmed seek any form of professional help for their mental health (Bruffaerts et al., 2019; Gollust et al., 2008; Han et al., 2019; Michelmore & Hindley, 2012). To understand this, studies have looked at what factors are correlated with help-seeking and treatment use. Negative attitudes and beliefs about mental illness and treatment, including stigma, have been significantly and negatively associated with help-seeking (including psychotropic medication, therapy, and non-clinical sources of support; Eisenberg et al., 2012). Perceptions of public stigma (negative attitudes held by others) influence self-stigma (negative attitudes towards oneself), which in turn, influence help-seeking attitudes (Vogel et al., 2007). As well as stigma, perceiving a need for help is strongly correlated with help-seeking. Students reported not needing help due to believing the problem will get better by itself, that stress is normal in college, questioning how serious the problem is, preferring to handle problems alone, and not having time to seek treatment (Eisenberg et al., 2011). Students' social context, such as having close friends or family members who have used treatment and being encouraged by others to seek help, have shown positive correlations with help-seeking (Eisenberg et al., 2011; Nam et al., 2018). However, receiving informal support from family and friends may also reduce the perceived need for treatment use, as students with higher levels of trusting relationships were less likely to use services (Downs & Eisenberg, 2012). Research suggests that on the whole, students with mental health problems tend to seek informal support, particularly from friends, more frequently than professional sources (Eisenberg et al., 2012).

However, these studies have focussed on university students with mental health problems in general. Help-seeking for self-harm may show different patterns of help-seeking. In relation to self-harm, greater physical severity or injuries, more physical pain during self-harm, more frequent engagement in self-harm, intensifying self-harm, more interpersonal influences, and suicidal thoughts make disclosure of self-harm more likely (Simone & Hamza, 2020). This suggests that disclosure may become increasing likely as distress increases. One study reported that undergraduate students who had disclosed self-harm had a greater desire

to stop self-injuring, which suggests that disclosure can sometimes be a first step towards recovery (Armiento et al., 2014). However, these studies examined disclosure, which is the act of telling someone about self-harm regardless of motivation, whereas help-seeking involves telling somebody specifically with the purpose of receiving help and/or support from the other individual (Simone & Hamza, 2020).

The extant literature on help-seeking is dominated by correlational studies in university students with mental health problems. Correlational studies, while helpful in identifying potential factors affecting help-seeking, do not capture students' lived experiences of help-seeking. There is also less research focused specifically on those who have self-harmed, who present with a potentially different pattern of need. The few qualitative studies that have been conducted report that self-harm is often kept secret, due to the feelings of shame surrounding it, which is linked to the stigma of self-harm (Cliffe & Stallard, 2022; Rosenrot & Lewis, 2020). Students felt that 'others' perceived self-harm as "more severe" than other mental health difficulties and feared that disclosure to informal contacts would result in rejection, judgement, or compromised future life opportunities (Cliffe & Stallard, 2022; Simone & Hamza, 2020). Students also feared that disclosure of self-harm would upset or burden informal contacts (Rosenrot & Lewis, 2020). Due to these concerns, some students said they would not approach friends and family for support with self-harm, or there would be limits on how much they could share with them (Cliffe & Stallard, 2022). In Cliffe and Stallard's (2022) qualitative study, some students said they would feel more comfortable talking to professionals about self-harm. However, many did not mention self-harm to professionals when seeking help for their mental health, because they did not feel that self-harm was their key issue. Students highlighted that the most important outcome of support would be to address their underlying distress, not stopping self-harm. They also reported access issues such as not knowing where to access support, long waiting lists, and being turned away from health services due to their self-harm not being perceived as severe enough (Cliffe & Stallard, 2022). Overall, these

findings suggest that students who have self-harmed often do not seek help for this, and if they do, there are significant access issues.

Help-seeking behaviour is dependent on a person's context, including what informal and formal support is available. In the UK, students can access to professional mental health support from the NHS, their university, Students' Union, third sector organisations, and private practice psychotherapy. Though universities have a general, common-law duty of care to their students in the UK, until recently, there has been limited guidance on how universities should support the mental health and wellbeing of their students. To address this issue, Universities UK (2020) launched the Step Change Framework, and the University Mental Health Charter (Hughes & Spanner, 2019), to work towards a 'whole university' approach to mental health, which foregrounds student mental health as a strategic aim of institutions. They recommend adequately resourced, effective, and accessible mental health interventions, as well as a culture that supports good mental health (Hughes & Spanner, 2019). However, the Charter acknowledges that the issue of student mental health is not something any university can do alone. Collaboration across sectors is likely to lead to better understanding and more effective responses to student mental health. Despite the possibility of strong, multi-agency support, evidence suggests that students find the current systems of support confusing and disjointed (Barnett et al., 2021), and cross-sector fragmentation is common (Duffy et al., 2019).

Cliffe and Stallard's (2022) research is the only recent UK qualitative study on help-seeking in university students who have self-harmed. Their study investigated what type of professional support students would consider receiving for self-harm. The extant research has not investigated the broader help-seeking experiences of students who had self-harmed while at university, including informal support from social networks, university staff, clinical staff, and others. Previous studies have neglected the role of contextual factors, such as the place of university staff in supporting students' mental health problems. There is evidence to suggest that this is an increasingly prominent part of their roles (Hughes & Spanner, 2019) so its significance in students' constructions around support needs investigation. Interrogating

students' overall help-seeking experiences would also help to understand how the different sources of support available interact with each other. This could inform adaptations to the current service model, to support a multi-agency response to respond to students' mental health needs. Historically, those receiving mental health care have been viewed as recipients, as opposed to active partners in their care. The World Health Organisation has argued that people with mental health problems should participate in decisions regarding their care (Baumann, 2014). Therefore, a service delivery model influenced by the views of students may better identify, assess, and respond to their needs, encouraging service uptake (Barnett et al., 2021). To this end, the present study conducted in-depth interviews with students who had self-harmed while at a UK university, to understand their decisions regarding sources of support, experiences of seeking help, and recommendations for services development. The design of the study was also influenced by a steering group of students with mental health difficulties and self-harm.

Methods

Design

This study formed part of a larger-scale qualitative project, joint with KH, recruiting students who had self-harmed while at a London university (see Appendix 2 for details of collaboration). This study focussed on students' experiences of help-seeking for their mental health difficulties and self-harm while at university, while KH's study focussed on their experiences of online activities and social media usage (Hajdú, 2022). The project was funded by the British Psychological Society Division of Clinical Psychology, under the Supporting Students at Risk (SstaR) project, and the UCL Clinical Psychology Doctoral Training Course. All procedures were approved by the University College London Research Ethics Committee, reference number: 16733/003 (see Appendix 3 for letter of ethical approval).

The design was informed by a steering group of six students at the university with experiences of mental health problems. They were recruited on a first come-first serve basis

via advertisements in newsletters and social media (see Appendix 4 for poster). They were consulted as a group on three occasions via videoconference and reimbursed £20 for each meeting. The aim was to maximise the relevance and acceptability of the project to students at the university. They were consulted on methods of recruitment, data collection, the content of interview schedules, and appropriate ways to discuss sensitive topics such as self-harm.

Data collection for the project consisted of questions relevant the current study and KH's study. This included a pre-interview survey and semi-structured interview (approximately 1.5 hours), conducted at two time-points, approximately three months apart, in April (T1) and July (T2) 2021. Students were reimbursed £5 for each questionnaire and £15 for each interview. Surveys were gathered to provide descriptive information about participants and identify prompts for discussion in the interviews. The steering group recommended that having a pre-survey interview may allow participants to share sensitive information by text, to "break the ice", which could then be gently elaborated upon in interviews. They also recommended conducting interviews at two time points to gather more in-depth data, to build rapport and facilitate the sharing of more sensitive information, and to capture experiences throughout the academic year as university demands and access to support may have varied (e.g., Barker et al., 2018). The project took place in the context of the COVID-19 pandemic, so contact with participants was remote, including online surveys and virtual interviews via videoconference. Prior to T1, England was in its third national lockdown. During the lockdowns, students had to study remotely. By T2 all legal limits on social contact had been lifted.

Participants

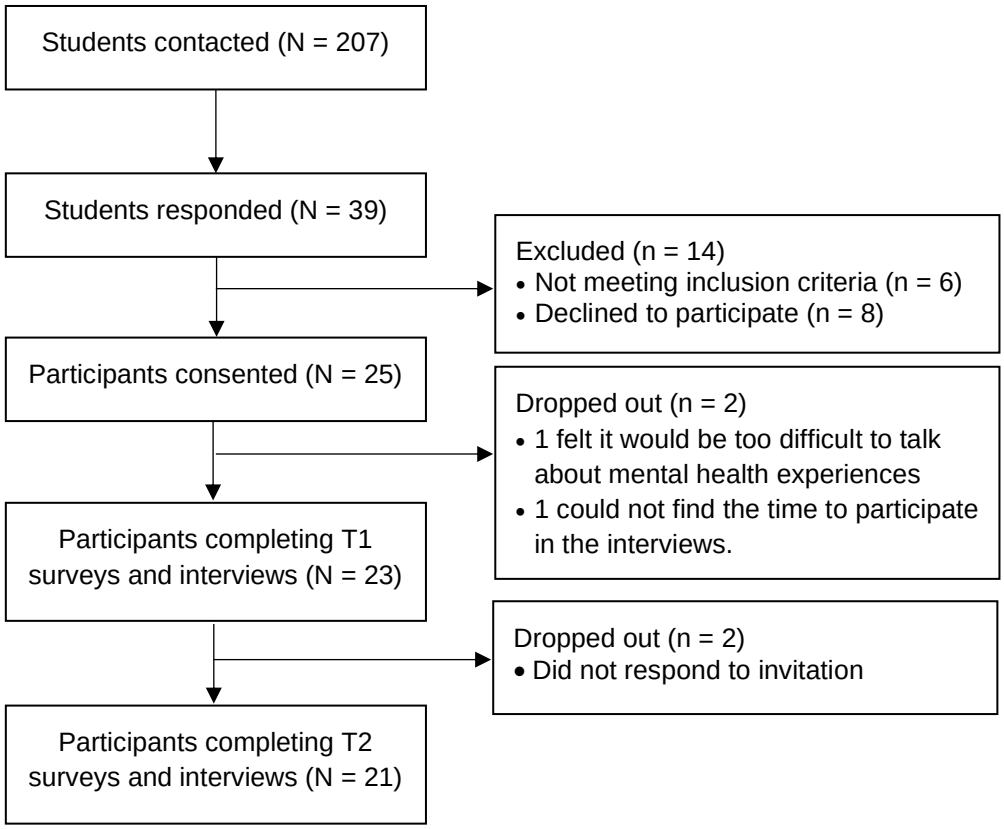
Recruitment

As mentioned above, participants were recruited as part of a larger-scale project joint with KH. Students were identified who said that they had recently self-harmed in two university-wide mental health surveys, the SENSE (ref: 14685/001), and the IMPACTS (ref: 14685/001) studies ("Have you hurt yourself on purpose in any way in the past 12 months

(e.g., by taking an overdose of pills or by cutting yourself?"). Those who had indicated "yes" and had agreed to be contacted for future research were emailed information about the study (see Appendix 5 for recruitment materials). Of those who indicated interest, the researchers checked eligibility to participate. Students were included if they were 18 years of age or over, a current student at the university, and residing in the UK. Informed consent was obtained electronically from eligible participants before data collection (see Appendix 6 for consent forms). Students were included on a first come-first-serve basis and reimbursed for their time. Twenty-five students consented to take part in the project (see Figure 1 for recruitment flow).

Figure 1

Recruitment progression for the larger project



This study analysed the subset of participants interviewed by the author (N = 13), to retain researcher reflexivity throughout the interview process. At T1, one student dropped out prior to interview because they decided it would be too difficult to discuss their mental health,

resulting in a final sample of 12 students. At T2, all 12 students consented to take part in the study, but one dropped out as they forgot to attend the interview and then did not respond to subsequent attempts to contact them (N = 11).

Materials

Online survey

At T1, the survey asked for demographic information (gender, age, UK/International student status, sexuality, domiciled country, ethnicity, and level of study), and the Counseling Center Assessment of Psychological Symptoms (CCAPS-62; Locke et al., 2011). The CCAPS-62 is a 62-item measure of student psychological distress, commonly used in university counselling centres, and psychometrically validated in UK student samples (Broglia et al., 2017). At T1 and T2, the surveys also gathered information on current and historical mental health concerns and diagnoses, service use, and frequency and method of self-harm (see Appendix 7 for survey questions). These questions were gathered to describe the sample and generate personalised prompts for the semi-structured interviews. As this was part of a larger project, the survey also included a measure of loneliness and online activities, which were not analysed in this study.

Semi-structured interviews

The interviews were structured by a topic guide, including open-ended questions to elicit detailed responses (see Appendix 8 for full interview schedule). The steering group were consulted on the interview topics and commented on a draft, to produce the final interview schedule. During the interviews, the researcher inputted minimally to give the participant space to tell their story, with flexible prompts to encourage them to elaborate on responses.

For the present study, students were encouraged to think about their experiences on a “timeline” to ascertain the chronology of experiences. At T1, the opening questions were about student’s mental health problems, to set the scene for the following questions about students’ help-seeking for these difficulties, focussed on eliciting perceived facilitators and

barriers. Then, the questions focussed on self-harm, first asking background information about experiences of self-harm, and moving on to ask about help-seeking for this. Questions about help-seeking were primarily focussed on experiences while at university, though experiences prior to university were also discussed to provide context. Then the interview questions elicited sources of support that students were aware of but had not approached, to try and elicit further barriers. The interview ended with a future focus to think about any anticipated help-seeking, and a 'clean-up' question to allow participants to raise issues that were important to them that have not already been covered (Braun & Clarke, 2013). T2 followed a similar structure but focussed on experiences of mental health and help-seeking since the following interview. There were additional sections to encourage participants to reflect more explicitly on perceived facilitators (What helped you to get the support you needed?) and barriers while at university (What got in the way of you getting the support you needed?). The final questions intended to elicit students' suggestions for improvements to mental health services, and a final clean-up question. As this was part of a larger project, the interviews also included questions relating to social media usage, which were not analysed in this study.

Data analysis

The online survey data were used to describe the sample's demographic characteristics, mental health history, self-harm behaviours, and service use. The interview data were analysed using reflexive thematic analysis (RTA) to identify and report themes within the data within a critical realist framework (Braun & Clarke, 2006; 2019; 2020). RTA was chosen in line with this philosophical paradigm because it allowed analyses of the data in a way that reflected students' accounts of help-seeking, while acknowledging the influence of the researcher's position. The analysis was more of an inductive and semantic process, meaning that coding was data-driven and not explicitly influenced by existing theories. The T1 and T2 interviews were analysed as one dataset, as the purpose of including two time points was to gather in-depth data, and not to compare differences between T1 and T2.

Broadly, the following steps were taken: The interview data were recorded and transcribed automatically by the videoconferencing software. These transcriptions were anonymised, refined, and then read and re-read to familiarise the researcher to the data. At this point, the research took notes of initial observations of trends in the data (see Appendix 9). Then, the data were uploaded to NVivo to begin the preliminary coding process. The researcher worked systematically through the whole dataset, to code aspects of data items relevant to the research questions. An excerpt of this coding process on one participant's interview transcript is presented in Appendix 10. At this point, KH coded a transcript from the dataset, and these codes were compared with the researcher's and discussed to encourage reflexivity. The codes were very similar, but the discussion elicited different interpretations of their meaning and relationship to other codes. Next, the researcher examined all the codes and associated data items, to consider how they might combine to generate themes. Then, the themes were reviewed for internal consistency, ensuring there were clear and identifiable distinctions between themes. By the end of this phase, the researcher had produced candidate themes and sub-themes. Then, a detailed analysis was written for each theme, selecting illustrative quotations to represent each one. This was an iterative process, moving back and forth between the phases (Braun & Clarke, 2020). Quotations were linked to randomly assigned ID numbers in order to protect participants' anonymity.

Researcher position

Throughout the research process, I engaged in the self-reflexive process of bracketing, where I brought awareness to my own perspective, pre-existing thoughts and beliefs, and developing hypotheses (Starks & Trinidad, 2007). The purpose of this was to critically reflect on the ways that I as the researcher may have affected the process (Braun & Clarke, 2013). This included a bracketing interview (see Appendix 11 for full transcript), a reflexive diary, and reflective discussions with my supervisor, co-researcher, and the steering group.

I am a doctoral student at the same university as my participants. Therefore, I came to the study with my own experiences of being a student and engaging with university systems

and support services. When I was an undergraduate student at a different university, I recall experiences of friends struggling to access support for self-harm. This influenced my motivation to conduct the research, to give voice to students and influence systems to become more accessible. I expect that having a shared identity with my participants as a 'student' helped to foster an alliance between us, which enabled more open sharing of their experiences. However, I noticed my expectation that students would have had similar experiences to those that I had previously experienced at another institution. I reviewed my interview schedule to ensure questions were open, to capture all types of experiences. As well as being a student, I am a trainee clinical psychologist, which means that I believe that psychological approaches to supporting people are often effective and helpful. However, in my interviews I wanted to interrogate all aspects of help-seeking, not just psychological therapy. I discussed this with the steering group in advance, to gain a more balanced view of all the potential source of support that students may be interested in. During interviews and analysis, I brought curiosity to examples of successful help-seeking, alongside challenges.

Results

Demographics

Of the 12 participants, there were eight undergraduate students (67%) and four were doctoral students (33%). The majority were UK fee paying (92%), with one overseas student. They were aged between 20 and 29 (M = 23.3, SD = 3.3). Participants mostly described their ethnicity as white (58%), and two as Asian or Asian British (17%), one as mixed ethnicity, one as Black British, and one as South American.

The participants were mostly cisgender women (83%), with one transgender man, and one non-binary person. The majority of the participants identified as bisexual (50%), followed by heterosexual (33%), one lesbian, and one questioning their sexuality. Therefore, the majority of the sample were LGBTQIA+ (67%).

Mental health

All participants said that they had experienced mental health problems while at university. Most said that these problems had their onset before university (92%). When asked to describe their mental health problems, all participants mentioned ‘anxiety’ or an anxiety disorder, eleven depression or suicidal ideation (92%), five an eating disorder (42%), one emotionally unstable personality disorder (EUPD), and one bipolar disorder. Comorbidity was the norm, with all participants identifying more than one mental health issue. Two students also mentioned autism spectrum disorders (ASD).

Psychological distress scores were computed from the CCAPS items at T1. Only one student (8%) fell in the low distress range, indicating minimal or no distress. Six students (50%) were in the moderate distress category with scores similar to students seeking psychological treatment. Five students (42%) were in the elevated distress range and likely would meet diagnostic criteria for one or more psychological disorders.

Self-harm

Students were recruited on the basis that they indicated that they had self-harmed while at university. Mostly the onset of this was prior to starting university (83%). Students reported the number of times they had self-harmed while at university: 25% 1-5 times, 33% 5-10 times, 8% 10-12 times, 17% 20+ times, and 17% were not sure or preferred not to say.

In terms of the methods of self-harm, ten students said they had cut, scratched, or stabbed themselves (83%), three had punched or hit themselves (25%), two had burnt themselves with fire or hot objects (17%), and two had choked themselves or tied ligatures (17%). Students also mentioned banging their head against the wall (8%), ingesting toxic substances (8%), hair pulling (8%), and biting themselves (8%).

More typically classed as ‘indirect’ self-harm (RCP, 2010), two students said they starved themselves as a form of self-harm (17%), one mentioned deliberate sleep deprivation (8%), and one identified substance misuse as self-harm (8%).

Mental health service use

All participants said that they have received therapy or counselling for a mental or emotional problem before. The majority indicated that this experience had been positive (58%), or neither positive nor negative (33%), and only one student said this experience was negative (8%). Almost all participants (92%) said that they had taken medication for a mental or emotional problem before. Students' experiences of medication were more mixed, with 33% saying the experience had been positive, 17% saying it was neither positive nor negative, and 42% saying it had been negative.

Themes

The analysis of the interviews at T1 and T2 generated four themes, which were organised into sub-themes (see Table 1).

Table 1

Summary and description of themes

Theme	Description	Sub-themes
The beginning of university was the hardest part	Starting university was often the hardest stage of help-seeking, as students had to establish new systems of informal and formal support alongside balancing the demands of student life and the transition to adulthood.	Suddenly no one knows your name I didn't know how to access services Being shipped from person to person
Mental health problems needed to be severe	Some students felt their mental health problems were not serious enough to ask for help from over-burdened mental health services where the severest presentations were prioritised for support.	My problems were not bad enough I needed to get worse to deserve support Diagnosis validated that my problems were bad enough
Escaping judgement, worry, and repercussions from others	Students shared information about their mental health and self-harm selectively to try and control the impression other people formed of them, to reduce the impact of stigma and to maintain autonomy.	I didn't want people to judge me When they freak out it freaks me out Avoiding negative consequences
Choice and flexibility of treatment supported recovery	Students wanted their needs and preferences to be at the heart of decisions around mental health treatment and felt that this was instrumental in their recovery.	Treatments to suit my preference Long-term support for long-standing problems

The beginning of university was the hardest part.

Suddenly no one knows your name. Students found starting university one of the most difficult stages in their help-seeking journey, as it often coincided with leaving behind previous systems of support and feeling lonely: “I very much felt like one in about a million, and no one knew who I was.” [118]. Students approached close contacts for emotional support and advice with mental health problems (family, romantic partners, close friends). However, some did not arrive with a close network, because their friends and families were abroad, or because relationships had broken down. Undergraduate students experienced a developmental shift from school, where teachers and parents were always present for emotional support, to university, when suddenly supportive adult figures were not as available to them. From the outset, they felt the university expected them to take “responsibility for your own mental health” because as a student you were “supposed to be an adult” [118]. This transition was described as being too harsh and sudden:

> I get that we’re adults, so it’s good to be less hand-holdy, but […] I don’t think that means like, people should just be running loose and having no emotional support, and […] leaving home for the first time and then they’re just like ‘OK, deal with it,’ you know? [103]

Some students found it difficult to make friends due to their mental health difficulties (e.g., social anxiety, low self-esteem, low mood). They said the resultant feelings of loneliness exacerbated their mental health difficulties, and in turn meant that support felt less accessible. Students described how organised structures such as societies or mentorship programmes, introduced them to peers with shared facets of their identity (e.g., other students with mental health problems, autism, who were LGBTQIA+), enabling friendships and peer support networks to form. Some students found it difficult to approach others to talk about their mental health, so they found it really helpful when others “checked in” on their mental health proactively:

> I remember one time he [the warden] also checked up on me, he was like "I haven't seen you for a few weeks are you OK?" And I was like "No, but I'm getting like help so it's fine." He's like "That's fine." So that was really good […] 'cause I think like, that idea of like building a community is like very important beyond just like getting psychological help. [123]

However, having people to "check in" relied on developing those social connections. Therefore, students suggested having someone allocated from the university who could check in on them regularly. Students commented that their personal tutor was the only guaranteed point of contact throughout university, but some were "more interested in like doing their research for their work rather than engaging with students". Students acknowledged that tutors are not "therapists or counsellors", but there was a need for more consistency so all tutors "feel comfortable talking to you" and "can direct you to whatever services." [103]. Students called for tutors to consider emotional health alongside their academic progress:

> It doesn't really feel like support for your life in general or for things to improve in general. […] Everything is very academic focussed […] It's a question of […] Do you want to support students in their studies, or do you want to support students full stop? [110]

I didn't know how to access services. Students found it difficult to seek help when they lacked awareness of support services. Many had left behind valued sources of professional support when they started university (e.g., CAMHS, GPs). Declaring a mental health diagnosis as a disability to the university helped in setting up new support systems (e.g., access to a mentor, reasonable adjustments, mental health assessments). However, some did not realise you could do this, as they thought "disability" related to physical health or learning disabilities. Additionally, many were unsure if they had ever received an official "diagnosis" from a professional. A student who arrived at university with a history of PTSD, anorexia, and depression, described how this delayed valuable academic support:

> I didn't know that I was entitled [for support] at all [...] But I like never, actively told [the university] on my application process and I think it like, apparently, under UCAS comes under disabilities, which like never entered my head to talk about. [108]

Students did not recall information about support being communicated directly by the university, which meant they heard through "gossip" and "chatting to people around you" [110]. A student described how this discouraged them from approaching the university for support:

> I know that the university has a counselling service, but in first year I heard a lot of negative things about it […] I heard that the waiting times were too long, that you could only get an appointment if you were like suicidal or in a very extreme position […] I regret not doing my own research and just basing it off of other peoples' experiences or reputation. [103]

Students said it would be helpful for information about services to be delivered during mandatory contact, such as part of dedicated mental health orientation sessions at the start of university. Student said they did not want more information delivered to them by email, as they already received too much content and found it difficult to engage with this.

Being shipped from person to person. Once students had approached services for support, they experienced a lack of integration in university and health services, which delayed receiving treatment. For instance, university services often signposted students on for further support within private practice psychotherapy or the NHS. Though signposting was viewed as helpful, students also felt disappointed that they had worked hard to access services in the first place (e.g., long referral form, waiting list, assessment interview) only to be sent elsewhere to repeat the process. Some students said that their help-seeking journey "trailed off" at this point. One student described how this process led to a deterioration in her mental health:

> Being shipped from person to person and referral to referral saying you know they don't know what's wrong with me […] All the referrals like that took another, six months. And in between that time it was […] lots of self-harming. I had kind of an attempt, erm, and like lots of, massive mood swings, really, erm, low, low suicidal moods. [108]

Students said they needed to advocate for themselves to receive further support, by insisting on the severity of problems, or checking that referrals had been processed. However, not all students felt able to advocate for themselves and felt “discouraged from things not working perfectly the first time” at university where you are “just so busy, you’ve got so much pressure on you, and you kind of don’t always have the time you need to really get through a problem.” [107]. Students called for more integration between services, and to “put everyone in the same room with my questions and […] figure it out” [100]. Students suggested having university staff with a healthcare background as a “bridge” between the university and healthcare systems.

Mental health problems needed to be severe.

My problems were not bad enough. Students were sometimes hesitant to ask for help, as they believed that their problems were not serious enough to deserve support from others, and would be dismissed:

> They might feel that I’m kind of whining ‘cause I do tell that myself like “You shouldn’t be feeling like this […] You don’t have a reason to become like this, then everyone else will think the same, so don’t bother them or don’t call them.” [117]

Some students *wanted* to believe their problems were not serious, due to negative beliefs about needing mental health treatment. They preferred to deal with issues on their own:

> How long do I have to, you know, keep doing this before I can just go off into the world? And I think I'm sort of hesitant to be a problem again. Erm, which is obviously like influenced by my own like stigma […] In a perfect world, I would not feel this, but I do. [110]

Stress was normalised among students, and they dismissed the symptoms of mental health difficulties (e.g., insomnia, changed appetite, self-neglect, substance misuse) as “normal student stress” that everyone was coping with. Students also had the impression that university and NHS services were over-burdened, and they did not want to take the place from a person who needed the help more. A student who had struggled with depression and self-harm since adolescence described how this delayed seeking help from the NHS:

> It's always been a problem in terms of like, me like, seeking, sort of formal support, or even informal support from friends and stuff, is like, like ((sighs, pause)). Things are bad, but […] I'm not actively like standing on the edge of a bridge. […] Even when I'm seeking like, help from like the NHS […] am I really like, you know, the priority here? [118]

Generally, problems were viewed as worthy of support if they compromised physical health or safety, for instance if self-harm was suicidal in nature. Students felt they should only ask for help from the university if their problems were seriously impacting their studies.

I needed to get worse to deserve support. Students compared themselves to peers and used this information to judge how bad their problems were. They found it invalidating if they perceived others' problems were worse, which led to the belief that they needed to get worse to prove they needed support:

> I get really like, weirdly, I get embarrassed if people have like deeper cuts. I feel like they'll tell me that like what I've gone through isn't real and I feel the need to make up for it. [110]

In some cases, this belief was reinforced by interactions with health professionals (e.g., GPs), where students received dismissing responses to their requests for mental health support:

> The doctors said that I'm fine, then I'm not that sick […] I was hoping that by getting worse, I would finally get help 'cause I felt unwell. Which is actually what happened […] About eight months after I had to go to the hospital because of a beginning of the beginning of organ failure because of anorexia ((laughs)) that's when they reacted which is a bit late and referred me to a specialist in an eating disorder hospital. [100]

Another student also said they felt that "asking for help" from GPs was not always enough, and you only received their attention if your physical safety became compromised:

> I just had to really, really, push, and this is sad to say, but I think unfortunately sometimes me, having gone A&E, or had something, had a bit of a crisis, gave the GP the push that

they needed, if that makes sense. Like, it's sad that it had to be that way, that me going and having a conversation with them, and asking for help wasn't enough. [108]

Diagnosis validated that my problems were bad enough. Some students sought a mental health diagnosis from the NHS. Having a diagnosis in turn made it easier to access appropriate services within the NHS and academic support from the university. A student who was diagnosed with a personality disorder described how this contributed to a sense of relief and validation that they deserved professional support:

> It has changed how I feel about myself, in that it has actually been really affirming to me, to like know that there is this thing wrong with me. But that then like, I can get help and it can be treated. [108]

However, by seeking support in the NHS, they felt they needed to engage in a more medicalised or pathologising view of their mental health difficulties:

> Like they were showing us brain scans of how people who have what, you know, we're all diagnosed with, their brains look, look different […] And that felt quite like, scary and intimidating to me […] this, this sounds bad and like pathologising but, it feels like it was just like scientifically showing how messed up we were. [108]

For this reason, some students did not seek support from the NHS, because they did not want to receive a diagnosis:

> I'm just, I'm scared […] To actually have something permanent, in a way, that is, that is not separable from me. Erm, it feels like a bigger thing. [110]

Some students sought a less medicalised route to receiving support, though this involved paying for private psychotherapy. One student described how they received a diagnosis of bipolar disorder, but did not want medication from the NHS and so sought private therapy:

> I didn't really mind the diagnosis, but I didn't want to be treated with Lithium […] My psychotherapy has been very focused on like… trying to not label myself as depressed and

> […] just allowing emotions through and […] not "This is me and this is what I'm like, and I'm always going to be this way." [105]

Escaping judgement, worry, and repercussions from others.

I didn't want people to judge me. Students were selective about who they disclosed their mental health difficulties to, due to fear of being judged by others, and because talking about your mental health problems could be construed as "attention-seeking". Discussions about mental health were often reserved for trusted friends and family members. In addition, students were more secretive about self-harm relative to other mental health problems. This was because they feared that talking about self-harm could "trigger" people into doing the same, and because people may have reacted badly in the past:

> Because of people's reactions to it, it's completely demonised. In terms of family and friends, it's not something I talk about at all. Always hide it. […] I could talk to them about my anxiety or my grief […] but I would never be like "I'm struggling with self-harm." [108]

Students also reported judgemental responses from GPs when they sought help:

> I had a really bad experience the first time I'd spoke to the GP, 'cause she asked me about, because I tried to kill myself when I was fifteen. […] She's like "Well, why do you study medicine then?" […] I was just shocked […] It probably made me more aware of speaking openly to a professional, like. If they're gonna like, judge me again. [123]

Students said their peers with mental health problems were the least likely to be judgemental, as they could relate to their problems. However, they also felt it could set up an unhelpful dynamic "like switching between carer and patient between the two of us, which was just really unhealthy." [116]. Therefore, more organised opportunities to talk to peers, such as group therapy, were viewed a helpful safeguard to avoid such dynamics arising. Students conceptualised judgemental responses in terms of a generational difference, with the younger "new generation" who are open about their mental health, and still feeling unsure about "Is this

the right person? Is this person […] in the old mindset or the new mindset?" [117]. They felt that older health professionals may not have had as much training in mental health problems:

> [If] they're a specific mental health professional, then they're great with it, but if they're anything else, like a general doctor, or nurse in A&E, or a GP, then I feel like they know nothing […] this is a generalisation, but loads of GPs are quite old, they haven't done their training for so long. When they became doctors, what we know about mental health now isn't what they knew then […] So I just think they need to be more informed on it. [108]

When they freak out it freaks me out. Some students concealed self-harm from others to avoid worrying them, because they did not perceive it to be a serious problem. They often conceptualised self-harm as an effect of their problems, rather than the cause:

> In a way it doesn't feel like that much of a big deal, like it feels like a lot of the other stuff like the anxiety is what causes it, and so the anxiety is the real problem, in a way. Like the self-harm is a symptom, not the cause. [116]

In particular, self-harm was viewed as less serious if it was not done with suicidal intent. Therefore, students felt that telling others just worried them unnecessarily, especially those emotionally closest to them such as parents or partners who would "automatically become ten times more worried about you because they think that you know take an inch you like, you're gonna kill yourself". This worry was viewed as unhelpful and an extra burden on others:

> I know that I'm not gonna do that, so… I suppose it's like well, what benefit is telling anyone […] it would almost kind of be selfish, just because it's going to give someone else that I care about extra burden of worry and it's not actually going to help me in any way. [106]

Some felt conflicted because they perceived self-harm as something helpful to cope with difficult feelings, but felt guilty for upsetting others:

> If no one else had an opinion on it, it [self-harm] would kind of be a good thing for me […] [But] it like it really upsets people, if they see a scar […] not just my boyfriend, but my mum's seen it, my sister, like it really really upsets them, so in that way it's a negative thing. [105]

Some resolved this tension by attempting to stop self-harming or by concealing it better. However, they said it was difficult to stop self-harming without resolving the causes of underlying emotional distress and developing alternative coping mechanisms:

> I just wanted someone to be like "I understand why you're doing what you're doing, why you feel like you haven't got any other ways to cope, it's not, it's not, it's not the best way, but like. I understand why you feel that this is your only option." [108]

Students found it helpful to talk to professionals confidentially or anonymously (e.g., helplines), who had more understanding about self-harm and who could support them with their underlying distress by developing alternative coping mechanisms.

Avoiding negative consequences. Students reported concealing mental health problems and self-harm, for fear of a negative consequences. Some students were afraid of talking to their GPs in case they got sectioned or if it affected the cost of insurance. Students also feared declaring their mental health problems to the university due to uncertainties about confidentiality, in terms of what would end up on their "official records", and how this might affect their future employment opportunities. Graduate students had to declare mental health problems to their supervisors in order to gain reasonable adjustments, but supervisors could also end up being their future employers if they wanted to pursue a career in academia:

> I'm just very on the fence about officially declaring that to UCL […] that reputation shouldn't pass on to an employer, but I just worry about people hearing that and like kind of affecting my future like options […] so I've never officially classed myself as disabled. [105]

In responses to disclosure, most university staff supportive, but sometimes students received unhelpful responses, such as pressure to interrupt studies or to drop out of university:

> They almost always say “Have you thought about interrupting your studies?” And I always think, “Yes I have thought about it, but that’s not really gonna help me deal with the problem.” […] I want more help for dealing with being a student with it, rather than I’m either a student, or I have a mental illness. [107]

Medical students received intrusive reactions from their department, such as compulsory check-ins from occupational health, which were viewed as unhelpful because the purpose was to “risk assess” and check if they were fit to practice. For these reasons, some students did not want to disclose their mental health problems to the university. However, at the same time, they felt pressured to disclose, so they could access academic adjustments. Students found it helpful that during the pandemic, there had been an appreciation from the university of how changing situations might affect someone, leading to more academic leniency without the needing to go into as much detail to “prove” you had a mental health difficulty:

> You asked to defer something, or you ask for an extension, and you, basically you can’t be refused, which is good, and I think they should keep this structure in place. [120]

Choice and flexibility of treatment supported recovery.

Treatments to suit my preference. Students wanted a variety of treatment options to suit their preferences. They said that medication was easy to access from GPs, but psychological therapy was harder to access. Students said the NHS primarily offered CBT and did not offer many other options. Some students said they reached the end of their help-seeking journey when they felt they had exhausted all the free treatment options. One student, who had struggled with anorexia since childhood, described feeling hopeless because they had accessed all the NHS therapy available to them, but were still struggling:

> I’m like, “Well is this, is this just how it is, is this how I’m going to be for my whole life?” It’s not like I’m going to get a second life where I can do things properly, this is it. But then I have no way of changing […] Unless I pay, like from my savings for private therapy, which might not even be effective.” [106]

Students felt positive when mental health professionals discussed their preferences and took this into account when planning treatment:

> [The therapist was] like “Yes, CBT probably doesn’t work for you” and I was like, “Yeah, no it doesn’t.” […] And then she referred me to the compassion-based one, ‘cause she was like, “That might work more for you.” And it has! [118]

Students also wanted flexibility on whether therapy was available online or face-to-face: for some, online therapy was a barrier to engagement if they did not have a private space at home. For others, the option of online therapy made mental health treatment much more accessible to fit in around the demands of being a student. Having the option of online contact was useful over the summer period where students may “never be in one place for long enough” [123] to engage with face-to-face support from services and the university.

Long-term support for long-standing issues. Students discussed how short-term therapy was the norm that they were offered from both university counselling and NHS services. Some students found short-term therapy a helpful start to their help-seeking journey:

> I didn’t really gain any more understanding of what the problem was from the therapy, but I think it is kind of stabilised me a bit, so it just kind of got me out of the really difficult period and got me somewhere that was a bit more manageable. [107]

However, the majority of students found short-term therapy did not resolve their problems:

> It was helpful right then, but I don’t think they actually solved anything, if that makes sense. Like it was really great for […] like short term […] stress. But didn’t get to the root of anything. Because there just wasn’t enough time. [116]

The students said that long-term therapy was the most helpful approach, regardless of modality, as they felt it would help them to “get to the root” of problems once and for all. The university often signposted students to private practice psychotherapy to access longer-term support, rather than the NHS. This was only affordable if parents were able to pay for it, and

students often felt guilty for asking their parents. Students felt that they were not offered longer-term therapy from the NHS because services were under-funded. One student reflected on how long they had struggled without access to long-term treatment from the NHS, before resigning themselves to paying for it privately with the support of family:

> I think it is frustrating I just feel like you know, I've been dealing with these like issues for seven years and I kind of feel like if I had just had access to long-term therapy like seven years ago, I think things would be a lot different. [105]

Discussion

Summary of clinical and research implications

The current study provides an account of the help-seeking experiences of twelve students who had self-harmed while at a London university, across two in-depth interviews. The analysis generated four over-arching themes that reflected the facilitators and barriers to receiving appropriate support: "The beginning of university was the hardest part", "Mental health problems needed to be severe", "Escaping judgement, worry, and repercussions from others", and "Choice and flexibility of treatment supported recovery". Some of these themes referred to getting support for self-harm, and some for mental health difficulties in general.

In line with previous studies, students often reached out to social networks for support with their mental health (Michelmore & Hindley, 2012). However, starting university was a particular difficult time because students often did not have established social networks. Loneliness was mentioned as a main contributor to students' distress, and also made it harder for people to seek informal support. Students felt it was crucial to their mental health for the university to foster a sense of community among staff and students. Prior research confirms that loneliness is one of the strongest predictors of mental distress in students, and that many students struggle to make friends without pre-prepared structures (Hughes & Spanner, 2019; McIntyre et al., 2018). This study suggests that this may be particularly challenging for students who arrive at university with a history of mental health difficulties, as this can affect

interpersonal functioning. There is a lack of research to understand how to address loneliness in students, particularly in this group. Students said organised social events and societies were helpful for connecting to others. More large-scale studies are required to draw conclusions about what approaches are effective and in what university contexts (Victor et al., 2018).

In line with previous research, students were selective about who they spoke to about self-harm for fear of being judged and experiencing negative consequences (Cliffe & Stallard, 2022; Rosenrot & Lewis, 2020). Students found their peers to be the least likely to judge, particularly those who had experienced mental health difficulties themselves. This highlights the potential benefit of peer support programmes, where empathy and acceptance from others can reduce fear of stigma (Gulliver & Byrom, 2014). However, there are no studies that evaluate the effectiveness of peer support in people who have self-harmed (Seif et al., 2022). This may be due to the perceived risks that peer support could lead to the reinforcement of self-harm. However, it is possible that any risks could be mitigated by providing professional facilitators, which needs to be evaluated in future research (Seif et al., 2022). Stigma reduction interventions may also serve to facilitate help-seeking. In the extant literature, most university stigma interventions have focussed on educating students about mental health problems (Eisenberg et al., 2012). These interventions may be useful, as this study found evidence of stigma, even though students had mental health difficulties themselves. However, most judgemental responses came from parents, and poorly trained medical and university staff. Given that stigmatising beliefs are formed through an interaction with others, targeting stigma requires a systemic approach (Vogel et al., 2007). Stigma reduction interventions could be usefully targeted at healthcare and university staff, whose unhelpful responses appeared to influence students' negative perceptions of their own difficulties. This could be integrated and evaluated as part of staff training. NHS mental health services could also offer support for carers to learn how to better understand and respond to mental health problems. There are existing psychoeducation programmes for carers, which can be peer-led, and aim to teach carers to be less judgemental and communicate about mental health more effectively

(Chiocchi et al., 2019; Gunderson & Hoffman, 2005). Such programmes improve wellbeing, reduce burden, and increase family empowerment in carers (Chiocchi et al., 2019; Gunderson & Hoffman, 2005), and improve service users' engagement in treatment and reduce relapse (Pilling et al., 2002; Sin et al., 2017). Such interventions must be evaluated to support carers in relation to self-harm, to improve the quality of informal help-seeking.

Students also wanted more consistent relationships with university staff and wanted to feel supported beyond their academic work. Students called for better training for academic staff to provide pastoral support, and so they were at minimum able to signpost to services appropriately. This speaks to a sector-wide uncertainty regarding the role of the academic in relation to student mental health. Interviews with university staff have highlighted that there is a lack of clarity around the term "pastoral support", resulting in unequal support for students (Hughes & Spanner, 2019). Universities need to clarify what responsibilities academics hold around duty of care. If staff were to take a central role in providing pastoral support and signposting, this would require extra time in their work plans and comprehensive support and training (Hughes & Spanner, 2019). The university could also integrate regular support from non-academic pastoral staff into university life. This could facilitate division of labour so that academic staff can focus more time on supporting students with their studies.

Another reported hindrance to help-seeking was the complexity of mental health services and being "shipped from person to person". This echoes the recommendations of previous studies to simplify the route for accessing support at university (Barnett et al., 2021). People who have self-harmed are a clinically heterogeneous group, including those who are experiencing situational distress, through to more enduring patterns of distress. Given this heterogeneity, there is not one service that can cater for students who have self-harmed, and students need to be carefully assessed and matched to appropriate services. This highlights the need for clearer pre-university entry communication, so that students with a history of mental health problems can be linked with appropriate support from the outset. A barrier to this was the terminology around diagnosis and disability, which was confusing and alienating

to students. Universities should adapt their language to be more accessible and person-centred, which could be evaluated with focus groups of students. The students also recommended integrating psychoeducation as a mandatory part of the curriculum. Such sessions could address common fears that students reported regarding the negative consequences of disclosing mental health difficulties to the university or health services.

The current study also identified signposting as a vulnerable point in students' help-seeking journey. A solution could be a "no wrong doors" approach, where students can be referred directly from one psychological treatment service to another, without needing to repeat assessments a second time (Gibbon, in preparation). This could be facilitated by stronger partnerships between universities and local NHS providers, for instance by sharing assessment protocols. The university could also create roles for university staff with a background in healthcare, who could provide advocacy and containment for students who are struggling to access mental health services. This is in line with a recommendation from the Mental Health Charter to hire university staff who were also mental health professionals, who understood the context, language, and systems of the NHS (Hughes & Spanner, 2019).

Some students concealed self-harm from people because they felt it was serving an important function for them in helping them to cope with difficult emotions, they did not see it as serious, and they did not want others to worry about it. This was linked to risk, as students felt if they were not self-harming with suicidal intent, then their self-harm was not serious. However, "non-suicidal" self-harm is strongly associated with a history of suicide attempts and a predictor of future suicide attempts (Klonsky et al., 2014). Therefore, an important balance needs to be struck, where confidants do not collude in students' perception that their problems are not serious, as this may reduce help-seeking. However, students also found it unhelpful when people "freaked out" and focussed excessively on risk, thereby explicitly or inadvertently pressuring them to stop self-harming, thus fuelling students' secrecy around self-harm. Students emphasised that they did not view self-harm as their primary issue, but as a response to other difficulties such as loneliness, low mood, anxiety. This is in line with previous

qualitative studies (Cliffe & Stallard, 2022) and other accounts from lived experience groups such as the National Self Harm Network ([NSHN], 2021) who state that “self-harm is rarely the problem, but the solution until other issues are resolved. It is the reasons that lay behind individuals’ self-harm that need to be addressed in order to aid a recovery from self-harm.” Therefore, students said it did not make sense to focus on stopping self-harm as an end unto itself, and rather, they wanted to focus on resolving their underlying difficulties. They felt that self-harm would reduce naturally as a result of having addressed the underlying issues.

Some students felt distressed by their problems and self-harm but dismissed this as a sign of “normal university stress”. The is a commonly cited barrier to help-seeking support across different student populations, including those with suicidal ideation (Downs & Eiseberg, 2012; Samlan et al., 2020). This could reflect the fact that self-harm does not always indicate a mental health disorder but can indicate a period of transient distress (Hawton & Rodham, 2006; RCP, 2010). This highlights that support should be offered across the spectrum of need, including lower intensity interventions to help students manage stress, with self-correcting mechanisms built in to catch instances where treatment needs to be stepped up. This type of support could be provided by university wellbeing services or Improving Access to Psychological Therapies (IAPT) services. Though some students may benefit from interventions to improve their stress-coping ability, students’ experiences of stress must be considered as part of the university environment. Research suggests that stress is a pervasive challenge to university students’ well-being, which has worsened during the COVID-19 pandemic (Hoyt et al., 2020). This sheds light on a concerning aspect of university culture, whereby high levels of stress accompanied by self-harm and suicidal ideation are normalised. Alongside investing in the provision of services, universities need to consider a more holistic approach to stress, by considering what aspects of university culture contribute to meaningful, challenging activity, and which aspects contribute to unhelpful levels of stress that undermine students’ sense of self-efficacy, confidence, and competence (Hughes & Spanner, 2019).

Some students were struggling with their mental health but were deterred from accessing support due the perception that mental health services were overwhelmed and unable to meet their needs appropriately. This was based on experiences of long waiting lists, strict limits on the number of therapy sessions offered (regardless of need), lack of treatment choices, and dismissive responses from GPs. Though some students viewed short-term therapy as helpful (e.g., to process situational stressors such as relationship break-ups), or helped to "stabilise" them to a level of better coping, none of the students felt like short-term therapy was enough to resolve their underlying issues, and they felt that their problems would simply recur after being discharged. Students struggled to access community and specialist mental health services where they might have received more flexibility regarding the number of sessions offered, or did not want to, for fear of their problems being pathologised within a medicalised system. A high level of risk seemed to be embedded in the criteria for accessing this type of support (e.g., low body mass index as a criterion for accessing eating disorders services; self-harm or suicide threats as criteria for accessing personality disorder services). This suggests that some NHS services may be overburdened to the point that they need to prioritise high risk clinical presentations, at the expense of lower risk presentations. Reports from healthcare services confirm that a rising demand for mental health services is not being met by NHS service provision (British Medical Association, 2021; RCP, 2021). This is an issue of accessibility, where students' problems might be too high risk to be managed solely by the university or IAPT, but not high risk enough to meet criteria for specialist support from the NHS. These students were often signposted by the university to private practice psychotherapy, but this was only affordable for students whose parents could pay for it.

Recommendations for service configuration

The present study highlighted that people who have self-harmed will present across all services, without necessarily seeking support *for* self-harm. Indeed, they may not mention the fact that they have self-harmed to professionals if they do not see it as a priority for change. Some people who have self-harmed may be experiencing non-clinical distress or mild-to-

moderate mental health conditions that could be managed by the university or IAPT alone. This suggests that it may be helpful to equip professionals across all services to ask about self-harm and manage it sensitively (rather than for instance, excluding students from mainstream services and creating specialist services for people who have self-harmed). Across all themes identified in this study was the common thread that students did not feel listened to or understood regarding their mental health experiences and hopes for treatment. It is important for all professionals to enquire about and empathise with a person's reasons for self-harming. In the current study, asking students, "Do you see self-harm as a good thing or a bad thing, or something in between?" opened up fruitful conversations about the reasons why students felt the need to self-harm to cope with difficult feelings in the absence of other coping strategies or social support, and students were able to articulate the kind of support they wanted. Interventions explicitly targeted at self-harm or risk reduction are unlikely to be viewed as relevant or acceptable to this group. There is some limited evidence for the effectiveness of psychosocial approaches targeted at reducing the frequency of self-harm in those with multiple episodes of self-harm and a probable personality disorder (Hawton et al., 2016). However, it is possible that many interventions are ineffective at reducing self-harm because they operate on the underlying premise that people want to stop self-harming, while many people who seek mental health support are not in this position. The use of motivational interviewing techniques may be an effective way to have discussions about self-harm in a way that respects a person's sense of personal agency and control (Kress & Hoffman, 2008; Miller & Rollnick, 2002). This is particularly pertinent in people who have self-harmed, as many people self-harm to regain control in response to feeling powerless (NSHN, 2021). In addition, rather than focussing on risk assessment of self-harm, which may alienate students and elicit dishonest responses to avoid perceived negative consequences, services could focus on safety planning and supporting people to develop alternative coping strategies (NICE, 2022).

Some students presented with complex circumstances, where secondary or specialist mental healthcare was indicated. However, students found that these services offered a more

diagnostic or medicalised view of mental health. Some found this helpful and validating, while others felt disenfranchised and pathologised by it. This highlights the importance of keeping people's preferences at the heart of clinical decision-making, such as offering a non-diagnostic formulation of their difficulties. In addition, the present study suggested that overburdened services may be allocating secondary care and specialist mental health treatment based on risk assessment, which was iatrogenic because it encouraged students to deteriorate and communicate their distress by having a crisis to "prove" their need for mental healthcare. Existing mental health services need to be better resourced so they can provide person-centred support to more people, regardless of risk. This seemed to be particularly the case for accessing eating disorder services. Though the study was focussed on students with self-harm, there was a high co-occurrence of eating disorders in the sample, and food restriction was often described by students as a form of self-harm. The care pathway could be strengthened by providing first episode early intervention services for eating disorders, which have shown early promise of contributing to a more complete recovery compared to treatment as usual (Austin et al., 2022).

Limitations and contextual considerations

The study was advertised to students as investigating their experiences of trying to seek help for self-harm and mental health. This could have attracted students who had significant experiences of help-seeking and strong feelings about improving mental health care pathways. Previous studies suggest that less than half of students who have self-harmed seek any form of professional help for their mental health (Bruffaerts et al., 2019; Gollust et al., 2008; Han et al., 2016; Michelmore & Hindley, 2012). However, all of the current sample said they had sought some form of professional help while at university, so it is a limitation that this was a more help-seeking sample than the general population of students who have self-harmed. Students who do not seek help may experience more pronounced barriers to their help-seeking, coupled with fewer facilitators, or may face additional barriers not identified

by this study. Future studies could attempt to purposively sample students who have never sought support for their difficulties, to understand their experiences.

The sample mostly identified as women (83%) and non-heterosexual (67%). This could reflect the fact that women and sexual minorities are at increased risk of self-harm (Bresin & Schoenleber, 2015; King et al., 2003). There is some evidence to suggest that LGBTQIA+ students are less likely to access traditional services, so it is useful to have captured their voices in the current study (Eisenberg et al., 2012). In addition, the majority of the sample were white (58%) and cisgender (83%). Other similar qualitative studies on self-harm also reflect this demographic skew in their samples towards white, cisgender women, which suggests that this a broader trend in the field of self-harm research (Cliffe & Stallard, 2022; Rosenrot et al., 2020). The study was limited to students who were residing in the UK, so that the findings would be relevant to a UK service context. However, this means that the current study did not capture the experiences of students trying to access student support services from abroad, who may have faced additional barriers. Therefore, future studies could purposively sample other student groups, such as international students, men, transgender students, and students from other racial/ethnic groups, who access traditional services less, and were relatively under-represented in the current sample.

The findings must also be considered in their geographical context. For instance, the fact that the students were sampled from a large London university where the campus is spread across the city may have influenced students' experiences of help-seeking, relative to universities where the campus is all on one site. It would be useful for other universities to conduct similar research, to facilitate comparison between different systems, which would support sector-wide learning. However, there is a degree of consistency in the way student mental health services are designed across the UK and the world, so it is hoped that these findings may be useful for other universities (Thorley, 2017). It is also crucial to consider how the study's cultural context influenced "what gets defined as a problem, how the problem is understood, and which solutions to the problem are acceptable." (Hernandez et al., 2009, pg.

1047). For instance, the context of the UK health system, in the wake of the COVID-19 pandemic, students' perceptions of "overwhelmed" mental health services influenced their understanding of their difficulties as "not severe enough" to warrant support (Sokol, 2021). More broadly, this study on young people took place within a Western and capitalist society, where conceptions of adulthood place high value on achieving independence, self-reliance, and productivity (Markus & Kitayama, 1991). This cultural belief may underpin stigmatising attitudes of mental health and help-seeking, whereby students felt that relying on others made them a "burden". Students expressed their wish for a cultural shift towards a more interdependent university community, with a focus on mutual reliance, rather than feeling like "one in a million" and a "problem".

Conclusions

In conclusion, it is known that many students who have self-harmed often do not seek support for their difficulties. The current study identified four over-arching themes to summarise students' help-seeking experiences and their suggestions for service improvements. An important direction for future research will entail implementing and evaluating the suggestions made in this study within the university and NHS context. A service delivery model informed by the suggestions of students may be more accessible than those developed solely by professionals (Barnett et al., 2021). Underlying many of students' concerns about help-seeking was the sense that mental health services are currently over-burdened and under-funded. If professionals are to encourage students to seek help from mental health services, these services need to be well-resourced so that students are received with accessible and effective support. Existing interventions being implemented by universities are often not evaluated, which means that there is a lack of clarity about what constitutes good practice (Hughes & Spanner, 2019). To advance the field of student mental health, universities must now focus on rigorous and systematic evaluation of services and interventions to inform decision-making (Hughes & Spanner, 2019).

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Part 3: Critical Appraisal

Introduction

This critical appraisal is my reflection on the process of the research, exploring how my various social identities may have shaped the project conceptualisation, data collection, analysis, and write-up (Tufford & Newman, 2010). I anticipated that the topic would elicit strong feelings in me, so at each stage of the project I engaged in ongoing personal reflection in relation to the research topic and process, as part of "bracketing". This included an interview with my colleague during project conceptualisation, and ongoing reflexive journaling, discussions with my co-researcher, supervisors, and the steering group. The purpose of this was to acknowledge and name my own perspective, pre-existing thoughts, and developing hypotheses, so that they could be set aside as much as possible, with the goal of attending to participants' accounts with an open mind (Starks & Trinidad, 2007). However, I do not believe that humans have the ability to completely "bracket out" their pre-conceptions from the research process. Therefore, in the following sections I outline the dimensions of my identity that I believe are pertinent in relation to the research topic and I acknowledge the ways in which they could have affected the production of this knowledge: my identity as a friend to people who have self-harmed, a university student, a mental health professional, and a clinician-researcher. I also discuss the conceptualisation of the steering group and how true co-production is challenging within the financial and time constraints of the DClinPsy. Throughout these sections is a discussion of how the research affected me, how it may have affected the participants, and what I will be taking forward in my future research endeavours.

My position as a friend to people who have self-harmed

I do not have lived experience when it comes to self-harm, however, I am a friend to people who have self-harmed. In the bracketing interview, I explored my memories of these friends struggling to access support for their mental health. One time, I was called to the accident and emergency department to support a friend who had self-harmed and felt shocked at what I perceived to be iatrogenic responses from the accident and emergency department (for instance, hospital staff talking in a derisive way regarding self-harm). I remembered

wondering when the university were going to step in and facilitate the situation, but the support never materialised. I reflected on an account from one of the participants, which resonated with my own experience at that time:

> Even though we're adults, I think, especially for first years, that universities, kind of, not let us have too much freedom, but I think because we're adults they expect us to just kind of get on with it. Whereas I feel like most eighteen-year-olds don't know what they're doing, and don't know how to help a friend in crisis. [103]

I believe these experiences were instrumental for me in choosing the research topic for this study. I continued to engage in reflexive journaling regarding these experiences and remembered strong feelings of anxiety and anger at the mistreatment of my friends. I wondered if this project had been conceptualised as a way to channel these uncomfortable or unwanted feelings into something helpful or productive (known as “sublimation” in the psychodynamic literature; Lemma, 2016). It was crucial that these memories and emotions were noticed and elaborated so that they did not bias my perception of participants’ experiences. Journaling facilitated the “surfacing of previously hidden memories or unconscious preconceptions” (Tufford and Newman, 2010, p. 10) to my conscious awareness, so that I could acknowledge that these experiences belonged to *me* and not the participants. Through this process, I cultivated a sense of open curiosity and recognised that though the participants’ experiences may bear similarities to what I witnessed, ultimately, they were attending a different university, at a different point in time, and so I could not assume their experiences would be the same.

In the interviews, participants often talked about the unhelpful responses from friends in relation to self-harm and help-seeking, such as the perceived burden of people worrying about them. It was helpful to reflect on my own experiences of worry about my friends, and whether through a process of countertransference, this could have influenced my view of the participants (Lemma, 2016). To borrow terminology from cognitive analytic therapy, being “worried” puts the other in a reciprocal role of being perceived as “vulnerable” or needing help

(Corbridge et al., 2017). By viewing my participants through this "vulnerable" lens, I could have overlooked narratives of them as empowered or self-reliant, for example. Also, my difficult memories could have led me to empathise with participants' accounts of their struggles in trying to seek help for their mental health, while overlooking narratives of care and successful help-seeking. In the interviews and analysis, I was mindful to ask open questions regarding help-seeking, and not to foreclose on exploration of useful instances of help-seeking.

My position as a fellow student

I also considered my identity as a current student at the same university as the participants and how this could have impacted the research process. This created an ethical dilemma that we may know each other from outside of the research context, which would compromise the participants' right to privacy regarding their mental health and self-harm. Even by expressing an interest in the study, they would have been disclosing self-harm to me. To resolve this issue, alongside the participant information sheet I also sent a picture of myself and a professional biography, to give students the opportunity to recognise if we knew each other, or if we occupied similar professional circles.

Research suggests that young people feel more comfortable discussing self-harm with people of a similar age and background to them (Klineberg et al., 2013). From my biography, students would be able to see that I am a student, which may have facilitated participation. From my picture, they may also infer that I am a white cisgender woman, which also corresponds to the characteristics of the majority of the sample. It could be that my identity as a researcher influenced who chose to participate in the study based on our shared visible characteristics. As mentioned in the empirical paper, other qualitative studies reflect the same demographic skew towards young, white, cisgender women (e.g., Cliffe & Stallard, 2022; Rosenrot et al., 2020). It will be important to qualitatively investigate the experiences of students who are even less likely to access traditional services (e.g., men, gender minorities, racial/ethnic minorities), as their characteristics may intersect to influence their help-seeking experiences in important ways. Given the finding that students prefer to discuss self-harm with

people of a similar background to them, participation in future research could be facilitated by involving researchers who share similar characteristics to purposive samples. This highlights the need for championing more diversity in the field of clinical research in general, as it is well known that the clinical psychological profession is predominantly comprised of white middle-class women (British Psychological Society, 2016).

My position as a clinician-researcher

When bracketing, I also considered my dual identity as a clinical practitioner and a researcher, and the different purposes of the therapeutic encounter and the research encounter (Thompson & Russo, 2012). The researcher's main aim is gaining information, while the therapist's aim is facilitating psychological change. This was a difficult transition for me, because I have developed natural ways of responding that are more appropriate in a therapeutic context, which I had to self-monitor (frequent summarising of participants' responses, offering of interpretations, empathetic responses). I ended up doing some pilot interviews with colleagues in the research team to practice this new way of interacting. I worried that when using this new style, participants would view me as detached or unempathetic. However, Rowling (1999) suggests that taking part in research may make people feel powerful, due to being in the position to help others, as opposed to being the one who needs help. To emphasise this (and to manage my own anxiety of using a different style of interaction) I prefaced each interview with the following:

> I won't be commenting on your answers very much because I want to give a platform to your voice, not mine. So that might feel a bit different from a normal discussion where we might have more of back-and-forth. Please don't be put off by that, and I hope you can use the space to feel comfortable elaborating on your views.

I also reflected on the potential for internal role confusion when conceptualising the study, where I may feel conflict between my researcher and clinician role (Thompson & Russo, 2012). During the study, there was the potential to identify students who were experiencing current

problems with their treatment and care from services. This would have created a conflict between an ethical duty to help support students through the provision of information, and the objective of the research study to observe natural behaviour and situations. In discussion with my supervisor, it was decided in advance that it would not be ethically appropriate to observe students' behaviour without the provision of information if needed. Therefore, it was decided that if students disclosed problems with current treatment and care, the researchers would offer to signpost to relevant advice services to support them in exploring their options moving forward. There was only one instance of a participant disclosing that they were currently struggling to access appropriate support. I organised a separate time to talk to them about this, to compartmentalise this instance of me stepping out of the researcher role, and I signposted them to appropriate services. This was following the T1 interview, so it is a limitation that this intervention will have influenced their natural behaviour at the T2 interview. At T2, they had just accessed a service in response to my intervention. I was mindful of this during analysis, but our conversation was almost exclusively focussed on their experiences prior to my intervention, so this did not influence the results in a meaningful way.

Thompson and Russo (2012) emphasise that it is important for psychologists conducting qualitative research to consider biases in the theoretical models used generally, for instance with a focus on problematic functioning. They say this could contribute to ethical dilemmas, for example, by implying to a research participant that their experience is "abnormal". I interrogated my unspoken beliefs about what is "normative" in relation to self-harm and help-seeking, so that this would not inadvertently impact the messaging of the study or my language during the interviews. In my clinical work, though I have attended lectures on self-harm, none of my clients have brought self-harm as the focus for therapy sessions. Therefore, I did not come to this study with preconceptions of working clinically with a person to manage self-harm. In lectures and when conducting the literature review for this project, I read many different descriptions of self-harm from the perspectives of clinical professionals: for instance, the ideas that self-harm is a harmful behaviour, which damages the body, and is

associated with a higher risk of suicide. This very much positioned self-harm as a “bad thing” that needs intervention. However, in my interviews, and in the research literature, not all participants saw self-harm as a “bad thing” that they wanted to stop. In fact, some saw it as a “good thing” because it helped them to cope with difficult situations or because it prevented them from wanting to end their life. This left me feeling conflicted about how to position myself in relation to the topic of self-harm. I spent time journaling on this and reconciled that while people who have self-harmed may view this a helpful way to cope with difficult feelings, in the words of the Royal College of Psychiatrists (RCP), “no one harms themselves because they are happy” (RCP, 2010, p. 21). So, I positioned my research from the perspective of wanting to help to reduce people’s distress and to access the right support if needed.

Another issue I encountered in the literature was regarding definitions of self-harm. When I asked participants how they had self-harmed, their responses did not always match onto the research definitions of self-harm. For instance, some students said they starved themselves, deprived themselves of sleep, or misused recreational drugs as a form of self-harm, whereas these would not come under traditional definitions of self-harm in the literature. I felt conflicted about this, because I thought it might be experienced as invalidating to the participants, to imply that their experiences are not valid descriptions of self-harm. There is also an ongoing debate regarding the development of the term “non-suicidal self-harm”, to categorise self-harm behaviours where the motivation is not suicidal (Klonsky et al., 2014). However, some of the participants expressed ambivalent or unclear motivation towards whether they lived or died. It struck me that we are far from having a consensual definition of self-harm within the research community, and between researchers and people with lived experience of self-harm. Therefore, in the write-up I included a description of all participants’ descriptions of self-harm, to acknowledge their perception of their own behaviours.

Due to my position as a clinician, I feel that in an ideal world, people should feel able to open up and seek support for their difficulties from their social networks and professionals, and in the existence of “facilitators” and “barriers” that influence people’s ability to engage with

this support. I decided to focus my interviews on formal and informal sources of support, because an exclusive focus on formal support (e.g., from mental health services) might imply that people *should* seek support from these services. I appreciated that support may come in many different forms, not just the university or NHS, for example, from family, friends, religious or spiritual communities, non-Western medical practitioners, alternative therapists, strangers online, etc. I wanted to remain open to the possibility that there may be sources of support that I was not even aware of. Therefore, I ensured that my questions in the interviews were deliberately open: "Who knows about these difficulties? Who have you spoken to about it?" (see Appendix 8). However, it is possible that due to participants' knowledge of my role as a trainee clinical psychologist, positioned at the university and within the NHS, their responses may have been biased towards these sources of support. In fact, many students said during the interviews that they assumed the focus of the study was on support from the university, because the university were conducting the study. I had to reiterate that the questions in the interview related to all sources of support, not just the university services. Therefore, students' perceptions of who was conducting the study may have influenced their answers to some extent (though this was partly mitigated by my prompting for them to discuss other sources of support).

Reflections on the steering group

When conceptualising the study, I wanted to ensure that the voice of lived experience was at the core of the project decision-making. My co-researcher and I set up a steering group of students with lived experience of mental health difficulties and self-harm. This was to ensure that the project direction and aims would be relevant to students at the university, and that any communication about mental health and self-harm with participants would be sensitive and respectful. I wanted the steering group to be a meaningful and enriching experience for the steering group members too, where they felt their contributions were valued. When setting it up, I considered the various levels of student engagement, through from consultation through to co-production, with an increasingly greater role of the student voice (Piper & Emmanuel,

n.d.). Co-production is seen as the highest level of student engagement, where there is collaboration between the institution and students, involving joint decision-making on both processes and outcomes (Piper & Emmanuel, n.d.). Within the financial and time constraints of the DClinPsy, I was able to use a consultation model, where students provided their opinions, perspectives, ideas, and concerns to the design of the project (Piper & Emmanuel, n.d.). Unfortunately, it was not possible to involve them in the analysis and interpretation of the qualitative data. Firstly, it was due to financial constraint, because for this experience to be meaningful and valuable to the participants this would have necessitated training in qualitative methods for the participants, for which there was no budget. In addition, the interviews involved in-depth discussion of students' methods and perceptions of self-harm, as well as their experiences of help-seeking. The steering group self-identified as having a history of mental health difficulties or self-harm, and so reading these descriptions may have caused vicarious trauma, triggered or reinforced self-harming behaviour, or led to comparing the methods or extent of injuries to those in the descriptions (Seif et al., 2022). This would have needed to be a carefully considered and negotiated process, with appropriate support in place to mitigate these risks. In addition, reading about the experiences of others' more negative help-seeking experiences may have influenced their own beliefs about those sources of support, thus affecting help-seeking behaviour. Therefore, if students were to be involved in the process of reading the interviews, it would have been important to ensure adequate support and opportunities for reflective discussion, for which the research team was not resourced to do at this time.

This is the same reason why the results of the overall study have not yet been sent to the participants themselves for comment. Within a reflexive thematic analysis framework, participants are not required to "verify" the results of the study, because the aim of this type of qualitative research is not to search for "truth", but rather to produce knowledge in context. However, it could have been valuable to include an account of the students' views on the final results, as part of the process of reflexivity and to amplify their voices in the research. Due to

delays in the project because of the COVID-19 pandemic, there was not time to give it the attention to ensure that it was done safely. However, I am committed to discussing this further with my supervisors, beyond the time constraints of the DClinPsy, but prior to journal publication. This is accepted as a limitation of the current thesis. The participants of the study and the steering group will be able to publicly access this thesis online if they wish, however, I want to be thoughtful and responsible regarding how I communicate with them directly.

I was aware that consultation can be considered “tokenistic”, because while their voices are heard, they “lack the power to ensure that their views will be heeded by the powerful. When participation is restricted to these levels, there is no follow through, no "muscle," hence no assurance of changing the status quo.” (Arnstein, 1969, p. 217). Therefore, I checked-in regarding their feedback and whether I had understood correctly. At the start of each steering group session, I summarised my take-aways from the meeting and before and described how I had implemented their ideas. When conducting future research, I would prefer to use a co-production methodology, including steering group involvement in the analysis and interpretation of data, as this has been shown to produce richer, more detailed analysis, to lead to new lines of enquiry, and to increase readability and credibility to other experts by experience (Hemming et al., 2020). In a study that involved an individual with lived experience co-analysing qualitative data, the person said that through this process they felt listened to and respected and felt positive about contributing to an area using their own lived experience (Hemming et al., 2020). However, they cautioned that researchers need to consider their training needs and the emotional impact of being involved with research (Hemming et al., 2020).

Conclusion

Before conducting this research, I knew on the intellectual level that a researcher’s subjectivity influences all stages of a study, from conceptualisation through to writing up. However, conducting this piece of research, and engaging in an intensive process of reflection over these years, has truly fostered an experiential awareness of what this means, as outlined

in this critical appraisal. This will impact all my future endeavours as a clinical psychologist, when consuming knowledge and when producing it, to be more critical and transparent regarding how the knowledge was produced. As an undergraduate student learning about research methods, I was always focussed on understanding what is the “done thing” and how to do research “right”. However, taking ownership of a doctoral piece of research, from start to finish, has made me realise how important it is to interrogate the “done thing” and to take personal responsibility for making research decisions. For instance, historically, research has been conducted by researchers, and people with lived experience were the “subjects” or “participants” in this research. However, I realise now how this model of knowledge production is limited by the power dynamic inherent here, as participants do not have the "muscle" and hence have no assurance that the status quo will be challenged in the way that they would like. In my future research endeavours, I will advocate for the time and funding to include increasing levels of participant involvement, so that the production of new knowledge is directly influenced by those with lived experience.

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Appendix 1: Summary of Systematic Review Search Strategy

Table 1

Summary of records retrieved from each database

Name of database	Date of search from:	Date of search to:	Records retrieved
MEDLINE	1946	15/11/21	154
PsycINFO	1806	15/11/21	338
ERIC (EBSCO)	1972	15/11/21	117
		Total	**609**
		De-duplicated	457

MEDLINE

1. help-seeking behavior/
2. Disclosure/
3. Self Disclosure/
4. (help seek* or help-seek* or helpseek* or health care util* or healthcare util* or "health care use" or "healthcare use" or health care seek* or healthcare seek* or disclos* or self-disclos* or self help or self-help).mp.
5. (seek* adj2 (help or support or advice or treatment or therapy or counsel* or care or medic*)).mp.
6. (us* adj2 (mental health service* or mental health care or health care)).mp.
7. (util* adj2 (mental health service* or mental health care or health care)).mp.
8. (hid* or conceal* or withhold*).mp.
9. 2 or 3 or 4 or 5 or 6 or 7 or 8
10. Self Mutilation/
11. Self-Injurious Behavior/
12. Suicidal Ideation/
13. Suicide/ or Suicide, Completed/ or Suicide, Attempted/

14. (self harm* or self-harm* or selfharm* or self 109uicide109* or self-mutilat* or self injur* or self-injur* or self inflicted wound* or self-inflicted wound* or self destructive 109uicid* or self-destructive 109uicid* or self poison* or self-poison* or 109uicide* or self cut* or self-cut*).mp.
15. 10 or 11 or 12 or 13 or 14
16. (undergraduate* or under-graduate* or postgraduate* or post-graduate*).mp.
17. ((college or university or collegiate) adj3 (student* or wom?n or m?n or adult*)).mp.
18. ((higher or tertiary) adj2 education).mp.
19. 16 or 17 or 18
20. 9 and 15 and 19

PsycINFO

1. health care utilization/
2. health care seeking behavior/ or help seeking behavior/
3. self-disclosure/
4. (help seek* or help-seek* or helpseek* or health care util* or healthcare util* or “health care use” or “healthcare use” or health care seek* or healthcare seek* or disclos* or self-disclos* or self help or self-help).mp.
5. (seek* adj2 (help or support or advice or treatment or therapy or counsel* or care or medic*)).mp.
6. (us* adj2 (mental health service* or mental health care or health care)).mp.
7. (util* adj2 (mental health service* or mental health care or health care)).mp.
8. (hid* or conceal* or withhold*).mp.
9. 1 or 2 or 3 or 4 or 5 or 6 or 8
10. exp self-destructive behavior/
11. suicidality/
12. suicide prevention/

13. (self harm* or self-harm* or selfharm* or self 110uicide110* or self-mutilat* or self injur* or self-injur* or self inflicted wound* or self-inflicted wound* or self destructive 110uicid* or self-destructive 110uicid* or self poison* or self-poison* or 110uicide* or self cut* or self-cut*).mp.
14. 10 or 11 or 12 or 13
15. Graduate Students/ or Dental Students/ or International Students/ or Nursing Students/ or Medical Students/ or College Students/ or Education Students/ or Postgraduate Students/ or Business Students/ or Law Students/ or Junior College Students/
16. (undergraduate* or under-graduate* or postgraduate* or post-graduate*).mp.
17. ((college or university) adj3 (student* or wom?n or m?n or adult*)).mp.
18. ((higher or tertiary) adj2 education).mp.
19. 15 or 16 or 17 or 18
20. 9 and 14 and 19

ERIC (EBSCO)

1. DE “Disclosure” OR DE “Self Disclosure (Individuals)”
2. help seek* or help-seek* or helpseek* or health care util* or healthcare util* or “health care use” or “healthcare use” or health care seek* or healthcare seek* or disclos* or self-disclos* or self help or self-help
3. seek* n2 (help or support or advice or treatment or therapy or counsel* or care or medic*)
4. us* n2 (mental health service* or mental health care or health care)
5. util* n2 (mental health service* or mental health care or health care)
6. hid* or conceal* or withhold*
7. 1 or 2 or 3 or 4 or 5 or 6
8. DE “Suicide” OR DE “Self Destructive Behavior”

9. self harm* or self-harm* or selfharm* or self 111uicide111* or self-mutilat* or self injur* or self-injur* or self inflicted wound* or self-inflicted wound* or self destructive 111uicid* or self-destructive 111uicid* or self poison* or self-poison* or 111uicide* or self cut* or self-cut*
10. 8 or 9
11. DE “College Students” OR DE “College Freshmen” OR DE “College Seniors” OR DE “College Transfer Students” OR DE “First Generation College Students” OR DE “Graduate Students” OR DE “In State Students” OR DE “On Campus Students” OR DE “Out of State Students” OR DE “Preservice Teachers” OR DE “Two Year College Students” OR DE “Undergraduate Students” OR DE “College Freshmen” OR DE “College Seniors” OR DE “College Transfer Students” OR DE “First Generation College Students” OR DE “Graduate Students” OR DE “In State Students” OR DE “On Campus Students” OR DE “Out of State Students” OR DE “Preservice Teachers” OR DE “Two Year College Students” OR DE “Undergraduate Students”
12. undergraduate* or under-graduate* or postgraduate* or post-graduate*
13. (college or university or collegiate) n3 (student* or wom?n or m?n or adult*)
14. (higher or tertiary) n2 education
15. 11 or 12 or 13 or 14
16. 7 and 10 and 15

Appendix 2: Details of Collaboration in a Joint Project

The empirical research reported in this thesis was conducted as part of a joint project with Katalin Hajdú, another trainee clinical psychologist at UCL. Katalin's research project aimed to investigate the perceived impact of online activities and social media on the mental health of students who had self-harmed while at university. Further details on this project can be found in her thesis submission: Hajdú, K. (2022). "It's cool to feel sad": A thematic analysis of the social media experiences of university students who have self-harmed. Unpublished doctoral dissertation. University College London, London.

Details of how the research workload was allocated

Aspects of research collaborated on and how workload was divided

- **Systematic review.** We each reviewed 10% of the references during screening, data extraction, and quality assessment for each other's systematic reviews.
- **Recruitment of steering group.** Alice produced the posters to be disseminated by social media, Katalin wrote accompanying text for newsletters. Sign-ups were allocated evenly, so we were the point of contact for half the steering group each.
- **Steering group sessions.** For each steering group meeting, we were each allocated a section of time to discuss our projects. Some sections were joint when they related to shared aspects of the project (e.g., recruitment, design of the study).
- **Study design.** All aspects of study design were discussed with the steering group and then mutually agreed in joint meetings with supervisor Laura Gibbon.
- **Research governance.** The ethics and data protection application for this study involved an update to an existing project set up by our supervisor Laura Gibbon. We allocated an equal number of sections and recruitment documents to update between the two of us, and we shared numerous drafts with each other to comment and edit.

- **Setting up the online platform for questionnaires.** Alice set up a joint Qualtrics questionnaire and inputted the joint demographic questions and her own study questions. Katalin inputted her own study questions.
- **Development and production of interview schedule.** Alice and Katalin each produced their own interview schedule, which were then joint together into Part 1 (Alice's questions), followed by a break, and then Part 2 (Katalin's questions). We met several times together with supervisor Laura Gibbon to ensure coherence and non-overlap across the two interview schedules.
- **Recruitment of study participants.** The Research & Evaluation Coordinator for the PsychUP for Wellbeing Team, Kirsty Nisbet, extracted the names and contact details of eligible participants from the SENSE and IMPACTS databases (Alice and Katalin were not authorised access to this database). Kirsty sent out the recruitment emails and materials to all eligible participants. Expressions of interest in the study were allocated evenly between Katalin and Alice, so we were the point of contact for roughly half the participants each. We each contacted our group of students to check eligibility and give more information about the study. We continued this process until we both had roughly an equal number of participants consented (Alice, n = 13, Katalin, n = 12).
- **Data collection.** As mentioned above, participants were allocated evenly between Katalin and Alice, so we were the point of contact for roughly half the participants each. We were each responsible for disseminating surveys and conducting interviews for these participants. The overall project recruited 25 students, to select purposive samples for this study, Katalin's study, and future publications. The present study included the sub-set of 12 participants interviewed by the author, to retain researcher reflexivity throughout the interview process. Katalin's study included the sub-set of 11 participants who were 21 years of age or under.
- **Transcription.** The videoconferencing software produced automated transcriptions of the interviews. Alice refined 2 of the transcripts. The rest of the transcripts were

anonymised and edited by members of the PsychUP research team: Rebecca Hodges, Sam Keen, and Jonathon Ding. They were all reimbursed for their time.

- **Researcher reflexivity.** After I had finished coding, Katalin independently coded one my transcripts, using an inductive approach based on my research questions. We then compared and discussed our codes, to encourage reflexivity. I did the same for one of the transcripts from her study, using her research questions.

Aspects of research undertaken independently

- **Systematic review.** All aspects of the process and write-up of the systematic review were conducted independently (except, as outlined above, that we each reviewed 10% of references during screening, data extraction, and quality assessment for each other's systematic reviews).
- **Funding application to UCL DclinPsy.** My funding application was written independently, and then discussed with Katalin to ensure consistency across our applications.
- **Research proposal for UCL**. My research proposal was written independently, and then discussed with Katalin to ensure consistency that I had accurately represented her study in the description.
- **Data analysis.** Quantitative analysis and summary of survey data was done independently. Qualitative analysis of the interview data was done independently.
- **Thesis write-up.** All aspects of the thesis write-up were conducted independently.

Appendix 3: Letter of Ethical Approval

UCL RESEARCH ETHICS COMMITTEE
OFFICE FOR THE VICE PROVOST RESEARCH

UCL

18th March 2021

Dr Laura Gibbon
Division of Psychology and Language Sciences
UCL

Cc: Alice Tickell, Katalin Hajdu, Hanna Hirvonen, Kirsty Nisbet

Dear Dr Gibbon

Notification of Ethics Approval with Provisos
Project ID/Title: 16733/003: Student mental health journeys

Further to your satisfactory responses to the Committee's comments, I am pleased to confirm in my capacity as Chair of the UCL Research Ethics Committee (REC) that your study has been ethically approved by the REC until **18th March 2022**.

Approval is subject to the following conditions:

Notification of Amendments to the Research
You must seek Chair's approval for proposed amendments (to include extensions to the duration of the project) to the research for which this approval has been given. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing an 'Amendment Approval Request Form'
http://ethics.grad.ucl.ac.uk/responsibilities.php

Adverse Event Reporting – Serious and Non-Serious
It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Joint Chairs will decide whether the study should be terminated pending the opinion of an independent expert. For non-serious adverse events the Joint Chairs of the Ethics Committee should again be notified via the Ethics Committee Administrator within ten days of the incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Joint Chairs will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Final Report

Office of the Vice Provost Research, 2 Taviton Street
University College London
Tel: +44 (0)20 7679 8717
Email: ethics@ucl.ac.uk
http://ethics.grad.ucl.ac.uk/

At the end of the data collection element of your research we ask that you submit a very brief report (1-2 paragraphs will suffice) which includes in particular issues relating to the ethical implications of the research i.e. issues obtaining consent, participants withdrawing from the research, confidentiality, protection of participants from physical and mental harm etc.

In addition, please:

- ensure that you follow all relevant guidance as laid out in UCL's Code of Conduct for Research: https://www.ucl.ac.uk/srs/file/579
- note that you are required to adhere to all research data/records management and storage procedures agreed as part of your application. This will be expected even after completion of the study.

With best wishes for the research.

Yours sincerely

Professor Michael Heinrich
Joint Chair, UCL Research Ethics Committee

Appendix 4: Recruitment Poster for the Steering Group

Are you a student with experiences of living with a mental health difficulty while at [redacted]

[redacted] research group focussed on **improving student mental health**. We want to hear the voices of students with mental health difficulties when planning our research. Please join us for a one-off student consultation meeting to provide feedback on our latest project plans!

Who are we looking for?

- We would like to hear from anyone who has had **personal experience of any mental health issues**, of any severity.
- In particular, we want to hear from students with **experiences of self-harming**, as this will be one important focus of our research.
- Please join us for a 1.5-hour consultation meeting via videoconferencing, before the Christmas break.
- **Attendees will be thanked for their time with a £20 Amazon voucher**.
- All students are welcome, and no knowledge of research required!

At the meeting we will:

- Describe the projects and get your feedback on our plans
- Ensure that everyone treats others' views confidentially, and with sensitivity and respect.

To get involved please, fill in this form by 27th November. If you have any questions, please contact the organisers Alice or Katalin

Appendix 5: Participant Recruitment Materials

Recruitment email template

Subject line: Are you interested? New opportunity in student mental health

Hello!

I hope you are well! My name is [name] and I am a member of the research group PsychUP at UCL. We are running a new study into [redacted] student mental health. Last year, you completed the [SENSE/IMPACTS] survey and agreed to be contacted about future research in this area, so I was wondering if you would be interested in participating in our study?

What is our study?

Student mental health problems are increasing, but many students do not seek support from student or NHS services. We want to understand what could improve students' experiences of seeking support for their mental health while at [redacted]. We would also like to understand the online lives of students better and how this impacts their mental health. Therefore, we are looking for current [redacted] students who have self-harmed while at university. Ordinarily, people find it hard to speak up about these kinds of experiences, so we want to make it easier for you to have your voice heard.

If you would like to find out more about the study, please read our information sheet (attached). I have also attached a bio and photograph of my colleagues who are running the study, so you can find out a bit more about who you may be talking to.

To register your interest, or if you have any questions, please fill in this short form.

Numbers will be limited, so if you are interested, please do sign up soon! Thank you so much for reading this email, and I hope to hear from you.

Kind regards,

[Name]

Participant information sheet

Participant Information Form

Thank you or your interest in participating in this research. This document tells you more about our study. It is important to us that you feel fully informed and comfortable as a participant. Before you decide whether you would like to take part, please take your time to read the following information carefully and do not hesitate to get in contact with the researchers listed above if you would like more information.

This project is being conducted by researchers from the Division of Psychology and Language Sciences, University College London.

Name and contact details of the Principal Researcher (staff member with overall responsibility): Dr [redacted]

This study has been approved by the UCL Ethics Committee (Project ID): 16733/003

Who are we?

We are researchers in UCL's Division of Psychology and Language Sciences. We are independent, which means we will not share your data with the university registry or other central departments. Some members of the team are working with [redacted] student services to help improve the support available to students. The outcomes of this research will be fed back to UCL senior management and will help improve student services.

What is the purpose of the study?

Over the last decade the number of students declaring a mental health problem has increased dramatically. Furthermore, increasing numbers of students are coming forward to say they have intentionally hurt themselves in some way. In this document, we refer to this behaviour as "self-harm", but we fully recognise that some people might use different words to describe it (and this is also something we would like to learn more about). There is a need for better provision of mental health care for students, including those who may have self-harmed while at university. However, there are lots of gaps in knowledge of the experiences of students seeking help for their mental health and how they navigate various supports and services. To improve services for students, we need to understand more about students' experiences from their own perspectives.

We want to gain a better understanding of the experiences of students seeking help for their mental health, by mapping students' mental health support journeys. One important focus of our research will be students who report that they have recently self-harmed in some way.

In particular we want to understand:

- What are the current support journeys experienced by different students?
- What are the things that help or hinder students accessing support for their mental health?
- What can we do to improve the mental health support journeys of students?
- How do students spend their time online and how does it impact their mental health?

Who can take part?

We have contacted you because you meet one or more of the following criteria:

1) You disclosed that you have experienced mental health difficulties while at university
2) You disclosed that you have self-harmed while at university

However, you can only take part if you also meet all three of these criteria:

1) You are a student at [redacted]
2) You are at least 18 years old
3) You are currently living in the UK

We are particularly keen to understand the experiences of students with a **range of mental health problems**, including more and less common problems and those with multiple difficulties. Also, we want to make sure that we hear from both UK and International students.

What will I need to do?

At the beginning of the study, you will be assigned a 'participant case manager' (Alice or Katalin) who will be your main contact throughout the study and facilitate all discussions. Before you agree to take part in the study, you will have an introductory call with them, to find out more about the study and whether you want to take part, and for us to ensure that you are suitable for the study. If you decide you want to participate, you will be invited to complete a secure online survey where we will ask you to answer some questions about your mental health (including self-harm), mental health service use, and your online activities. You can leave out any questions that you do not wish to answer. After completing the first survey, you will be invited to attend an interview-style discussion with your case manager, conducted via Microsoft Teams or telephone (in March-April). This discussion will be an opportunity for you to share more about your experiences of mental health, support, and online activities while at university. This discussion will be up to 1.5hrs for you to share your experiences in detail. Then, roughly three months later (May-August), your case manager will invite you to complete a second online survey and interview-style discussion. We want to collect information from you at two time-points to fully understand your experiences over a period of time that captures some of the ups and downs of the academic year. These timepoints will be agreed flexibly with you so that they are convenient and in line with your availability. With your consent, these conversations will be audio-taped for data analysis purposes. Only the researchers in the study will have access to this data.

Optional linking of this study data with previous study data

If you have taken part in any of our studies before, you can consent for your data collected in previous studies to be linked to your mental health journeys study data. Previous studies that you may have taken part in include the online student mental health survey called 'SENSE' and a study investigating students' views of accessing mental health support (which involved an online questionnaire and optional follow-up interview). This linkage each study's data is optional. You do not need to consent to the linkage of data to take part in this study.

Do I have to take part?

Your participation in the study is entirely voluntary. If you choose to take part you will be asked to sign a consent form, but you will be free to withdraw at any time. You will not need to give a reason and there is no penalty for withdrawing. If you wish to withdraw your participation in the study and also wish for your data collected up until that point to be deleted, you can contact your participant case manager (either Alice Tickell, [redacted] or Katalin Hajdu, [redacted] who will delete this data).

What will happen to the results of the research?

We are planning on publishing the results in a peer-reviewed journal. Our aim in doing this research is to improve mental health services and so we will also be publicising our findings widely. For example, by presenting the results at workshops and publishing the findings on the UCL website. *We will take care to ensure that no students can be identified in any reports or communication about the study.*

What are the possible benefits of taking part?

You will be thanked for your participation in the study with e-shopping vouchers. For each online survey you complete, you will be sent a £5 voucher. For each interview you complete, you will be sent a £15 voucher. Therefore, if you completed both surveys and interviews, you would receive £40 in total. You can leave out any questions you do not wish to answer in the interviews and online surveys, and this will not affect your compensation. Participants will also be contributing to knowledge in this important area. This research is likely to have an impact on services at [redacted]

Are there any possible disadvantages or risks to taking part?

It is possible that participants may feel discomfort as a result of being asked questions about their mental health. No question at any point in the study is mandatory – you do not need to answer any question you do not feel comfortable answering. Information of mental health support resources will be provided at any point if you would like more information about services. If you feel at risk of harming yourself, please discuss this with your GP or go to a hospital A&E department. Any serious adverse events or complaints should be reported to the Principal Investigator, Dr Laura Gibbon [redacted]. If you feel like your complaint has not been handled to your satisfaction, you can contact the Chair of the UCL Research Ethics Committee by email [redacted]

Who is organising and funding the research?

The research is organised and funded by University College London (UCL).

How will my data be kept safe?

We will try to limit the amount of personal information we ask you, but some details are essential for us to be able to carry out our research project. The information we collect from you includes "personal data" and "special category data", which is regulated under the Data Protection Act (2018) and General Data Protection Regulation or GDPR (2018), which means that we must make special precautions to ensure that your information is not shared with third parties or unauthorised people. Under GDPR, "personal data" is any information from which a person could potentially be identified from, for instance, a name or identification number. GDPR also singles out some types of personal data as "special category" because they are more likely to be sensitive, such as data concerning racial or ethnic origin, health, or a person's sexual orientation, and gives these data extra protections.

Any data you share with us will be stored on secure, password protected servers, in line with national and UCL guidelines. After the surveys and interviews, researchers will download the survey data, audio recordings, and interview transcripts and store them in secure UCL servers in a folder that only the research team can access. They will encrypt audio recordings using 7-zip and password-protect all files using strong passwords. After ensuring that the data has been downloaded safely to the UCL server, the researchers will delete any recordings stored elsewhere. At the end of the project, audio files will be deleted. The CSV files and transcriptions will be retained for up to seven years beyond the end of the project. However, retained data files will not contain any information which could directly identify you. This project is part of a larger programme of work aiming to better understand student mental health. The Principal Investigator may repeat the study in the future, comparing data collected for this study with future data.

Will my taking part in this study be kept confidential?

If you participate in the study, your data will be *pseudonymous:*

- You will be assigned a study ID number. Your responses in the interviews, online surveys, and questionnaires will be linked to this ID number only.

If you participate in the study, your data will be kept *confidential*:

- All data will be collected and stored in accordance with the Data Protection Act 2018 and the General Data Protection Regulation (GDPR) 2018.
- Pseudonymised data will be stored on a password protected UCL server.
- Only the researchers involved in the study will have access to your pseudonymised data. These will *not* be shared will any third parties including your academic department or the UCL student services.

However – if during the research project you disclose something that makes us feel worried for your safety or the safety of someone else, we may need to contact professionals outside of the research team, such as your GP, a crisis service or [redacted] Student Support and Wellbeing, to ensure that you receive the support you need. In such cases we would always try to speak with you first and we would only share information that is relevant to ensuring your safety. You will have the opportunity to discuss confidentiality in more detail in your initial call with your participant case manager.

Thank you for taking the time to read this information sheet.

Local Data Protection Privacy Notice

Notice:
The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk

This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our 'general' privacy notice:

For participants in health and care research studies, click here

The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices.

The lawful basis that will be used to process your personal data are: 'Public task' for personal data and' Research purposes' for special category data.

Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

Researcher biographies

If students expressed an interest in the study, this would disclose self-harm to myself and Katalin Hajdú. Researcher pictures and biographies were shared as part of the recruitment materials, to give potential participants the opportunity to recognise if we knew each other, or if we occupied similar professional circles. However, these are not shared here to preserve the researcher's privacy.

Appendix 6: Study Consent Form

Student Mental Health Journeys: Consent Form

This project is being conducted by staff from the Division of Psychology and Language Sciences, University College London.

Name and contact details of the Principal Investigator (staff member with overall responsibility): [redacted]

Name and contact details of the Researchers [redacted] and [redacted]

This study has been approved by the UCL Ethics Committee (Project ID): 16733/003.

Please complete this form after you have read the Participant Information Sheet.

Thank you for your interest in taking part in this research. Before you agree to take part, please read through and complete this form to acknowledge that you understand your involvement in this study and that you consent to participating.

I confirm that:

	Yes
I have read and understood the written information above and the information sheet, and I understand what the study involves.	○
I have been given the opportunity to ask questions about the study and my participation.	○
I voluntarily agree to take part in this study.	○
I understand that the study involves participation over the course of 6 months and involves two components: two online surveys, including questionnaires, and two discussions via videocall.	○
I consent to participating in the discussions via videocall.	○
I consent to participating in the online surveys.	○
I consent to participating in completing the questionnaires.	○
I understand that the information I provide is confidential, but if the researchers assess that I am in serious risk of harm, then they may contact external stakeholders such as my GP. I understand that the research team will never share any of my information to external stakeholders without my knowledge.	○
I understand that I can withdraw from this project at any time, without having to give a reason and without penalty, and my collected data up until the point of withdrawal can be deleted by emailing the researcher.	○
I understand that my data gathered in this study will be stored pseudonymously and securely. It will not be possible to identify me in any publications.	○
I understand that according to data protection legislation, 'public task' will be the lawful basis for processing personal data, and 'research purposes' will be the lawful basis for processing special category data.	○
I understand that the data will not be made available to any commercial organisation but is solely the responsibility of the researchers undertaking this study.	○
I understand that the Researchers involved in this study will have access to this data.	○
I agree to sign and date this informed consent form.	○

I consent for my data to be linked with other studies that I have participated in:

If you did not participate in these studies, please select 'not applicable'.

	Yes	No	Not applicable
IMPACTS (a short online survey about access to mental health support, with an optional follow up interview).	○	○	○
SENSE (an online survey about mental health and other factors such as finances, university life, and seeking help).	○	○	○

UCL researchers may use my details to invite me to take part in related follow-up studies (optional)

Yes

No

Appendix 7: Survey questions on mental health, service use, and self-harm

The following questions ask about your mental health.

Have you ever had, or suspected that you had a mental health problem?

- Yes
- No
- I prefer not to say

Please provide more details about the mental health problems you have experienced:

How old were you when you first experienced any mental health problem?

Have you had any mental health problems while at university?

- Yes
- No
- I prefer not to say

Has a professional ever diagnosed you with a mental health problem?

- Yes
- No
- Not sure
- I prefer not to say

What was the diagnosis you received? If not sure, please also provide further details:

The following questions about your use of services.

Have you ever had counselling or therapy for a mental, nervous, or emotional problem?

- Yes
- No
- Not sure
- I prefer not to say

Which type(s) of counselling or therapy did you have?

Select all that apply

▢ Psychotherapy or psychoanalysis

- ▢ Cognitive behavioural therapy
- ▢ Art, music, or drama therapy
- ▢ Social skills training
- ▢ Couple or family therapy
- ▢ Sex therapy
- ▢ Mindfulness therapy
- ▢ Alcohol or drug counselling
- ▢ Counselling (including bereavement)
- ▢ Drop-in support service
- ▢ One-off wellbeing workshop
- ▢ Not sure
- ▢ Another type of therapy (please describe): _____
- ▢ I prefer not to say

What type of service did you receive this from?

Select all that apply

- ▢ University support service
- ▢ NHS service (or equivalent in home country)
- ▢ Private service
- ▢ Secondary school support service
- ▢ Charity
- ▢ Other (please describe): _____
- ▢ I prefer not to say

How old were you when you received these services?

Please list if you have accessed multiple services

How was this experience?

- Very positive
- Quite positive
- Neither positive or negative
- Quite negative
- Very negative

Please explain the reason to why your experience was positive/negative here:

Have you ever taken any medication for a mental, nervous, or emotional problem?

- Yes
- No
- Not sure
- I prefer not to say

What was the type of medication that you had?

- Antidepressant
- Anti-anxiety
- Antipsychotic
- Other (please describe): _____
- Not sure
- I prefer not to say

How old were you when you received this?

Please list if you have taken multiple medications.

How was this experience?

- Very positive
- Quite positive
- Neither positive or negative
- Quite negative
- Very negative

Please explain the reason to why your experience was positive/negative here:

The following questions ask about times you may have intentionally hurt yourself.

Have you hurt yourself on purpose in any way while at university?

- Yes
- No
- Not sure
- I prefer not to say

What did you do to hurt yourself?

Leave blank if you prefer not to say

How old were you when you first remember doing this?

Leave blank if you prefer not to say

How many times have you done this while at university?

If you are not sure, it is okay to make a rough estimate

- 0-5
- 5-10
- 10-20
- 20-50
- 50+
- Really not sure
- I prefer not to say

When was the last time you did this?

Leave blank if you prefer not to say

Appendix 8: Interview Schedules

Table 2

T1 interview schedule section 1: Self-harm and help-seeking

Question	Prompt
1	Firstly, I would like to start by talking about your experiences of mental health while at university. Can you tell me about the times you have struggled with your mental health since starting at university? We could think of it a bit like a timeline. Can you give examples of specific times that you found particularly difficult?
Follow up/prompts	• In your questionnaire, you said that you have experienced <anxiety/depression/eating disorder, etc.> while at university. Can you tell me about how that impacted you?
2	Who knows about these difficulties? Who have you spoken to about it?
Follow up/prompts	Encourage them to list everyone they have spoken to… Prompt: • This could be a person from your family, a friend, academic staff, a therapist/counsellor, doctor, people online… • If they don't mention it: You also mentioned in your questionnaires that you have received counselling/therapy/medication while at university. Then explore each in more depth, in chronological order if possible • Starting with <person>, can you tell me about your experience of talking to them? Additional prompts: • When did you talk to them? • Why then? How did the conversation come about? What prompted the conversation? • Did you approach them, or did they approach you? • What made you want to talk to them? What were you expecting? • What happened? Did it match your expectations? What was good/bad about it? • How did that make you feel? (About yourself/your problems?) • How did this affect you/ change things for you? Who did you speak to next?

	• Same as above (If relevant) COVID-19 impact: • How did the COVID-19 pandemic affect your experience of talking to them? Prompt anyone else not mentioned: • Is there anyone else who you have spoken to or tried to speak to about your difficulties? If they have not spoken to anybody: • What influenced your decision not to talk to anybody?
3	So far, we have covered who you have spoken to about your difficulties while at university, and we will certainly discuss that in more depth as we go along. Next, I would like to ask some questions about experiences of self-harm. Remember, you do not have to answer any of my questions, and you can tell me if you do not feel like answering any of them. In your questionnaires you indicated that you have [self-harm method(s)] while at university, X times. Can you tell me about the situations that led you to [self-ham method(s)] while at university?
Follow up/prompts	Prompts: • What would you say are the main triggers (for self-harm)? • Can you tell me about the times or situations where you were doing that more? • What about the times or situations where you were doing that less or not at all? Prompt intention: • When you do that, what is your intention? • [Has your intention ever been to end your life?] • How do you feel about the term ‘self-harm’? Do you feel like those words reflect your experience? Prompt for their views: • What effect does this have on you? • Is this a good thing or a bad thing? • Has it always been like that? Have you ever felt differently about it? If they have mentioned more than one self-harm method: • Do you do one method more than the other?

	• In what ways do the [self-harm methods] differ for you? Expand on self-harm: • Thinking about self-harm more broadly, is there anything else which you did not mention in your questionnaire that you have done even though you knew it would hurt you, or with the intention to hurt yourself?
4	Before, we talked about who you have spoken to generally about your main difficulties, but I am interested to hear if there is anybody who knows about [self-harm]? (This could be a person from your family, a friend, academic staff, a medical professional in the NHS or a private service, a therapist or counsellor, somebody on a helpline)
Follow up/prompts	Get them to list everyone they have spoken to… Then explore each in more depth, in chronological order if possible • Starting with <person>, can you tell me about your experience of talking to them? Intention: • When did you talk to them? • Why then? How did the conversation come about? What prompted the conversation? • Did you approach them, or did they approach you? • What made you want to talk to them? What were you expecting? Their intention/the impact: • What happened? Did it match your expectations? • How did that make you feel? (About yourself/your problems?) • How did this affect you? Did that change things for you? How? Who did you speak to next? • Ask the same questions as above (If relevant) COVID-19 impact: • How did the COVID-19 pandemic affect your experience of talking to them? Prompt anyone else not mentioned: • Is there anyone else who you have spoken to or tried to speak to about the self-harm? If not mentioned, prompt medical attention: • Have you ever received medical attention for your [self-harm]? • How many times has that happened? • Ask questions above

	If they have not spoken to anybody: • What influenced your decision not to talk to anybody? • Have you thought about approaching anybody?
5	Are there any other sources of support you know about that you think could be helpful for your difficulties? This could be anything we have not talked about yet – such as a person, helpline, online information, anything at all that you think might help you.
Follow up/prompts	• What do you know about them? How did you find out about them? • Have you tried to get support there? Are you planning to get support from them? What has influenced that decision? • What would need to change for you to reach out?
6	Thinking forward, what is coming up for you at university? When I next talk to you in 3 months or so, how do you think things will be for you? Do you anticipate any particular challenges? How do you plan to handle things going forward?
7	Is there anything else you would like to say about your experience of seeking help for your mental health while at university? How have you found it answering those questions?

Table 3

T1 interview schedule section 2: Social media use

Question	**Prompts**
1	In the next part of the interview, I will be asking about the types of things you do online. By that I mean the types of things you spend your time on when you are using the internet. Some people find it helpful to open up their phone and look at their apps to help with this or look up most visited websites or their laptop or PC so feel free to do that whilst answering this question. What sort of things do you do online? What do you like and dislike about your online activities?

Follow up/prompts	Types of activities – refer to questionnaire answers to ask about specific activities. If more than one for each type, please ask to choose 3-4 most significant/impactful to discuss regardless of category - e.g., decide to talk about Whatsapp, Reddit and Instagram based on usage/impact
	
	- What do you usually do on x blogging site/social media site/website/gaming/etc? – explore 2-3 main
	- Do you consider yourself part of any online community?
	  ○ [if yes] How involved are you in x online community? (explore each if more than one)
	- Do you use any anonymous accounts on any of the websites or apps we discussed?
	  ○ [if yes] What made you want to be anonymous?

	○ How does that impact on your use and experience of x website/app? - What is the impact of the covid-19 pandemic on your online life and activities?
2	We spoke a bit about your online life and the sort of things you do on the internet. How do these activities influence or impact on you?
Follow up	Prompt to expand on each online activity discussed in previous question – max 3-4 different Prompt to expand on strong emotional reactions, behavioural changes following consumption of specific content Make sure to cover the following: Online activities impacting on mood - How does [online activity] influence your mood? (expand on 2-3 significant ones identified in question 1) - Based on what they describe, prompt for the other, e.g. any positive experiences if mentioned negative - What was it like when you felt x after [online activity]? (they may expand on behaviour here, e.g. withdrawing when feeling sad, etc) - Did your behaviour change in any way as a result of this experience? (doing more or less of stg) Mood impacting on online activities - Have you ever noticed your mood impacting on what you do online? Can you give me an example of that? (e.g. doing more/less of something when feeling x? -> try to explore positive and negative emotions) - [if yes] What expectations did you have when you felt x and sought out [online activity]?
3	Now I'd like to ask a few more questions about your online interactions. By that I mean both reading posts from people and actually interacting with others such as. Friends, family, strangers, public figures, etc Who do you follow and engage with online?
Follow up	Depending on who they mention, briefly ask about others: - Family - Friends - Public figures - Professionals - University staff If not mentioned yet, explore for each mentioned above: - What kind of topics do you talk about with x? - Do you talk to x about the difficulties we spoke about earlier in the interview? - And if you know, what might impact on these decisions to talk to x about y? - And what might impact on your decision to not talk to or share with x about y?

	- How do these experiences impact you? o [if not mentioned yet] How do you usually end up feeling after talking to x? o Is there any way your interactions with x would impact what you do?
4	You've mentioned that you have been struggling with/diagnosed with [mental health difficulty]. What has been the impact of your online activities on this difficulty?
Follow up	• Which experiences have been the most negative? • Which experiences have been the most positive?
Final question	I've asked all of my questions now. Is there anything you were expecting me to ask about / anything you thought I would ask you about, when you first heard the topic of this interview? How have you found answering the questions in the interview?

T2 Interview Schedule

Table 4

T2 interview schedule section 1: Self-harm and help-seeking

Question	**Prompts**
1	How has your mental health been since we last spoke to each other?
Follow up/prompts	Prompts: • On your survey you mentioned that your mental health has been better/stayed about the same/gotten worse. Can you say more about that? • What contributed to your mental health being better/the same/worse? • How has the ongoing COVID-19 pandemic affected your mental health? Self-harm: • On your survey, you mentioned that you [self-harm method] X times. What do you think triggered that? What was the sequence of events? • What did you think after? How did you feel after? • Has anything changed about how you self-harm?

	Or if they have not self-harmed: • On your survey, you mentioned that you did not self-harm since we last spoke. Are you aware of anything that might explain this? Anything that happened or any changes for you?
2	Who have you been speaking to about your mental health since we last spoke to each other?
Follow up/prompts	Prompts: • If they don't mention it: You also mentioned in your questionnaires that you talked to [your GP/a therapist] • When? Why then? What prompted the conversation? • What made you want to talk to them? • What happened? What was good/bad about it? • How did that make you feel? • How did this affect you/ change things for you? • How did the COVID-19 pandemic affect your experience of talking to them? Self-harm • We have talked about who you have spoken to generally about your main difficulties, but I am interested to hear if there is anybody who you spoke to about your [self-harm] or [self-harm] in general? • If yes: use some of the prompts above • If no: see below If they have not spoken to anybody: • What influenced your decision not to talk to anybody? • How did the COVID-19 pandemic affect your experience?
3	So far, I have asked you about your recent experiences of your mental health and who you have spoken to about that. Now I would like to ask you to reflect on your mental health journey as a whole since starting university. Up until now, how much do you feel that you got the support you needed for your mental health?
Follow up/prompts	Prompts: • What was the most helpful type of support you received? What was less helpful? • What got in the way of you getting the support you needed? What helped you to get the support you needed?

4	If you could take a blank sheet of paper, and design the ideal type of support you would have wanted for your mental health, what would it look like?
	Prompts: • Where and how would it be offered? How would you access it? • When would it be offered? Self-harm: • During your time at university, would you have ever wanted additional support to manage [self-harm/crisis]? o What would that look like? o Where/how would it be offered? How would you access it? o When would it be offered?
5	Is there anything else you would like to say about your experience of seeking help for your mental health while at university?

Table 5

T2 interview schedule section 1: Social media use

Question	Prompts
1	In the last interview we discussed your online activities in general and some ways in which it has impacted on you. In the interview today, I would like to focus on your social media experiences. Since the last interview, how have you been using social media? 1. Have there been any changes in your views of social media since our last interview? 2. Have you had any particularly positive experiences? Negative experiences? Anything that has stood out as significant or impacted you significantly?
2	In the previous interview we spoke about what you typically do online. Now I'd like to know more specifically what information about mental health have you encountered online and especially in your social media use? 1. [if did not already listed] What negatives/positives? Any specific examples? 2. How do you think that impacts society's view of mental health? 3. What has been the impact of this on your view of mental health? 4. What has been the impact of this on your own mental health and how you see yourself? (rather than view) 5. How has the view/impact changed for you over time? How long did these thoughts/feelings/behaviours stay with you? (e.g. from child/adolescent to now)

	6. [if disclosed negative experiences] What do you think would have helped you manage the impact of these experiences better?
3	Have you ever encountered any content related to self-harm online? [If relevant, explore more than one specific experience but focus on what had the most significant impact] 1. Where/What was it about? 2. How did you encounter it? 3. How was self-harm depicted (positive/negative light, normalised, etc)? 4. How did it make you feel? 5. What did it make you think? 6. How might other people feel seeing such content? 7. What do you think about it looking back now? (if talking about past, rather than current experience) 8. [if disclosed negative experiences] What do you think would have helped you manage the impact of these experiences better?
4	Some people when looking at posts by others find themselves comparing themselves to these while other people do not. Which seems closer to how you are? 1. Do you ever find yourself comparing yourself to them whether they are friends, public figures, celebrities? a. Can you give some examples of this happening? [try to explore positive/negative/neutral experiences] b. How does it make you feel/how do you think this influences you? [try to explore thoughts, emotions, behaviour] i. Explore friends/celebrities/family/professionals separately if applicable 2. [if disclosed comparisons] Do these online comparisons ever involve comparing your mental health or difficulties to other people's? a. Can you give some examples of this happening? [try to explore positive/negative/neutral experiences] b. How does it make you feel/how do you think this influences you? [try to explore thoughts, emotions, behaviour] 3. [if disclosed negative experiences] What do you think would have helped you manage the impact of these experiences better?
5	Is there anything else you would like to say about your experiences of social media that we haven't touched on yet? How have you found it answering those questions?

Appendix 9: Initial observations of trends in the interview data

- The transition to university is very hard for people - adult responsibilities, taking care of yourself for the first time. Easy for things to slip. Losing your previous systems of support (family, old friends, counsellors from before). Study pressures. Feeling like you 'can't hack it' if you are struggling.
- Stigma of talking about mental health. Easier to share with other students where they know they have similar difficulties. But don't want to be a burden on others. Caring for people and being cared for.
- Difficult to share with parents / closer people who might get emotionally concerned. But parents can be important for providing practical support. Financial support for private therapy.
- Hearsay from other students can influence reputation of a service. If people say good things ➜ more likely to speak. If people say bad things ➜ less likely
- Situational mental health stressors - UCL counselling is helpful to get through a stressful situation
- Worst demographic seems to be severe mental health but not life-threatening. They get bounced around, until some find the right thing, others give up.
- Have to advocate for yourself (e.g., that you need medication). Advocating for yourself is very hard when you have a mental health problem. Part of your difficulties might be that lack self-esteem - don't believe you 'deserve' help. These experiences may reinforce this narrative.
- As soon as someone's problems are life-threatening (anorexia, suicidality) then they get support - e.g., in-patient care. For some people, inpatient care was life-changing ('saved their lives').
- Someone consistent to help with the practicalities - advocate or tutor. "Good eggs"- individual helpful people but not integrated into the system

- Helpful when academic staff reach out and make themselves available. Some academics just want to get on with the academic stuff.
- Physical manifestation. How can you "prove" anxiety or depression? Self-harm / losing weight automatically grants you more attention. When the mental health problem becomes a physical health problem, then you get taken more seriously. Academic metrics - if you are doing well academically then you slip through the cracks.
- Not feeling sick enough. GPs telling people they are not sick enough - e.g., your BMI is not low enough to warrant support. Encouraging people to get sicker.
- Long waiting lists - don't want to take up the space of others. Makes people compare whether they are sick enough to warrant support. The feeling that so many people are unwell/struggling
- Rude/insensitive GPs - people don’t complain because the NHS is overstretched
- Those registered with a 'disability' get access to good support at UCL - e.g., autism. But confusion as to who qualifies for this? The stigma of officially registering your mental health problem as a disability is a barrier.
- Having an "official" disability = support. GPs as gate holders to diagnosis. Medicalising.
- Interruption - being told to interrupt as a solution, rather than supporting people to stay in education. Can't hack it. SORAs actually being implemented?
- Length of therapy: Short-term therapy unhelpful… Longer-term therapy desirable/useful, but hard to get without paying. Most services offer 6 sessions.
- Choice is important / perseverance if the first thing doesn't work - trying something else

Appendix 10: Excerpt of the coding process

Table 6

Transcript excerpt with codes, demonstrating how they were incorporated into sub-themes and themes

Transcript	Code	Sub-Theme	Theme
I registered with [university] I think was [name of service] is that what it was called before, like the psychological services? […] I remember at the ass- end of the assessment. […] They obviously said that we can do, they can do six weeks of psychotherapy or CBT. Erm. But, at the end of the assessment I think I was like crying, and she was basic-, and she was like "well, I can walk you to A&E if you need to now?" 'cause I was quite like, passively suicidal but also a little bit, I was just suicidal basically. Erm, and, but it basically concluded that, I can't remember if she said it then or later on, that I wouldn't be able to be on the service, because it was too complicated for like six weeks, or she didn't want to do it short term and like, not be able to like carry out a full thing. So, then I went back to	University counselling 6 sessions not enough Problems too complicated for short-term therapy Sent on to A&E	Long-term support for long-standing problems Being shipped from person to person	Choice and flexibility of treatment supported recovery The beginning of university was the hardest part

the GP and got put on a waiting list. Started uni. My mental health was not great at the start of uni because I had quite bad anxiety and I don't really want to go out like clubbing and stuff. Erm, and, I didn't really make friends for like the first month, I just kind of sat in my room and watched TV. Erm, and, I found the whole experience quite overwhelming, erm. […] I was still just really shit at talking to people ((laughs)). And I didn't really make friends for a while. Erm. So, I was still going to the GP, I remember I had a really bad experience the first time I'd spoke to the GP, 'cause she asked me about, because I tried to kill myself when I was fifteen. Erm, so she asked me about that and was like, “Oh, do you like want to live now?” And I remember being like, erm, “No, but if I'm gonna live I might as well live” and she's like “Well, why do you study [subject] then?” ((laughs)). I remember, not being ((laughs)) thrilled with that.	The start of university was difficult Social isolation Socialising difficult due to anxiety Judgemental response from the GP	Suddenly no one knows your name I didn’t want people to judge me	The beginning of university was the hardest part Escaping judgement, worry, and repercussions from others
But I saw her again anyway later on, because I was like, “Well, I've talked to them before, so I might as well keep,” but now	Needing to switch GPs	I didn’t want people to judge me	Escaping judgement, worry, and

I've switched, I'm at the same practice, but I go to a different GP just 'cause like, why not? ((laughs)). And. So. This is probably about like, October, November time. I can't remember what happened fully. I was on the waiting list to be on psychotherapy, at [name of clinic], I think? Erm, so I, think I was going to be referred to be in group therapy for psychotherapy, but I needed an assessment for that. They lost my referral. Erm, so I had to chase it quite a lot, and finally got one at the start of January, which by then the group had already started ((laughs)). So, and then they were also like "I think you should try CBT before doing psychotherapy because I think you need to be like, that would help you more than psychotherapy because you're not really opening up in the assessment," which was a bit like annoying 'cause, that was the plan I had with the psychiatrist from CAMHS in [city], but I also probably wasn't very open as well so, eh. Erm. And, I felt really, really low in [date] as well. Erm, like quite suicidal, I think	Waiting for therapy Lost referral causing delays Needing to chase referrals Preference for therapy not considered by professionals	Being shipped from person to person Being shipped from person to person Treatments to suit my preference	repercussions from others The beginning of university was the hardest part The beginning of university was the hardest part Choice and flexibility of treatment supported recovery

that's probably when I self-harmed a bit, erm. And, I felt really lost and stuff, erm. […] And, then I went on medication in [date], is that right? [Date]. And I only went on it for like maybe six weeks and it didn't really help. Erm, partly because I think I just needed therapy ((laughs)). And it just kind of, made everything feel numb that I wanted to cry but I couldn't do anything about it. But at the time I was like, "Well, I literally feel like I'm gonna kill myself so" ((laughs)) "might as well try it", you know. Erm. […] So, the person on my floor is called [name] and he was really nice. Erm. And I think he must have had me crying or something, because […] was like "If you ever need to chat, come find me" ((laughs)). Erm. And. That must have been in [month], because I remember one time I did go chat with him, erm, 'cause I was just like "Ah I've got no friends and it feels awful." Erm. And that was really nice, erm.	Delays to therapy causing deterioration in mental health Easier/quicker to access medication than therapy Not receiving preference of treatment People checking in helpful Social isolation	Being shipped from person to person Treatments to suit my preference Suddenly no one knows your name	The beginning of university was the hardest part Choice and flexibility of treatment supported recovery The beginning of university was the hardest part

Appendix 11: Bracketing Interview Transcript

I: OK, so just to start off then it would be really helpful to hear a bit about your project and what brought to your project?

R: So, my project is a qualitative study interviewing students at UCL who have self-harmed while at university. And what I am interested to know from them is what their experiences of trying to seek help for their mental health have been like. And specifically, what their experiences of trying to seek help or not or not seek help for self-harm has been like and their motivations behind seeking help or not seeking help. What that was like, what their expectations were, and whether those expectations were met or disappointed. And really, to get any ideas, the aim of the project is to get any ideas on how to improve student services and NHS services to support people. What brought me to this topic was my own experiences at university, when friends of mine have been really struggling with self-harm, it's a memory, probably memories that I have of those friends ending up in A&E and really not getting the support that they needed. And I think that shock, at the time that you know this is something that's really serious, you know potentially fatal, I think that was obviously a shock to me personally, because these are people I really cared about. But then there's also the secondary shock of the services don't seem to be taking this that seriously, and the feeling of almost being left to our own devices to support these people. And we were just, you know, we were young people, we were like really young. I mean, I studied psychology, but I had no idea how to support someone in that position, really, I was just, you know, we were just doing our best to do what we could to make them feel supported and to try and get them the support that they needed. But I was really shocked at how there wasn't much follow-up from the university. And also, the experience that people have had with NHS services as well, whereby you do have a more serious mental health problem, you don't meet criteria for IAPT, you get you get turned away for being too severe, but then, the waiting lists for secondary care are so long and the criteria for that are so high that you often don't meet the criteria. And so, it's just this feeling of helplessness, of seeing my friends really struggling and not knowing what to do about it. And

now that I'm in a position, well, I'm training to be a clinical psychologist, I know a lot more than I did then, and I have a lot more, I guess I power to choose a research project to investigate this further, to understand it better and I just want to use that to hopefully influence mental health services in a positive way. So that they could make the changes that they need for young people to feel more supported when they are there in that position. And yeah, I guess on a serious note, it's just, you know, coming back to that shock that these you know this is something potentially fatal, like I could have lost my friends. And I would really just like to see more being done to support people in that position. And I guess we'll come on to how my strong feelings may influence my research, I'm very aware of that, and I'm looking forward to talking more about it. I think I'll leave it there.

I: Well, thank you so much for sharing that. It sounds really, really interesting. Do you have any thoughts or ideas on what you might find as part of the research?

R: Well, I think I've alluded to this already, but I do. So, I do expect, well, there are many reasons for this, but I would be surprised if people didn't talk about their experiences of struggling to access mental health care. I'm very aware that the type of people who might want to talk to me about their experiences might be people who have really struggled, whereas the people who maybe haven't struggled probably wouldn't be drawn in by that recruitment email. I think people who feel strongly on it might be people have had bad experiences. So due to my own experiences and due to the recruitment situation, I would be surprised if there weren't people talking about times that they really struggled to access mental health support. And I need to be aware of that because the aim of the project is on how to improve mental health services. So, I do want to know what's not going so well, but I also want to know about what is going well, because that's really important too. So, I can't let my preconceptions influence me to focusing more on the negative than the positive because I think what's being done well already is really important to know more about as well. Your question was what do I expect to find? Yeah, I think mainly that and another thing that has influenced me saying that is because we do have a steering group of young people at UCL who have had experiences of mental

health problems. A lot of what I was hearing was disappointment about the support that they've received while at university. So, that also leads me to think that my results may show that people do struggle. And that they might get six sessions of therapy, and that's not enough, and they might struggle to meet criteria for the kind of perfect service for them. So that's why I expect to find.

I: Yeah, and I'm just wondering, you mentioned about that you want to be aware of that and kind of aware of your position. How do you think you might do that?

R: Well, I think reflecting on it is really important to know what my position on it is and what my experiences are bringing to this project. I think knowing that is really useful because it can help me think about my research questions and I have already thought about that quite carefully about making sure my questions are open and not focusing too much on the negative, but rather asking quite open questions about like what has your experience been, as opposed to, you know, tell me all the bad stuff? So, I think that's one thing that I can do in terms of just making sure the questions are open, and making sure that in the interview I don't seem more interested when people talk about the negative than the positive as well. You know, even our body language conveys what we were interested in, so just trying not to express more of an interest in the negative than the positive.

I: And you've touched on this a little bit out, but what do you think you might find that might be negative, difficult or might clash with your ideas?

R: Well, I guess we've kind of touched on this already, yeah, but if people only had good things to say, it would slightly negate the purpose of my project, because, that's a bit strong, but the purpose of my project is to gather suggestions for what services could do better, because there is a lot of research evidence to suggest that young people aren't accessing mental health, that they are under accessing mental health services, and those who do access services drop out quite quickly, so that's kind of where I'm coming from, so I would be surprised, I would be surprised if people only had good things to say about mental health

services, but not in a negative way, I'd be really happy to hear that, but yeah, I suppose the purpose of the project is to think about what services could do better, so I can't help being interested in that, I suppose, but again, it comes back to just, it's really helpful to talk about it now and think about how that might influence the project because it is so like intrinsic to the aim of the project. What else I think I would find really difficult if someone was having a difficult time accessing support, but I've thought about that quite carefully when designing the project and we've built that into the risk protocol so that we've accepted it as a limitation of the project. That if someone says that they are receiving care that's inadequate, or if they express that they're really struggling to find appropriate support that they need, we will step in and signpost to appropriate services. So, we have to accept that that's a limitation of the project, that we are intervening with people's mental health experiences, but it's a necessary intervention. And if we didn't do that, I would feel really uncomfortable about doing the project. And well, I think I'll find it difficult if I just sign-posted someone to a service, and they have already had negative experiences there. That's not something I've really thought about until now, and it's something I'm going to have to think about carefully. If I give them a list of resources and they say, oh I've already tried with all of these people, I think that will leave me feeling quite stuck. I'm grateful to have my supervisor, who I could talk to in that situation, but it's worth thinking about in advance because it may well happen. If people are really desperate, they may have tried everything already. I think I'd find that quite difficult.

I: Absolutely. And how do you think that you sharing participants experiences or backgrounds will influence the different stages of your project?

R: So, I suppose you could think about it in terms of recruitment, and then the interviews, and the analysis. I think having been a student, I mean I am currently a student, so that is a characteristic I'll share. But the type of student I am might differ so I doubt we'll recruit anybody who is doing exactly the same course as me. But we do share that are both students at UCL. And how that will affect the different stages? I think it will help with recruitment, if participants or if students want to talk about their experiences, they might feel uncomfortable doing that

with UCL staff. There might be something quite reassuring about the idea of talking to someone who they may view as more of a peer. So that's something that I do share with them and that might help participants to feel more comfortable talking about their experiences. But, on the other hand. I might over-identify with some of the participants, if they're talking about experiences where I may have had some, you know, I kind of identify with the experiences or almost what's the word, that transference, you know, if they remind me of someone, I may over identify with them. And that might make it harder to just listen and afterwards it might be really hard because when you're a researcher you don't have the same access to their internal life that you might as a psychologist. I think I need to make sure I've got the right support throughout the project. It's not an easy subject matter to talk about so I think I need to make sure that I don't go into it too naively thinking that because I'm a clinical psychologist, it's going to be, you know, I'm gonna be fine. I think I'll need to make sure I've got support systems in place in case I do need to talk to someone about how I'm feeling.

I: And do you think that could have an influence on the analysis as well?

R: Yeah, definitely. I think it could, yeah, and I think that's the stage when I'm gonna have to be the most careful because it's a semi-structured interview. It's going to be fairly pre-determined questions I'm asking and the topics that I'm exploring, but the analysis might become a time where it's easier for your subjectivity to influence. For instance, when pulling out themes. Maybe like we talked about before, maybe focussing on problems rather than what's going well, if I identify with that. So that's the time when I'm gonna have to maybe come back, read this interview and do more reflective logs just to try and step back from how my experiences might be influencing my analysis and maybe get other people's perspectives. I'm doing a joint project so there will be someone else who I can bounce ideas off. She might be able to let me know if my subjectivity is influencing my analysis. But it's impossible to completely detangle yourself from the research and be entirely objective. So, I think that's why doing this bracketing, being really explicit, explicit about where I come from will be important for people to know when reading my project, because I'm not a firm believer in the idea that

you can like completely separate yourself from your research. So yeah, just being aware of it and being really explicit about where I'm coming from.

I: And then just on the other side of so, how do you think potentially not sharing participants experiences or background might influence the different phases of your project?

R: Yeah, So what comes to mind is that I did my undergraduate at different university, whereas I haven't been a UCL student for that long, so maybe it is really important to reflect on the fact that I might be bringing experience my previous experiences from a completely different university. You know, it will have some commonalities, but it might have a lot of differences in the way that services are structured and the support that people receive. So, I definitely can't assume that it's going to be exactly the same. The pathways that people can go through might be completely different as well. So, I'm thinking I should probably familiarize myself quite intimately with UCL student support services so that I understand the logistics of where people go and when so that when people are talking about that I understand what they're talking about. I think that would make it easier for me to fully understand what they're saying. So that's the main thing that comes to mind, I think also being a psychologist in training, that's a difference. I may be a UCL student, but I have clinical experience, which might set me apart from my participants who may not, I mean they might as well, so that would be interesting in itself, but just being aware of that as a dimension of difference as well. That kind of knowledge of psychology and their experiences with clinical psychologists. And I mean the whole project is about accessing help, so it's likely they might have spoken to psychologists in the past and they may have had really good experiences, or they may have had awful experiences with the psychologist. On recruitment I think we send them a little bio about who we are so they will know a lot about my background and who I am. But I'll have to be thoughtful about when they're talking about their experiences with psychologists, they might feel they need to hold back and, you know, give more of a positive impression about the profession. They might not feel comfortable talking to me at all, but then I probably won't be interviewing those people. But that's an important limitation of the research that I have to acknowledge that there might

be people who just don't want to talk to me in the first place because they've had such bad experiences with psychologists or with people affiliated with UCL. So, we're going to capture quite a specific group of people, and that's important to keep in mind. There are lots of ways that I might differ from them, but those are the main ones that came to mind at first.

I: Are there anymore that you want to?

R: I think those are the ones that are most relevant to the project, but. Of course, people might differ to me, and in a lot of ways. I think as psychologists we are encouraged to think about that in our clinical work. So, I think I'll try and carry that through as much as possible to be mindful of people's differences and not let that affect the conversation in a way that will be detrimental to the person.

I: And what assumptions might your participants make about you?

R: That's a really good question. It could go so many ways. So, they know that I'm a student at UCL. They know that I'm a clinical psychologist in training. They might assume that I am an authority on issues of mental health. They might assume, yeah, that might be a bit of a power dynamic. In that respect, they might see me as a clinician rather than a researcher. Which might, well, that might affect how they think the conversation will go, so I need to be really careful that I'm clear, that it's not a therapeutic space, it's a research conversation and I have thought about how to set that up in a way that people don't feel misled in terms of what the purpose of the conversation is, I think that will be really important. I wonder what they'll think about the fact that I'm interested in self-harm and why I'm interested in that. They might assume I've got personal experiences with self-harm, that's why I'm drawn to the project, you know, they may think that I have self-harmed and that's what draws me to this topic. I'm not going to be talking about what brings me to the project that in our conversation, so they won't know either way. But they might be curious, they might ask, so I guess I have to prepare question and answer in case people do ask. I guess on the flip side is they might assume that I know nothing about self-harm and that I really don't understand where they're coming from.

I think there's a big stigma about self-harm. People might feel I don't understand what they're going through. And I've been thinking quite a lot about how to word my questions because I've read a lot of research that suggests that a lot of people who self-harm don't necessarily view it as a bad thing, whereas if we're positioned as clinicians, they might assume that we're coming from the position that it's bad and they must stop. Whereas because I'm a researcher, I don't have the same intentions as a psychologist would, I'm here to listen and to understand their experiences. I'm not here to try and change their experiences and I have been quite self-conscious or mixed when designing my research questions, thinking, oh God, how's that going to come across? I don't want them to think I'm judging them, I don't want them to think that I'm contributing to the stigma in any way, so I've been quite thoughtful about it. So that is something that I have considered just making sure that people feel that it is a non-judgmental space. Coming from a position where they might feel very judged by literally everyone in their life. So, that is something that I hope will come across.

I: And that does make sense, and you've spoken quite a bit about the assumptions that participants might make about you in the interview phase. Do you think there might be any differences about the assumptions that participants might make at the recruitment phase, and whether that would influence them?

R: Yeah, I guess it's connected, so I mentioned before that we're sending them a bio, and that is to give them a sense of who their researchers are. But also, if they know us personally from the university, it's also an opportunity for them to be aware of that and opt out at that point. So, they'll be reading that in the recruitment phase. And I have positioned myself as talking about myself as a UCL student and I think that was intentional, because there's a lot of research to suggest that young people find it easier to talk to other young people about their experiences, so I think that's how I was trying to position myself in something that we have in common. But then I have to be really careful in how I set up the interview. That they understand that the interviews about their experiences are not mine, and that it's a platform for them to talk about themselves. And I'm not going to be bringing myself into it, so it does affect the

different stages differently, and I think I'm realizing that now talking about it with you, so that's really useful.