University students lived experiences of support for a mental health problem:

An interpretive phenomenological study

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A thesis submitted in partial fulfilment for the requirements for the degree of Doctor of Philosophy, at the University of Central Lancashire.

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Abstract

Mental health is a growing concern in the university student population. University wellbeing services have seen an increase in demand, and statistics showing the number of students who have taken their own lives led to a public response calling for more support for students. The Student Minds charity has worked with the UK government to implement the University Mental Health Charter. This charter is making a positive impact on institutions adopting a whole university approach to mental health needs, yet little is known about students' experience of having a mental health problem and accessing support whilst at university.

A hermeneutic phenomenological approach was used to explore students' lived experience of having a mental health problem and seeking support for their mental health needs whilst at university. Sixteen individual semi-structured interviews were conducted with students who had used or were currently using a university mental health and wellbeing service. Interviews were transcribed, and NVIVO was used to develop the emerging themes. van Manen's six-step reflective approach to analysis and Merleau-Ponty's four lifeworld existentials were used to interpret the data set.

Findings are presented which illuminate the students experience of help for their mental health problems. Three temporal moments of 'pre-encounter', 'encounter', and 'post-encounter' of mental health support services are presented. Within each of these

temporal moments, Merleau-Ponty's interpretive lenses of temporality, corporeality, spatiality, and relationality were used to develop sub-themes and a deeper level of meaning. The sub-themes that came from using the interpretive lens, temporality included "its now or never' 'readiness to seek help, 'students' high expectations' and 'waiting'. The lens of corporality included, 'a weight has been lifted', 'self-stigma', 'identity' and 'transition'. Spatiality illuminated the 'therapeutic landscape', 'the library', and 'virtual space'. Finally, the lens of relationality found 'person centeredness', the 'role of the personal tutor', 'family and culture', 'peers' and a 'sense of belonging'.

These findings highlight the mental health support wanted and required by university students does not solely come from university wellbeing services. The course tutors, friends and family had huge relevance in the help-seeking journey of those who required mental health support. The physical environment where help was delivered played a significant part in the help seeking journey. This study also highlighted how the expectations of younger generations of students are shaping the future of education and how the consumerist approach is adding to these expectations.

This study has made a unique contribution to knowledge in several ways. It has delved into the lived experience of students with mental health problems and seeking support while at university, a perspective that has not been explored in existing literature. The findings have been underpinned by the three temporal moments that all the participants experienced. The findings create new knowledge in three central temporal moments. They provide a unique

understanding and insight into the students' experiences at university and the impact their friends, family, and tutors have on their university experience. Second, the use of van Manen's framework and Merleau-Ponty's four lifeworld existentials, offers original insights into how time, space, relationships and bodily responses affect students' access to, and experiences of support. Using van Manen's guidance and the reflective pillars of Merleau-Ponty's work has provided an effective combination to aid phenomenological interpretation.

These insights support key implications for practice including, enhancing mental health literacy via mental health awareness training for staff and students, manging student expectations early, developing better connections with NHS services, involving family and peers in support and adopting an open disclosure policy.

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List of abbreviations and glossary of terms

ONS - office of national statistics

IAPT – improving access to psychological therapy, now renamed as “talking therapy’

CBT – cognitive behaviour therapy

UMHAN – University mental health advisor network

SMARTEN – Student mental health research network

STARFISH – Student relationship manager

Student Minds - The leading university student mental health charity in the UK

Nightline - A free and private listening service facilitated by student for students in distress. (due to close on June 30th, 2025)

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Chapter 1 | Introduction to the thesis

1.0 Introduction

The purpose of this phenomenological study is to explore the experiences of students who have a mental health problem and had support for it whilst studying at university. While there are numerous studies on students and their mental health, there is a distinct lack of research on the lived experience of having mental health problems and seeking support at university. This study provides a significant contribution that aims to give a voice to students navigating mental health support at university, thereby making a substantial impact in the field.

This study is grounded in an interpretivist epistemological and ontological framework and uses hermeneutic phenomenology – drawing on the work of Martin Heidegger and Max van Manen- as its theoretical and methodological approach. I chose this methodological approach as it was the most effective way to investigating lived experience. Heidegger describes the hermeneutic circle as fore-structures which enable Individuals to interpret their lifeworld – these fore-structures comprise fore-having, fore-sight and fore-conception (Heidegger, 1962). Fore-having (Vorhabe) is our pre-existing background we bring into a situation, fore-sight (Vorsicht) is the viewpoint we have when interpreting a situation based on our own interests and fore-conception (Vorgriff) is how we make sense of new

information (Rousse, 2021) This threefold structure shapes how the world is interpreted and understood therefore providing context into how understanding occurs but also limits our ability to see things in different lights. Heidegger argues that these fore structures must be examined for rigorous interpretation to take place (Crowther & Thomson, 2020). Therefore, I present my 'fore-structures of understanding' - personally and professionally - here.

This chapter is about the study and the personal journey that led to it. It is about the experiences, the thought processes, and the perspectives that shape the interpretation of the students' experiences. Here, I share my role and background within the University of Central Lancashire (UCLan) wellbeing service, my experience as a qualified mental health nurse, and my roles as a daughter, sibling, and mother. These personal experiences have shaped my understanding of mental health and the need for effective support systems for students.

1.2 Personal and professional position

I have been a mental health nurse for seventeen years now. I am a 'people person' and one who likes to listen and fix problems; this is what drew me into mental health nursing. Speaking to people from all walks of life has really shaped me into the nurse I am today, and I am grateful for the experiences I have had across my seventeen years. I find joy in helping people, especially those with more complex issues such as mental health problems. Having worked in acute mental health wards and the prison service, I was aware of the stigma

and treatment of people with mental health problems. Seeing physical health services expand and multiply, and friends in adult nursing roles (including those who have very different experiences of delivering care to me) showed me that mental health nursing was treated like a poor relative. I felt myself comparing mental health service users and how they would be treated differently if their mental health problem was a physical health issue. I found myself wanting better for the service users in my care and to make sure the other mental health nurses, also wanted the best.

I became a lecturer practitioner after discovering my joy of working with nursing students in clinical practice but knowing I wanted to do more with them whilst also improving service user care. Half the week, I worked clinically with patients, and the other half of the week I taught at a university, supporting students become nurses. This is where I found my niche. I worked across two universities, one as an academic and the other as a mental health advisor in student services. This became a big part of my identity as I felt content, excited, and like I was making a difference to service users and students on their nursing journey. I felt immense job satisfaction and knew I was making a difference clinically and academically.

In my role as a mental health advisor based in UCLan's student services, I was part of the team that set up the student mental health advisor service. The service had been commissioned and three mental health advisors, myself included, and one clinical lead were employed, and tasked with setting up this service to meet the mental health needs of the student population. There was very limited guidance at the time,

therefore had to use the “student mental health and wellbeing in higher education: a good practice guide” (Universities UK, 2015). This provided the opportunity to be creative and impact the experiences of students with mental health problems.

As the service developed, it was proliferating, so we had to start delivering the support that we had been planning. This led us away from the project development and into service delivery. It became the role of senior managers to continue to set up the service as we provided it. This led to decisions being made without any clinician involvement and from team members who did not have the skills, experience and attributes that us three mental health advisors and the clinical lead had. Furthermore, there was no consultation with students on what they felt they needed, wanted or desired. Some of the ideas that came from this development period were courageous and bold and did prove to be a success, but a lot of decisions on what interventions to offer and what assessment needed to be carried out were decided upon without any consultation with students or mental health clinicians.

As time passed, my concerns grew that there was potential for mistakes that decisions that would impact on student experience were not collaborative. A key memory was being in a small hot room for much of the day, trying to design the new logo for the wellbeing team. We had no design experience and again no consultation with the students had been planned. I was not overly sure that this was a good use of my nursing experience, but I engaged with it, as we had been asked to. We were told by the managers of student services that the

cost of this activity was expensive, adding to the pressure of us getting it right. Weeks later we were informed that new signage that included the logo was being installed and that the rebrand was now well underway and at a handsome cost. We had not seen the final designs and on viewing the product it was nothing like what we had developed. Weeks later, I was with a student from my caseload who mentioned how awful and stigmatising the signs were; they joked they might well be a 'sims' character with their problem written on their head. At that point, I knew I needed to speak with students to understand their experiences better. This is where my study started.

At the start of my PhD, I was employed as a mental health advisor at UCLan, where the study participants were recruited from. However, by the time I conducted the interviews in my third year, I had left the service and had no further affiliation with it. The following section provides context, and an overview of student services. I feel it is essential to explain a little about the service provision to help contextualise what the participants had access to.

1.3 Student services

Student services (where the participants were recruited for my study) sat outside the academic schools and covered all student-facing procedures, including accommodation, finance, inclusive support, wellbeing, careers and the <i>[1]. Accommodation service

[1]The <i> is the name of the student support and wellbeing service. This covered mental health wellbeing, inclusive support, finance, accommodation, security and careers.

supported students in their living spaces and worked closely with security who were also a point of contact for distressed students outside of the university's core working hours. Finance was a service offered to students to apply for grants, bursaries, money advice, and emergency food parcels should they face financial hardship. Inclusive support was available for students who disclosed a disability and assisted these students with applying for disabled student allowance (DSA), conducted educational psychologist assessments for specific learning difficulties, developed reasonable adjustment plans and offered support for anyone requiring additional support due to disability. The <i> was a one-stop shop for all student queries and was based inside the library; the carers service offered career advice.

The university wellbeing team consisted of mental health advisors who were either qualified nurses or psychological wellbeing practitioners (PWP), qualified counsellors and unqualified wellbeing advisors. This team supported mental health needs, security incidents and fitness to study cases. A student could access the wellbeing service or any student service department via email, phone call, turning up at the <i>, or to reception in a building that housed the wellbeing teams offices or raising a flag on 'Starfish'.

Starfish is a university computer system that hosts an array of student information. Students have a profile on Starfish, that includes their personal and emergency contact details, modules being studied, grades, and if they have declared a disability. Staff involved with that student have varying access to this information, so they can only see what is relevant to their role with the student. This system also includes

a feature named 'raising a flag'. This function enabled the student or staff member to generate an electronic referral for any of the services that are offered under student services. The student or an assigned staff member can raise this flag, and this leads to the referral being reviewed by the relevant team and the student would then be contacted and offered support.

1.4 On-campus NHS provision

In addition to student services, a National Health Service (NHS) general practice (GP) surgery provided students with access to primary care services on campus. This GP surgery could also refer students who were registered with the practice to the university's mental health and wellbeing service. If students moved to the Preston area and registered with the University based GP, then they would automatically be unenrolled from their previous GP. Many students move away from home to study therefore this could cause access issues if a student required GP support when not on campus. This would also impact any secondary care mental health services as they too are allocated based on the geography of the registered GP surgery. It was not an option for a student to be registered with more than one GP at any time, nor was it possible to be under two mental health teams.

NHS services that were available to students included 'Big White Wall’. This is an online wellbeing support platform that offers therapy-based support that is available 24/7. Big White Wall was a prescription-required online platform that offered a cognitive behaviour

therapy (CBT) type services and a blog-type area for people struggling with their mental health. As mental health advisors we were able to prescribe this service.

Minds Matter was another NHS service that is the local NHS talking therapies service. Minds Matter was the local Improving access to psychological (IAPT) service that offered high and low-intensity CBT interventions, a stress control group, group therapy sessions, 1:1 and counselling support. Access to Minds Matter was via self-referral, either by calling up or completing an online referral form. The university worked closely with this team and offered rooms as a venue to assist with the running of the stress control course. These services will feature throughout the thesis. I now present an overview of all the chapters.

1.5 A guide to the chapters

Chapter two explains the current issues with student mental health and why this area requires attention. It also highlights the public concern for student mental health whilst exploring what the current provision is and the increase in demand for services. I provide this chapter to help set the scene of why this study is necessary and worth conducting by using contemporary evidence to demonstrate the current trends in student mental health.

Chapter three captures a temporal moment when the public expressed their concern over the number of students who were reported to have taken their own lives by suicide. I felt compelled to capture the movement when Twitter (now ‘X’) responded to the Office

of National Statistics response to the publication of the statistics on student suicide. This was a novel approach, and the aim was to capture this moment to show how people were reacting to the number of students who had reportedly taken their own lives. I then compared the public response when further statistics were published three years later whilst presenting. Thematic analysis of the tweets across the two moments around publication of the data.

Chapter four presents the qualitative systematic review of the lived experiences of having a mental health problem at university. A systematic and thorough approach was taken to find all available literature on this subject. The review also explored the gap in the literature to enable me to highlight the need for my study. Papers were critically appraised using the Walsh and Downe critical appraisal tool (Walsh & Downe, 2006), and subsequent themes were generated from the included literature via thematic analysis.

Chapter five provides my understanding of the methodology along with an explanation and rationale for choosing phenomenology. It provides a brief overview of other approaches that I considered but decided against using them. My decision-making and progression of ideas are presented as I demonstrate my understanding of phenomenology via its history and evolution over time whilst appreciating the works of significant phenomenologists in chronological order.

Chapter six explains how I applied the methodology to my study. It identifies the specific steps and decisions I made throughout

the research process. It also presents my understanding of van Manen's six reflective activities for investigating lived experience and how I used the work of Merleau-Pontys lifeworld existentials as lenses to interpret the data I collected for my study.

Chapters seven to ten provide the findings from my study. These were collected from recording 1:1 interviews with the participants. I chose to dedicate one chapter (chapter seven) to introduce the participants as people and acknowledge them individually. Pen portraits of each person who offered their time and experiences with me are detailed to help the reader know the participants behind the data a little more. The next three chapters (chapters eight to ten) present the findings from each interview and are structured in the three temporal moments that were illuminated early in the interpretation stage.

Chapter 11 then goes on to discuss the findings whilst being contextualised with wider literature. It provides a narrative discussion of what I found and how this has generated new knowledge.

Chapter 12 identifies recommendations for practice, policy and further research. I also provide a dissemination plan and discuss the project's strengths and limitations.

Chapter 13 Provides a conclusion to my project.

Chapter 14 then presents with an exploration of reflexivity and how this was applied to my study.

Chapter 2 | Background of student mental health

2.0 Introduction

As mentioned in chapter one, this thesis aims to explore the lived experience of having a mental health problem and seeking support from university services. To help set the scene, this chapter presents the current concerns surrounding students' mental health, the increase in demand for mental health support, and finally what is currently offered to support students and their mental health.

2.1 student mental health

Student mental health has received increasing attention within the literature, the media, and the higher education sector (Student Minds, 2018). It has been reported that students have lower mental health and wellbeing than the general population (Neves & Comment, 2017) and that it has become a global concern (Brewster et al., 2022). Globally the mental health of students is a complex issue that is shaped by long term trends, the global COVID-19 pandemic, and growing awareness and evolving interventions for mental health. In a study conducted in America by (Emmerton et al., 2024), they report that university student mental health continues to decline, particularly for females with academic performance being the main contributing factor. This growing body of research from America has documented that mental health concerns for students have become a priority for universities (Meeks et al., 2023). Recent evidence from 2023 indicates that one-third of campus communities experience symptoms of

depression, anxiety, and/or stress. Similarly, a systematic review conducted in South Asia reported one fifth of university students now struggle with their mental health, and particularly when the resources to support these students are sparse and not regularly established in their universities (Dessauvagie et al., 2022)

For the UK, the Royal College of Psychiatrists published a report on student's mental health and wellbeing in 2011 (RCPsych, 2011) and found that the levels of mental health problems among students in the UK's higher education institutions were increasing and were comparably high to other sectors of the general population. A systematic review conducted in 2022 found that worsening mental health of university students is now a public concern (Campbell et al., 2022). Furthermore, the number of students disclosing having a mental health problem had seen a steep incline (Psych, 2011). While the reasons why this is happening were not made explicit within the report, this increase could be due to the stigma associated with disclosing a mental health problem, the change in attitudes toward mental health, and the change in the profile of higher education students (Pollard et al., 2021).

In 2024, the Office for Students, Universities UK, and the Student Minds Charity collectively called for student mental health and wellbeing to become a national priority (Office for Students, 2018; Universities UK, 2024). This contributed to a growing narrative that student mental health is in crisis. The framing od student mental health as a crisis has been shaped by stakeholders, cultural and political stances (Frawley et al., 2024).

2.2 What do student experience at university?

Starting at university can cause stress for anyone (Stones & Glazzard, 2019). Mental health problems can also develop during this time and cover the whole spectrum of mental health, from stress to suicide (Office for National Statistics, 2017). Complex biopsychosocial factors influence the development of mental health problems (Macaskill, 2013). These factors can include stressful life events, relationship breakdowns, family bereavement, exam stress, anxiety, panic, and feeling overwhelmed, along with developing severe and enduring mental health problems such as psychosis, bipolar, and personality disorders (Macaskill, 2013). These symptoms and life events can negatively affect their academic achievement and university experience (Universities UK, 2015). While these are experiences that the general public also face, Frawley et al (2024) reports that there are complexities surrounding the labelling of student mental ill-health. They highlight an overarching trend towards the psychologisation of economic and social norms, wherein economic hardships and societal pressures are increasingly framed as mental health issues. This reframing has precipitated a shift from traditional specialist mental health services to a more integrated, holistic approach to promoting mental wellbeing that involves the entire university community.

The peak age of reported mental health problems are diagnosed in the under 25's (Solmi et al., 2022) University aged students are at particular risk of developing a mental health problem

because the majority typically are under age 25; this is the age at which most mental health problems manifest (Johnson & Crenna-Jennings, 2018). Furthermore, this period of a student's life often coincides, for many, with a significant development period of the brain (Watkins, 2021).

In November 2022, the Student Minds charity and 'Altertline' conducted the 'Being well, doing well' survey to better understand students' mental health and wellbeing. The findings reported that over half of the 1037 students surveyed had a current mental health problem, and 30% of students reported that their mental health had declined since enrolling at university, particularly concerning the cost-of-living crisis and finances. The cost-of-living crisis refers to the increasing costs of necessities such as housing, food, and transportation, which can place significant financial strain on students. Further stressors that may create or exacerbate student mental health may relate to the transition to university -this can be complex due to the excitement and stress of starting a new phase in life (Burns et al., 2020; Cage et al., 2021). Unfamiliar places can also be stressful for students, particularly those with mental health problems (Universities UK, 2018). Students can struggle due to a variety of reasons, including but not exclusive to, separating from existing family and friends, moving to a new geographical area, experiencing a diverse number of cultures and personalities, exploring new ways of learning, and needing to manage their financial circumstances (Universities UK, 2015).

Likewise, social media can impact a student's mental health and wellbeing (Nazari et al., 2023). With its ever-growing user base, this may be an indicator of more problems to come, as it has been argued that the more time spent on social media, the higher the risk of developing a mental health problem (Dube, 2016). 20% of young people had experienced some form of cyberbullying on social media, which led to anxiety and depression and left 45% of parents worrying about the impact social media has on their children (Mental Health Task Force, 2016). More recently, the COVID-19 pandemic led students to become more reliant on social media due to the lack of face-to-face interaction (Haddad et al., 2021), therefore heightening their risk of cyberbullying. In addition to the risks identified here with the amplified use of social media, there was an increasing and ongoing critical commentary on younger people being dubbed as 'snowflakes'. The term snowflake suggests younger people are oversensitive, damaging the progress made around mental health and stigma due to this term being used in politics and the media (Talbot et al., 2023).

Despite these challenges, students still go to university. Widening participation is a commitment by universities that is arguably morally acceptable (Connell-Smith & Hubble, 2018). The Teaching Excellence and Student Outcomes Framework (TEF) also targets underrepresented groups to enrol in university courses (Office for Students, 2021). Widening participation aims to address the issues surrounding the uptake of higher education from underrepresented groups (Connell-Smith & Hubble, 2022). The widening participation agenda has captured students who do not experience this stability,

increasing their risk of vulnerability (Macaskill, 2013). Additionally, students appear to be stuck in a complex paradox of being encouraged to enrol on a degree and, at the same time, being charged to do so when financial debt is known to be one of the reasons people from a widening participation background do not go to university (Hordósy & Clark, 2019). This therefore increases their vulnerability by exacerbating anxiety in their educational and personal development (Young et al., 2020).

Likewise, students who attend and graduate from university experience increased job security, boosted financial achievement along with better physical health and wellbeing (Heaslip et al., 2017). Notably, in 2024, applications to higher education continued to increase, with the Chief Executive of the Universities and Colleges Admissions Service (UCAS) claiming that more students from disadvantaged backgrounds are now applying (UCAS, 2024). The government's widening participation agenda and potential for premium wages, which refers to the higher salaries that university graduates typically earn compared to those without a degree (Connell-Smith & Hubble, 2018). This financial incentive, along with the removal of the cap set by the government that indicates how many students a university can take (Universities UK, 2015), has led to an increase in university applications. The proportion of students who successfully enter university now, is far more representative of the broader society concerning socioeconomic background, ethnicity, gender, disability, and country of origin (Universities UK, 2018). This increase in demand for university places has left universities struggling to meet their

students' needs and support services being overstretched and requiring more resources (Brown, 2018; Remskar et al., 2022).

Striking a balance between recruitment and retention is required as universities face challenges with economic pressures, so attracting and retaining students is a priority (Trowler, 2010). Students who declare a mental health problem are less likely to complete their studies after their first year and are therefore less likely to go on to employment or further study (Office for Students, 2018). Mental ill health among students can impact course achievement and attainment, academic performance, lifestyle, and, therefore, the retention of students (Deasy et al., 2016; Martin & Atkinson, 2020).

2.3 What are universities doing?

It is not a new phenomenon that universities must offer accessible support and advice for students experiencing mental health problems. Universities must play a role in engaging with the broader community to offer opportunities to talented and able students with mental health problems (Student Minds, 2018). There has been an increase in the recognition that universities have growing accountability to promote and support student wellbeing (Watkins, 2021). However, it is also argued that universities need to be mindful of not becoming a therapeutic community at the expense of its educational priority (Student Minds, 2018). But as Frawley et al. (2024) highlights, responsibility for addressing mental health concerns has been diffused to universities, which often redistribute this responsibility across various departments and functions within the institution.

Universities have been supporting students and their wellbeing. Prior to any wellbeing services this support was delivered via personal tutors. The personal tutor's role involves a pastoral element, which assists students with accommodation, finance, and other issues unrelated to the course (Gidman, 2001). As early as 1995, Easton Van Laar, (1995) found that 97% of personal tutors' support was associated with distressed students. The passing of the Equality Act 2010 placed a legal duty on universities to ensure that the protected characteristics of the population are supported and not discriminated against, therefore adding more responsibility on personal tutors. Then in 2018, the Student's Minds charity found that supporting students with mental health problems had become more demanding due to an increase in high levels of student distress (Student Minds, 2018).

The mental health of university students emerging as a pressing concern has prompted a collective response from various stakeholders, including universities, counselling organisations, and student advocacy groups. This response has evolved from a focus on providing specialised mental health services to embracing a more holistic, 'whole university' approach. This shift emphasises empowerment, co-production, and the integration of mental health promotion across all aspects of university life. (Frawley et al., 2024)

In 2015, Universities UK published the 'Student Mental Wellbeing in Higher Education - Good Practice Guide' (Universities UK, 2015). This guidance targeted senior executive teams at universities to invest in and implement eleven recommendations to promote, prevent, and protect the mental health of their students

(Universities UK, 2015). However, these were only recommendations and there are no specific requirements for what the role of the personal tutor should be. Figure 1 below articulates the eleven recommendations.

Senior management/executive teams are encouraged to embed the recommendations offered in this guidance into strategic planning and operational practices.

To facilitate integration and embedding of student mental wellbeing across the institution, this guidance should be circulated widely and internal task groups, with student representation, should be established to enable individual departments to review the implications for their own policies and procedures.

Institutions should consult and collaborate with students' unions and associations, and particularly with students with mental health difficulties when formulating and implementing student mental health-related policies and procedures and in identifying areas for improvement.

Institutions are encouraged to work across their communities to ensure students and staff are not overlooked in terms of statutory services. Clear links with the local voluntary and statutory agencies will also ensure that cross-referrals are made effectively.

It is strongly recommended that robust arrangements are put in place for any student with a history of mental health difficulties who is required to undertake a period of time studying off campus, including those studying or working abroad.

It is recommended that institutions have a wide range of policies available to cover the diverse needs of their students, in order to support their progress through their course as effectively as possible. When temporary withdrawal is considered the best option, these policies should enable students to return to their course with support in place. It is also recommended that fitness to study procedures contain appropriate provision to enable a student to request a return to study following a required withdrawal.

Institutions should consider the applicability and implications of their student mental health-related policies and procedures in respect of arrangements with collaborative and other partners such as further education colleges, placement providers, schools and employers. They should also consider opportunities for joint action with partner institutions and bodies.

To ensure that services are adequately resourced and working effectively the operation and capacity of services should be regularly assessed in relation to demand and effectiveness. Ongoing evaluative feedback should be sought regularly from service users and other students and staff.

Client feedback and service evidence should be collated and reported to the institution's governing body with a view to identifying future enhancements and priorities in promoting student mental wellbeing.

In view of the crucial role of staff development, institutions are encouraged to give priority to incorporating relevant staff development sessions within their annual programme of activities.

Consideration should be given to making training on mental health awareness and the protocols for reporting concerns available to all relevant staff. This includes academic and related departments, service and support areas, frontline and auxiliary staff, personal tutors, house/hall tutors and departmental disability officers. Such training could be cascaded to staff who have a front line role including cleaners, canteen and library staff, whether they are permanent, contract or agency staff.

Figure 1 the 11 recommendations from the student mental wellbeing in higher education good practice guide

These recommendations were set out to create inclusive and supportive environments to support university student mental health and wellbeing. Yet within two years of these recommendations being published, only 29% of UK universities had a mental health and wellbeing action plan despite these recommendations being available (Thorley, 2017). The charity Student Minds advocates being proactive rather than the traditional reactive stance universities were used to delivering (Houghton & Anderson, 2017).

Further developments came when the UK government, in collaboration with Student Minds Charity, responded to the Office of National statistics publishing the number of students who had taken their life by suicide for the first time in their history of data collection. The government and Student Minds charity proposed developing a university mental health charter. This Charter went on to be developed by a range of people across the higher education sector to guide the work of universities in addressing student mental health issues (Hughes & Spanner, 2019). The Charter was finally launched in 2019 and set out a range of principles to aid universities in developing their mental health support for students (Hughes & Spanner, 2019). The Charter is awarded to universities who have demonstrated that they meet the requirements of the charter and therefore officially be awarded it.

Due to a significant increase in universities signing up to be accredited with the charter a further £4,000,000 has been allocated from central government to support this rising demand (Office for Students, 2024). This is a positive step forward as universities have

been called to take a whole university approach in supporting students with their mental health and wellbeing (Hughes & Spanner, 2019.) By supporting universities to consider that learning and living spaces, diversity on campus, and the provision of culturally appropriate support services has on student mental health is a starting point.

Now, five years on from the University Mental Health Charter being implemented, this voluntary accreditation scheme is proving helpful in seeing which universities are embedding a whole university approach to students' mental health and wellbeing (Zile et al., 2024). Due to its success, it is important that signing up to the charter does not become a mandatory tick box exercise (Farrier et al., 2024). Therefore, striking a balance between continuing with further developments and innovation for future students remains important.

Students themselves have also proactively tried to improve their mental health by engaging in student-led initiatives. 'Nightline' and 'Look after your mate' campaigns are two initiatives that have been available for students and their mental health needs. Nightline is an overnight listening service that is confidential and anonymous, provided by students to students within term time (Nightline Association, 2017). Their most recent annual report identified stress and anxiety made up for 10.9% of calls, 10.4% academic issues, and 10.4% mental health problems; the average call length was 25 minutes, with an average of 53 calls per night (Nightline Association, 2022). However, this service is due to discontinue in June 2025.

A further initiative is 'Look After Your Mate' - a workshop facilitated across universities to equip university students to support

their friends experiencing mental health problems and teach them how to look after themselves (Student Minds, 2018). This workshop came from a study investigating how friends who experience mental health problems are supported by their friends. It also explored the challenges of these supporters along with their approach to support (Warren & Byrom, 2016).

Similarly, peers have been supporting their friends with their mental health problems without any formal training. Peer support is a recognised intervention. Byrom (2018), the founder of the Student Minds Charity, raises the value of peer support for mental health needs and explains that students often turn to their peers in the first instance. Oates et al., (2021) found that students valued learning from peers' experiences and having peer support. Receiving peer support has also led to students feeling more validated and, therefore, enables enhanced coping and improved academic achievement (Grégoire et al., 2022).

Family support too, has been a long-standing form of support for students and their mental health. LeBouef and Dworkin (2021) found family support was one of the most important sources for first-generation students, with benefits for academic outcomes, emotional, psychological, and wellbeing needs, as well as engagement. However, it has been noted that not everyone has 'good' family support. For example, as highlighted earlier, some students come from underrepresented groups and do not have a family to support them. Some students experience cultural conflict with their desire to attend university (Covarrubias & Han, 2011). As mentioned above,

universities are acting to support student mental health. However, with more guidance on how to do it, it may be easier to understand the impact of what interventions are effective and not.

As identified here in this chapter, there is movement with student wellbeing service provision and each university who have adopted this guidance has done so to accommodate their HEI's needs rather than trying to duplicate what other universities offer. This has resulted in diverse provisions for student mental health services (Duffy et al., 2019). In light of this, Frawley et al (2024) adds that there is a compelling need for a nuanced understanding of student mental health that recognises the intricate social and political contexts that contribute to it. By acknowledging these complexities, universities can develop more effective policies and support systems tailored to the diverse experiences of their student population.

2.4 Conclusion

This chapter has highlighted the prevalence of student mental health, the increased demand for services, and the current provisions. While universities have been advised to follow the eleven recommendations set out by the Student Mental Wellbeing in Higher Education Best Practice Guide, there are wide variations in how the guidance is applied and a lack of insight into how best to support student mental health needs. This chapter demonstrates that universities are adapting to the demands of the students. This provides a clear rationale for why my study was needed. The next chapter presents a temporal moment of how the public reacted on Twitter to

the Office of National Statistics publishing the statistics on the number of students who had taken their own life.

Chapter 3 |#72hoursintwitter

3.0 Introduction

The previous chapter provided context to the current situation of student mental health. As highlighted, there are concerns about the mental health of university students and the support available to them.

This chapter provides additional context that was sparked by me noticing a significant amount of activity on the social media platform Twitter, now known as 'X', regarding student mental health, particularly the number of students reported to have taken their own lives. I felt compelled to capture what was being tweeted and how twitter added weight and context to the publics concerns about this issue. The chapter captures a 72-hour temporal moment on Twitter following an announcement by the Office of National Statistics (ONS) to release the statistics on student suicide between July 2016 and July 2017. The chapter was developed at that time, to capture the flurry of activity on Twitter and also presents a comparison with the latest data on student suicide published in 2022. When this chapter was written, the social media platform currently known as 'X' was called Twitter; therefore, it will be referred to as Twitter throughout this chapter.

3.1 The release of statistics tweet

The higher education sector has identified student mental health as a university-wide priority in the UK and globally (Universities UK, 2015). On June 25, 2018, the Office for National Statistics (ONS, 2016), for the first time, published the number of students who died by

suicide over one year (between July 2016 and July 2017). This chapter describes 72 hours of observing the nation's social media (Twitter) response to this news and reflects on the second round of statistics that were published four years later. I was reading the tweets as they were posted over the three days that student mental health was 'trending'. At the time, I did not know what I would do with the screenshots. Still, by embracing the principles of the hermeneutic circle, I read and re-read them until I realised the importance of capturing this temporal moment. This led me to review the tweets and develop a commentary to capture what was being said in response to the initial tweet about the student suicide figures.

The ONS report identified that the rate of suicide within the 12 months between July 2016 and July 2017 was 4.7 deaths per 100,000 university students. These figures equate to 95 students believed to have taken their own lives over this period. Figure 2 is the tweet that launched the statistics on students who had taken their own lives and subsequent twitter storm.

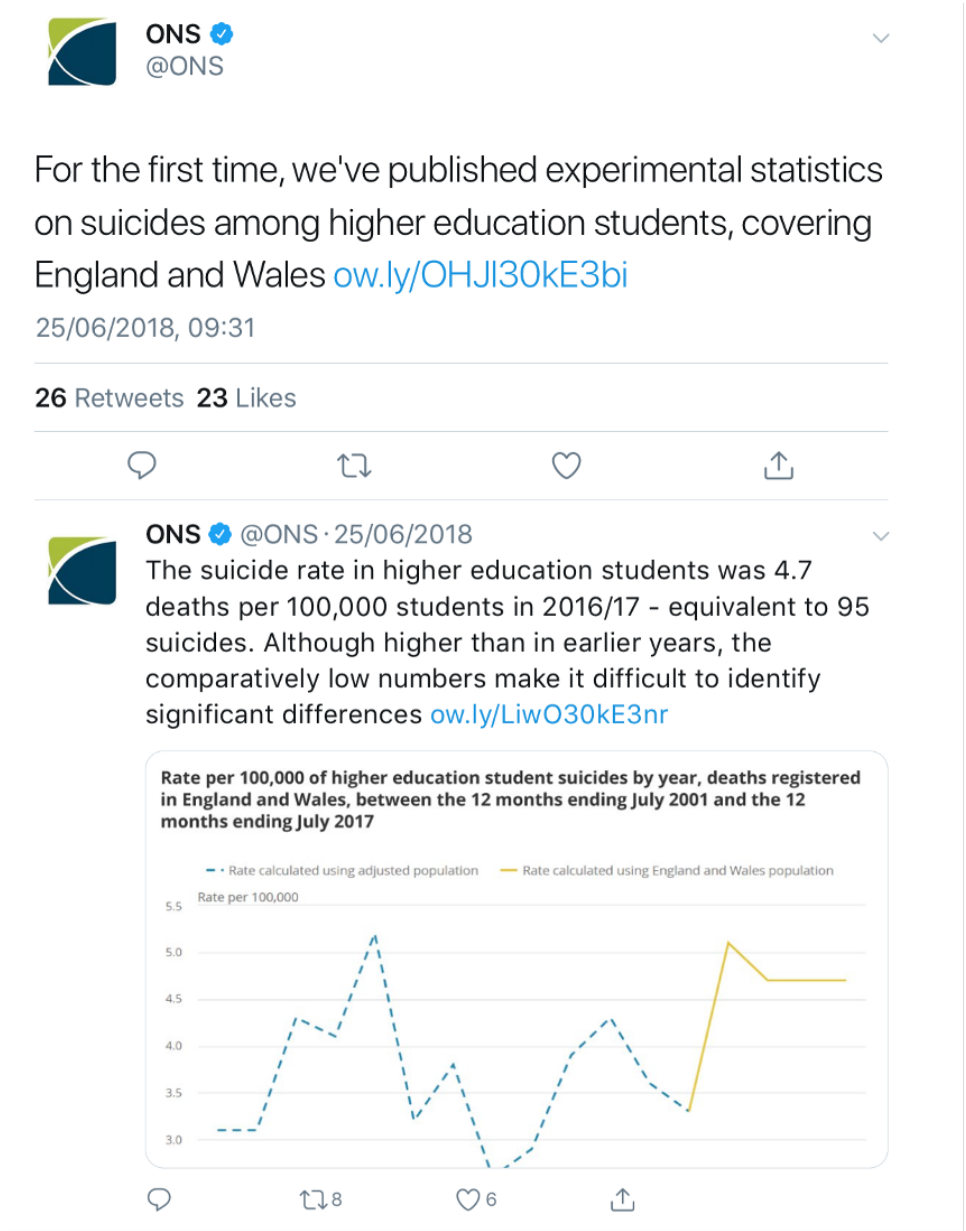

Figure 1 - The first tweet to publish the statistics on how many students had ended their life by suicide

This first tweet triggered an influx of tweet interaction following the publication of the ONS report. @XenZone_uk, an online counselling service, summarised and paraphrased what the ONS has stated and provided a hyperlink to a BBC news page that also reported the statistics. The Birkbeck University of London @BirkbeckUoL tweeted about the statistics, featured on the evening BBC news programme, and discussed the damming statistics with their senior

mental health advisor and head of student counselling services. The Times Higher Education @timeshighered also shared their article highlighting that the statistics were higher than ten years ago. @SFWChange, a social enterprise of qualified therapists, commented on the @TheConversation tweet, a professional blog offering commentary and debate on published topics. Tweets and retweets did not just come from the UK; @noustalk, a Canadian mental health support service, tweeted similar content and provided a hyperlink to the same BBC story. Figure 3 is a tweet from @XenZone_UK who tweeted about the publication of the data, they also provided a link to the news coverage from the BBC.

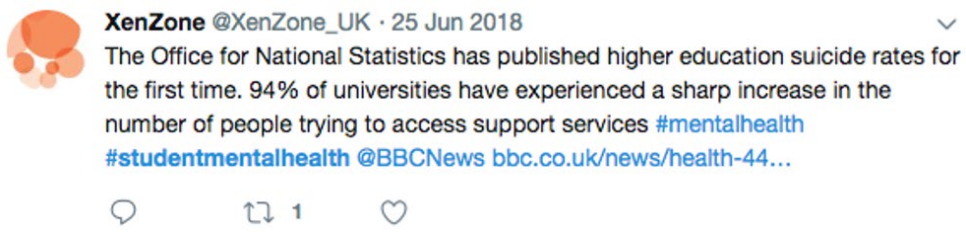

Figure 2 - tweet from @xenzone reiterating what the ONS had tweeted

Student Minds, the charity developed for students' mental health, @StudentMindsOrg responded by highlighting to Twitter users that their policy manager would be on BBC Radio 5 live later that day discussing student mental health and what changes could be made for better support.

Figure 3 – A tweet from student minds charity stating their policy manager will be discussing the topic on the radio 5 show later in the day.

The Chief executive (CEO) of Students Minds, Rosie Tressler, also tweeted and referred to changes they believed should be made and advised that a whole university approach is required to help support student mental health. Her proposal of a whole university approach included all staff, from cleaners to academics, to encourage students to support themselves and others' mental health (see Figure 4).

Figure 4 A tweet from student minds stating a whole university approach is needed.

@ProtectED_HEI, the UK's first HEI accreditation scheme that monitors security and student wellbeing, also suggested this. @Startlicencing suggested universities adopt an 'opt-in' agreement so

University wellbeing services could discuss wellbeing issues with nominated family members or carers. One tweeter advised pastoral care needs to be improved to avoid anyone' falling through the gap.' Shortly after this Tweet was published by @ProtectED_HEI advertising the offering that the @samaritans charity had on postvention to student suicide along with their response to the ONS estimated statistics as illustrated in figure 5.

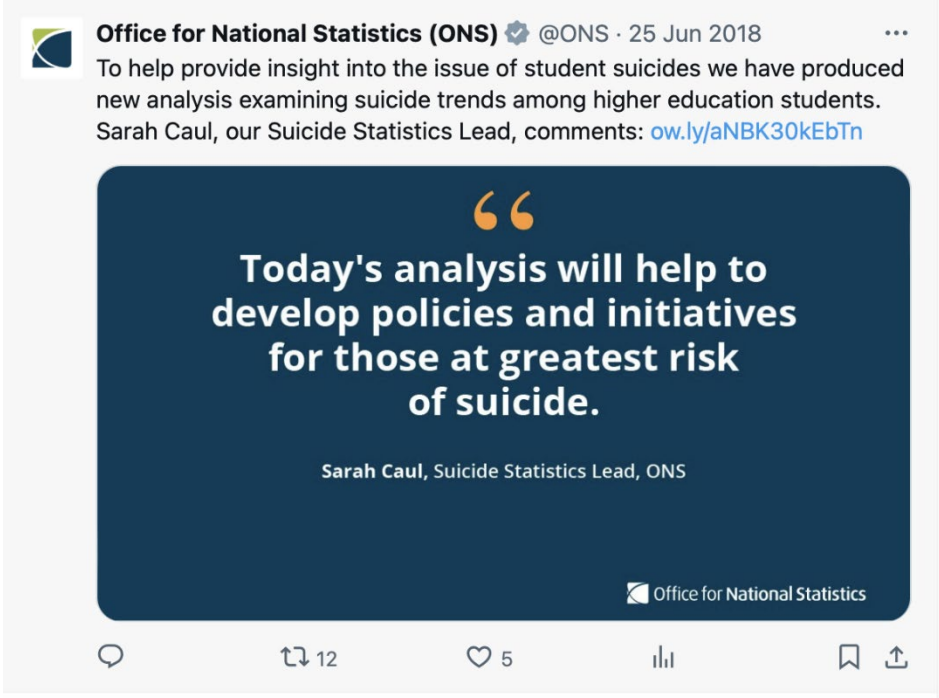

Figure 5 - further tweet from the ONS indicating the use of the statistics being published

3.2 Time to redouble our efforts.

Responses were not all constructive; one tweeter interested in student wellbeing and suicide prevention questioned whether we should look at other aspects of student wellbeing instead of focusing on suicide. As seen here in figure 6 @solutionpathedu quoted the university minister at the time, Sam Gyimah, who called for vice-

chancellors to prioritise students' mental health and suggested it was 'time to redouble our efforts on mental health support at universities'.

Figure 6 - Tweets from student minds charity and solution path commenting on what others are saying about the numbers of students taking their own life.

3.3 Sharing lived experiences.

Other 'tweeters' shared their own experiences of mental health whilst studying. One student named Olivia (see figure 7), tweeted their interview with BBC News about her experience of depression in her first year of study. She talked about giving students a community to ensure they know they are not alone. Another student 'liked' a tweet from @StudentMindsOrg that stated university was far more than just the course and that the whole experience is relevant. Another student described himself as 'one of the lucky ones', describing his mental health support as patchy at his [undisclosed] university. A student's mother gave her opinion on student mental health and described her son as having known someone who was a student and had died by suicide at age 19. Whereas another student tweeted that their experience of mental health support during an open day was negated and they themselves were branded 'too negative'. Another tweeter, clearly moved by the number of students dying by suicide, tweeted that he remembered the night, the hours, the minutes when he wanted to end his own life and the reality that he felt the university was inept at dealing with this issue.

Figure 7 – Student Olivia Willimas on BBC news sharing her lived experience of having depression in her first year at university

3.4 "Look after your mate"

As the tweets continued to be posted, several services embraced this opportunity to advertise help for students struggling with mental health. Student Minds charity advertised its 'Look after your mate' training and provided links to its online resources for help. @ProtectED_HEI tweeted about the Samaritans charity's postvention approach (see figure 8), whereas @Papyrustweets and @studentMindsOrg published content on how to look after your mental health.

Figure 8 – A tweet from protected mentioning wellbeing measures.

3.5 Celebrating good practice

There were also celebrations of good practice. Two days after the publication of the statistics, the Chief Executive Officer (CEO) of the Student Minds charity, Rosie Tressler encouraged her followers to recognise that universities are committed to improving student mental health and that some were demonstrating excellence in this area. This was followed by a London university's initiative to tackle student mental health. More personal-level tweets were also evident and came from academics who stated that although they were not a mental health professional, they had a passion for being a personal tutor and offering support.

3.6 More data is required.

In the days following the tweet of the newly published statistics, @Studentminds stated that they would welcome more data to provide greater insight into student mental health and improve it (see figure 9). This was echoed by @Mental_Elf, who agreed and highlighted that very little high-quality data about quality interventions to support this group existed at the time. This led other 'tweeters' to show their support and appreciation that more data was required and more needed to be done.

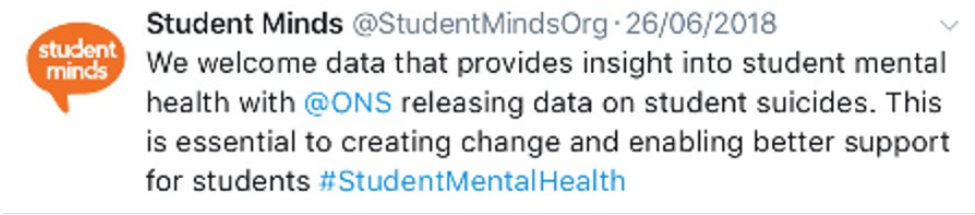

Figure 9- A Tweet from student minds commenting on the data

3.7 University Mental Health Charter

The conversation did not stop with the tweets. Following the statistics being released, as shown in figure 10, the government announced that a student mental health charter led by Student Minds would be developed (Hughes & Spanner, 2019). @StudentMindsOrg also mentioned the development of the charter and identified who would be working with them to co-produce the project: Universities UK, the Office for Students, and the National Union for Students. Later in the day, they announced that their CEO would be on Sky News discussing the University Mental Health Charter (see figure 10).

Figure 10 – A Tweet to announce the start of the university mental health charter

Typical of Twitter, items only 'trend' for several hours before something else occupies users' attention. This, unsurprisingly, happened with the response to the @ONS student suicide statistics tweet. After a few hours of the initial tweet, responses started to reduce and by 72 hours, minimal new tweets were being tweeted. The tweets were reduced, and student mental health was no longer trending.

3.8 More data arrives

Four years later, on May 31, 2022, another tweet from ONS was posted. This was the latest data between 2017 and 2020 on the number of students who had died by suicide. Rates were at their lowest, 3.0 deaths per 1,000,000, which is equivalent to 64 deaths (ONS, 2020). However, there was no Twitter storm in May 2022,

Professor Louis Appleby tweeted to remind us that the numbers do not negate the distress or impact. However, following the latest published data, in 2022 the UK government announced a £3 million investment to help close the gap in service provision between university students' mental health and NHS mental health services. They aim to provide a more seamless experience to help students who may miss out on mental health care at university (Gov, 2022). The previous chapter presented an insight into the current government funding available to student mental health in higher education.

3.9 Conclusion

This chapter has captured a brief but impactful moment in response to the ONS publishing, for the first time, the number of UK students who died by suicide. The rationale for presenting this narrative commentary was to demonstrate that student mental health is a contemporary issue that invokes a strong public response. Although Twitter holds no academic value, it does show what the public responds to and therefore adds to the relevance of my project, focussing on the needs of student's experiencing mental health. To further aid this relevance, the chapter compared the 2018 statistics to the next available in 2022. In the next chapter I present a review of the current literature surrounding student mental health.

Chapter 4 | A qualitative systematic review

4.0 Introduction

The previous chapter provided additional context to the student mental health movement. This was achieved by providing a narrative of the Twitter storm that followed the ONS publishing data on student suicide for the first time (ONS, 2018).

In this chapter, I provide details of a qualitative systematic review of the existing research that explores university student's experience of seeking support for their mental health at university. Following the Aveyard (2018) approach, I present the search terms and search strategy, inclusion and exclusion criteria, quality appraisal process, data analysis and findings. The structure of this chapter follows the IMRAD principles of introduction, method, results and discussion, as this has become the widely recognised and accepted format for academic works (Sollaci & Pereira, 2004).

4.1 The importance of a systematic review

The systematic literature review is an essential aspect of the research journey. It represents the current knowledge on a specific topic and demonstrates the researcher's critical thinking ability (Bloomberg & Volpe, 2008). A review can also be described as a process that systematically traces all available literature on a topic back to its roots (Callahan, 2010) and furthers advancing knowledge and research on specific topics (Elsbach & van Knippenberg, 2020). Conducting a systematic literature review is essential to the research

process as it supports the rationale for further research (Hart, 1998). It is usually the first step in the research journey and forms the foundations of the project (Hart, 1998).

However, Smythe & Spence (2012) assert that a literature review is not solely there to show a gap in the literature nor to argue that further research is required; its key requirement is to provoke thinking and, therefore, to identify the researcher's pre-understandings of the subject.

Some research methodologies recommend leaving the literature until after data collection to reduce the possibility of introducing bias to their findings (Grove et al., 2014; Munhall, 2010). Furthermore, conducting the literature review after the researcher's data collection and analysis is sometimes undertaken when using a phenomenological stance to avoid contaminating the interpretation of any data (Munhall, 2010). However, Munhall does not refer to a specific phenomenological methodology, and as I used a hermeneutic phenomenological approach (see section 5.2) which considers the views of the researcher in the final interpretations, rather than bracket or put these pre-understandings aside, I conducted the review before data collection. This decision was also based on this study being part of a research degree; therefore, it is essential to ensure that the focus of the research makes an original contribution (Hart, 1998).

4.1.1 Aim of the review

This qualitative systematic review was conducted to summarise the evidence on university students' experience of seeking support for

their mental health at university. A qualitative approach was undertaken, as this is aligned with the theoretical and methodological approach of my study (see section 5.1.3); the intention was to uncover any research that explored student's experiences, to identify any gaps in current knowledge and to inform the primary study.

4.2 Methods

This review was informed by another qualitative systematic review (Finlayson et al., 2019) using the same methodology. My method included searching the lived experiences of students seeking mental health support at university and included a comprehensive search strategy and a quality appraisal. My data analysis was then carried out using thematic (Thomas & Harden, 2008) and meta-ethnographic techniques (Noblit & Hare, 1988).

4.3 Reflexivity

Author reflexivity is, as Walsh & Downe (2006) stress, a 'key tenet' of qualitative research; therefore, as part of this project, I considered what I already knew about students and mental health by undertaking a reflexive activity that can be found in chapter 1 (Finlayson et al., 2019).

4.3.1 Development of the research question

Formulating a review question is crucial as it underpins the review methodology. It defines the scope and nature of the review, identifies keywords, determines a search strategy, provides guidance on selecting the primary research papers and guides the data

extraction and synthesis of the results (Bettany-Saltikov & McSherry, 2016).

The review question for my study was:

***What are the experiences of university students with mental health problems*?**

Frameworks have been developed to help formulate review questions and the review strategies (i.e., search terms, inclusion and exclusion criteria); one which is generally used in qualitative-based reviews is the PEO framework - Population, Exposure, and Outcome (Khan et al., 2011). The table below (table 1) demonstrates how I used the PEO method to develop my search terms.

4.4. PEO

P Population	Student , Student(s) , Student* , “University student*” “Higher education student”
E Exposure	“Mental health problem”, “Mental health", “Mental illness”, wellbeing, “Mental disorder”
E Exposure	Support, "support services."
O Outcome	Views, perceptions, experiences , “Lived experience” , “Personal account” , “Case study” , Experience , Encounter, phenomenology

Table 1 Table 1 PEO table adapted from Khan et al. (2011) that includes the search terms used

Initially, I intended my review question to be focused on students seeking support for their mental health problems at university. However, when I conducted a scoping search to see what search terms could be used, that search returned zero studies.

Therefore, I widened the search to include university students with mental health problems for a more inclusive focus.

The scoping search was also undertaken to ensure no systematic literature reviews had been conducted to answer this review question (Aveyard, 2018; Bettany-Saltikov & McSherry, 2016). As suggested by Aveyard (2018), undertaking initial searches helps to demonstrate that I carried out a systematic and comprehensive process. It also helped develop search terms and the inclusion and exclusion criteria.

The search terms presented in Table one details were developed using keywords, Medical Subject Headings (MeSH), Boolean operators, truncations, and wildcards. Wentz (2014) acknowledges that keywords can be challenging to develop and advocates producing a to-do list. I adopted this approach by writing a list of keywords, including their alternative spellings and synonyms, and selecting keywords used in similar studies to ensure they are derived from the research question. These words were tested in different databases multiple times to ensure they captured appropriate studies, as suggested by Gillespie & Gillespie (2003).

4.4.1 Databases searched

As student mental health is a topic that has crossed a range of disciplines, I chose to reflect this variety in the databases I used. For my search, I used five databases: CINAHL (Cumulative Index to Nursing and Allied Health Literature), MEDLINE, Embase (Excerpta

medical database), ERIC (Education Resources Information Centre) and PsycINFO.

4.4.2 Hand searching

Electronic searching was my first approach, but as Aveyard (2023) highlighted, this should not be the only component. I, therefore, looked at reference lists and author searching to ensure I had not missed any papers and to identify further literature.

4.4.3 Inclusion and exclusion criteria

The inclusion and exclusion criteria for the review are detailed below (see Table 2). I focussed on finding primary research papers that explored students' experiences of having a mental health problem whilst at university. I also focussed on looking for qualitative papers as this approach would enable me to investigate meaning and experiences (Aveyard, 2023). I also chose only to identify literature undertaken in the British Isles due to the vast differences between universities worldwide. I focussed only on Higher Education Institutions (HEIs), not schools and colleges, as they differ in service provision. There were no time restrictions for inclusion.

Inclusion criteria	Exclusion criteria
Studies on student's mental health experience at university	Non-English studies
Primary research	University settings outside of the UK
Qualitative studies (or mixed-methods studies with a qualitative component)	Non-University level students
Universities in the British Isles	Quantitative studies

Table 2 inclusion and exclusion criteria

4.4.4. Study selection

Searches were initially carried out in May 2019. They were then repeated periodically over the years of this research project to ensure that any new publications were captured. I also created an email alert to be notified of any new publications without directly searching the databases.

To help manage this systematic approach, I used the Covidence software. Covidence is an online tool designed to streamline the systematic review process (Kellermeyer et al., 2018). I imported the papers from the database searches into Covidence.

Once all searching had been completed, I then screened the titles and abstracts to assess whether the literature was appropriate for inclusion, and under the guidance of my supervisors. I searched for literature that explored the experiences of university students with mental health problems to avoid losing any papers that would be relevant. The Covidence software allowed me to mark each paper as either 'include' or 'maybe' as I worked my way through each paper and assessed it against the inclusion and exclusion criteria.

The next stage was full-text screening which included reading the text in full to assess for inclusion. My supervisory team and I reviewed the full text, and any disagreements were resolved by consensus. I then worked in the Covidence programme to extract any relevant data from the included studies into a data extraction table. This detail included the authors, year of paper, aim, methods and summary of main findings.

4.5 Data analysis

Data analysis was carried out in two stages. The first stage consisted of a general thematic approach, followed by the use of meta-ethnographic translation techniques to map the findings across the evidence base (Lewin et al., 2015). I undertook these analytical stages with all interpretations and decisions discussed in supervision.

4.5.1 Quality assessment

A quality appraisal is a structured assessment to ascertain the strengths and weaknesses of a particular study, as well as its quality and utility in answering a research question or identifying gaps in knowledge (Aveyard, 2019). Using the quality appraisal tool helps develop a consistent approach to the research critique. It also helps to question the literature in a more structured and in-depth way. However, quality appraisal tools have limitations, with Aveyard (2019) declaring that no one ideal appraisal tool exists. I used Walsh and Downe's (2006) quality appraisal framework to appraise the studies. This quality appraisal tool was developed based on a review of other valid tools with the best features adopted and amalgamated. It enables the epistemological, theoretical and methodological aspects of research papers to be analysed. It also has flexibility in a scoring system and is robust enough to aid a thorough critique of the included studies.

All included papers were quality appraised using the Walsh & Downe (2006) tool, and then each paper was allocated an overall quality score from A-D (see Table 3). Due to the limited number of studies, I included them all in this review, regardless of quality.

Grading System

A: No, or few flaws. The study's credibility, transferability, dependability and confirmability are high.

B: Some flaws are unlikely to affect the credibility, transferability, dependability, and/or confirmability of the study.

C: Some flaws may affect the study's credibility, transferability, dependability and/or confirmability.

D: Significant flaws are likely to affect the study's credibility, transferability, dependability and/or confirmability.

Table 3 Quality appraisal grading criteria for Walsh and Downe tool

4.6 Results

Initially, 1242 studies were found via database searching and other methods, and following de-duplication, this left 699 studies to be screened (see Figure 11 for the PRISMA diagram). Overall, seven papers met the inclusion criteria, and the characteristics of these articles is presented in Table 4.

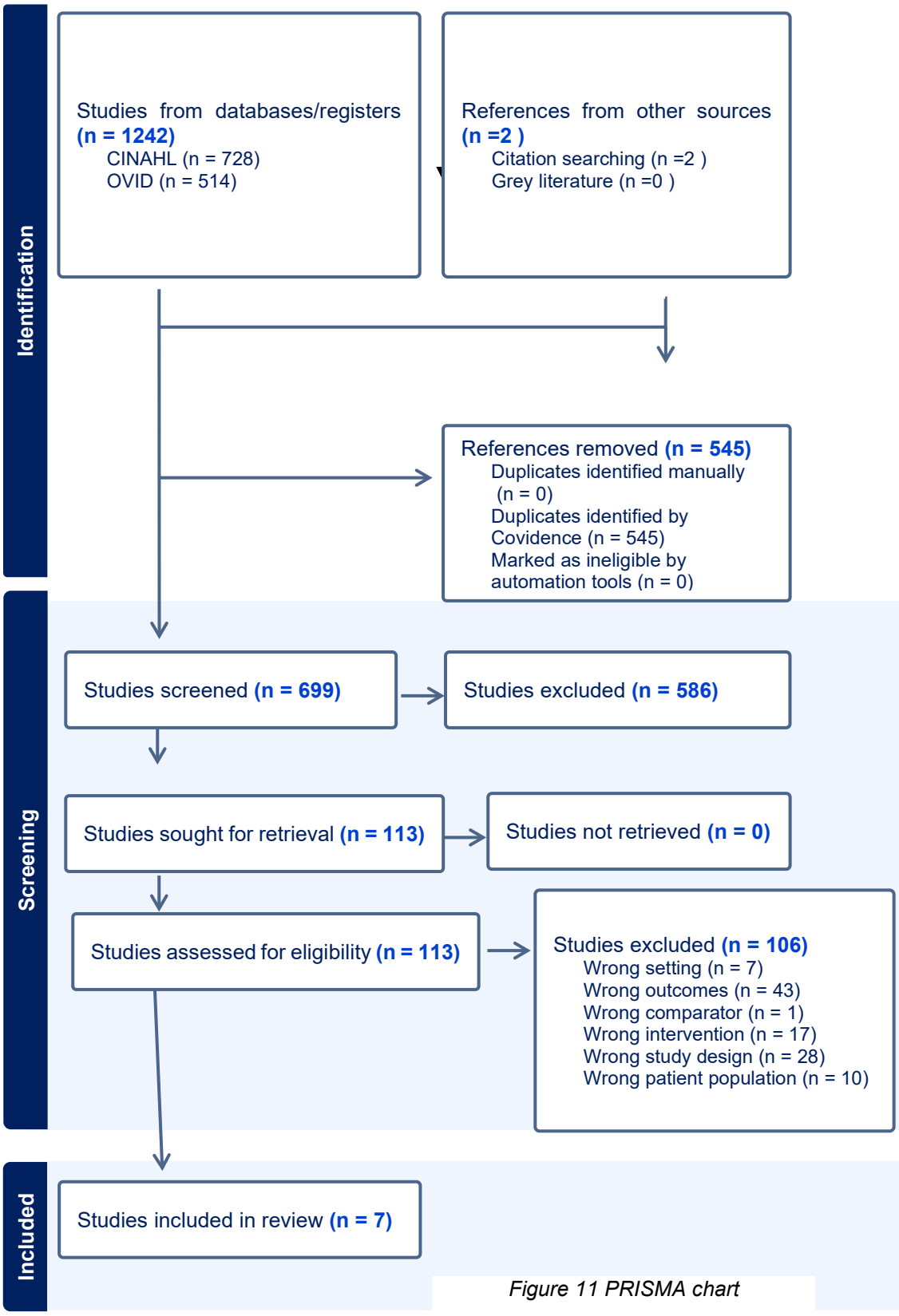

Figure 11 PRISMA chart

Author/date/location Country	Title of the paper	Type of Literature	Method of research	Main findings	Critical appraisal grade
Byrom, N. C., Batchelor, R., Warner, H., & Stevenson, A. (2022)	Seeking support for an eating disorder: a qualitative analysis of the university student experience – accessibility of support for students	Primary research	Qualitative online survey and semi structured interviews	This study explored students' perspectives of accessing treatment for an eating disorder at university, using qualitative data from in-depth interviews and a survey. Three overarching themes were identified; awareness of support, confidence in asking for help and early experiences with services.	A
Chew-graham, C. A., Rogers, A., Yassin, N. (2003).	'I wouldn't want it on my CV or their records': Medical students' experiences of help-seeking for	Primary research	Qualitative Semi-structured interviews	The study explored medical students' attitudes to the cause of stress and examined their help-seeking behaviours. Four themes emerged from the interviews with medical students: transitional stressors in becoming a medical student, the type of support these students sought out, barriers	A

England	mental health problems.			experienced, and different coping strategies voiced by the participants.	
Demery, R., Thirlaway, K., Mercer, J. (2012). Wales	The experiences of university students with a mood disorder.	Primary research	Qualitative, 1:1 interview Thematic analysis	This study explored the personal experiences of university students with a mood disorder. Four themes were found: social and family support, powerful symptoms, stigma and labelling, and interprofessional dynamics.	A
Freeburn, M., Sinclair, M. (2009). Northern Ireland	Mental health nursing students' experience of stress: Burdened by a heavy load.	Primary research	Qualitative 1:1 interviews in-depth Phenomenology	This study looked at personal stress experienced by university student mental health nurses. The illuminated main themes were influence on life, constraints, demands, ability to move on from the stress, and meaning.	B
England Oates. J	'The rollercoaster': A qualitative study of midwifery students' experiences	Primary research	Qualitative Semi-structured interviews	The study looked at the lived experience of midwifery students' wellbeing. Two themes were identified. The word rollercoaster was used to encapsulate the students' course experience. The second	A

(2020) England	affecting their mental wellbeing.			theme was noticed to encapsulate what could help the students enjoy their midwifery training.	
Quinn, N., Wilson, A., Macintyre, G., Tinklin, T. (2009). Scotland	'People look at you differently': Students' experience of mental health support within Higher Education.	Primary research	1:1 interviews Focus group Online web space Mixed methods	This study aimed to examine students with mental health problems' experiences of the Universities' response to managing student mental health. It found themes of disclosure, help-seeking, the support experience, academic support and counselling, NHS provision, and culture.	C
Tinklin, T., Riddell, S., Wilson, A. (2005). Scotland	Support for students with mental health difficulties in higher education	Primary research	Qualitative 1:1 interviews for up to 1.5 hours Case study	This study explored insights of university students with mental health problems. The themes found were stigma and alienation, culture and acceptance, staff being approachable and raising awareness.	D

Table 3 study characteristics and quality appraisal grading

4.7 Summary of included papers

All seven studies looked at the lived experiences of students with mental health problems while studying at university. The Tinklin et al. (2005) study was different; it was a list of case studies made available from an original study that looked at research policy and provision for disabled students.

All studies were set in British Isles universities and were conducted by researchers from the following disciplines: social work, education, human resources (HR), occupational therapy, para-athletes and psychology. The study participants were all studying at either undergraduate or postgraduate levels and had mental health problems of varying nature and degree. Each study used 1:1 interviews for data collection, the Quinn et al. (2009) study had an online platform that the participants could use, likewise Byrom et al . (2022) had an online survey in addition to semi structured interviews. The papers were undertaken between the years 2003-2022 and included a total of 188 students.

4.7.1 Summary of quality appraisal

Here, I summarise the quality appraisal findings of the seven included studies. Byrom et al. (2022) was a qualitative study that used an online questionnaire and semi structured interviews to ask participants experiences of accessing treatment for eating disorders at university. The students were recruited from the UK wide and were representative of students with an eating disorder. Due to the robust approach and declaration that the analysis may have been influenced

by the researchers lack of experience in service design and delivery reduced this as a limitation.

Chew-Graham et al. (2003) was a qualitative study that explored medical students' attitudes in the UK about their views on seeking help and the causes of stress. The data collection consisted of semi-structured interviews. The study used a representative sample of medical students and had an in-depth analysis of constantly comparing data. Given the study's robustness, I gave this an A quality appraisal grade. While the paper had a small sample size, they used constant comparison in their data analysis to help negate the small sample size as a limitation.

The Demery et al. (2012) study examined the experiences of students at university with a mood disorder. Demery et al. (2012) used the 'snowballing technique' to recruit study participants. Snowballing, also known as network sampling, is used to find hard-to-reach groups by taking advantage of social networks (Haber, 2017). Participants were approached due to being identified as potentially having 'rich data' and access to others. The student services' mental health advisors were given posters to display across the five participating universities, calling for interested students to contact the research team if they were interested in participating. A thematic analysis of semi-structured interviews for the 5 participants was used to interpret the data. The results found that stigma and lack of information hindered seeking support. I graded this paper as category A due to the study design's credibility, transferability and dependability.

The Freeburn & Sinclair (2009) study explored the personal stress experienced by mental health student nurses in a diploma program. This was based in Ireland and had six participants. This study used a phenomenological approach to gain insight into students' experiences of stress during their time at university. The study focussed on several themes that included the stressful event, the meaning of that event, the effects of it, the ability to move forward from it, and the influence it had on the participant's life constraints and demands. The quality of this study was graded at a B. There was a rigorous methodology that gave clear statements and rationales throughout. The only thing this paper did not have was any reflexivity, and this could also reflect the year of publication.

Oates et al. (2020) study explored midwifery students' experiences, mental health, and the emotional demands of their midwifery training. Twenty participants were included using semi-structured interviews to collect data, followed by 73 participants responding to a survey about their mental health. Two main themes were developed following the data analysis, including the roller coaster and being noticed; feeling connected was the second theme. There was potential bias from the research team, which had pastoral responsibilities for the students. However, it was clear that this had been considered; therefore, there was a conscious effort of 'bracketing' when interpreting the data during analysis meetings. There was apparent methodological and decision-making rigour, and therefore, it was graded as an A for quality appraisal.

Quinn et al. (2009) looked at assessing the experience of students with mental health problems and factors influencing their ability to seek help. Twelve participants took part in an in-depth interview, and an online space was also available for participants to upload comments. The study findings articulated reluctance from all students about disclosing a mental health problem, mainly due to stigma. Of the students who sought help from the university, they valued the support. I categorised this study as C, as reflexivity was not mentioned.

Finally, the Tinklin et al. (2005) study explored the impact of higher education environments on students with mental health problems. This study drew on five case studies of students experiencing mental health problems at university and provided insight from the student's perspective. Tinklin et al.'s (2005) study was different; it was a list of case studies made available from an original study that looked at research policy and provision for disabled students. For this study, I have categorised it as a D as this appears to have been taken as an opportunity to further investigate a previous study conducted with 48 students and lacked methodological detail. I was also unable to access the previous study. The paper had no clear method or design, and sampling was unclear There was no formal analytic approach, or clear audit trail.

4.7.2 Data analysis

I initially read each paper's findings and started to locate emerging codes. I noted down each code identified within the findings from each of the six papers and then started to merge these codes into subthemes and themes. During this process, I also drew on a meta-

ethnographic technique of reciprocal and refutation translation to see what was similar or different in the findings across the included studies (Noblit & Hare, 1988). This enabled me to decipher any limitations and relevance to my research question and to look for clear patterns across the studies. In the following Table, I provide a summary of the theme, the studies that contribute to the theme and the theme title.

Summary of theme	Studies contributing to review finding	Theme
Students move away from their homes and study at the university level.	Chew-Graham (2003)	Powerful symptoms
Culture shock: Students found the 'not cool to care' culture was evident when it came to mental health support. There was also a shock of university culture in general.	Oates et al. (2020) Quinn et al. (2009) Tinklin et al. (2005)	Barriers to help-seeking
Students reported that friends and family support their mental health needs.	Chew-Graham (2003) Demery et al.s (2012) Oates et al. (2020) Quinn et al. (2009)	Family and peer support
Students identified the need to seek support.	Freeburn and Sinclair (2009) Quinn et al. (2009)	Help-seeking behaviour
Students worried about the impact of stigma	Chew-Graham (2003) Demery et al.s (2012) Quinn et al. (2009)	Barriers to help-seeking

	Tinklin et al. (2005)	
	Byrom et al (2022)	
Shame and embarrassment were barriers to some students accessing help.	Chew-Graham (2003)	Barriers to help-seeking
	Oates et al. (2020)	
Students were worried their issues would not be kept confidential	Chew-Graham (2003)	Barriers to help-seeking
Coping strategies used for self-help.	Chew-Graham (2003)	Coping
	Freeburn and Sinclair (2009),	
Reluctance to disclose having a mental health problem.	Quinn et al. (2009)	Help-seeking behaviour
Students did not know about the service provision.	Chew-Graham (2003)	Awareness of support
	Quinn et al. (2009)	
	Byrom et al (2022)	
Students felt that the services there to help them needed better advertising.	Chew-Graham (2003)	Awareness of support
	Quinn et al. (2009)	
	Byrom et al (2022)	
The role of the personal tutor was instrumental in the overall experience.	Freeburn and Sinclair (2009)	Experience of support
	Oates et al. (2020)	
	Quinn et al. (2009)	
There was a lack of consistency between appointments with the student counselling team.	Demery et al. (2012)	Experience of support

Students had a good experience with the mental health advisor staff member.	Demery et al. (2012) Quinn et al. (2009) Byrom et al (2022)	Experience of support
The meeting to get support from the wellbeing team was negative.	Demery et al. (2012) Quinn et al. (2009) Byrom et al (2022)	Experience of support
There was patchy communication between NHS services, the university wellbeing team and academic staff.	Demery et al. (2012) Quinn et al. (2009) Byrom et al (2022)	Experience of support
Students felt they needed the ability to manage emotions	Oates et al. (2020)	Powerful symptoms
Symptoms of mental ill health interfered with the university experiences.	Demery et al. (2012) Byrom et al (2022)	Powerful symptoms
Experience of stress during the time of study.	Freeburn and Sinclair (2009),	Powerful symptoms
Physical and emotional health and wellbeing.	Freeburn and Sinclair (2009) Oates et al. (2020)	Powerful symptoms
Influences on life due to having a mental health problem during study.	Oates et al. (2020)	Powerful symptoms
Feeling that the course itself exacerbated mental ill health.	Demery et al. (2012) Byrom et al (2022)	Help-seeking behaviour

Table 4 - Development of themes

4.8 Thematic analysis

Here is a report of the themes from the qualitative synthesis. These included help-seeking behaviour, which explored the students' experiences of how they came to find help. The next theme, powerful symptoms, explained the symptoms that the students experienced at university. Following on, awareness of what support was available described the student's awareness of what was available for them about supporting their mental health needs at university. Next was the student's experience of receiving support. Lastly, the barriers to getting support for their mental health needs are discussed.

4.8.1 Help seeking behaviour

For the included studies, their findings showed that help seeking was evident. Most participants in the studies by Freeburn and Sinclair (2009), Oates et al. (2020), Quinn et al. (2009) and Chew-Graham et al. (2003) spoke of going to friends and/or family for support. In Chew-Graham's (2003) study respondents reported preferring to speak with friends and family before university services:

'I probably would rely on my family and friends first. I mean very much myself sort of my family and friends so I'd talk to family first, cos, but that helps cos they're very local. So I know I'm, you know, very fortunate in that sense.'

-(Chew Graham et al. 2003)

Whereas in the Oates et al. (2020) study, participants felt there was a certain level of confidence that was required to speak up and get help for mental health needs:

'I think you do have to be confident enough to be real with people and say, okay, I'm really struggling rather than ploughing through.' - (Oates et al., 2020)

However, participants in Demery et al.'s (2012) study acknowledged that they did need help for their mental health to continue with their studies. However, it was not until a mental health advisor approached them that they were comfortable seeking out this help. For some participants, this was due to not feeling very optimistic about the student wellbeing team:

It was not really until the Mental Health Advisor came that I really sought their help of specifically with a view to the Bipolar, because up until that point, it was the feeling of student support services whilst they were aware of the problem; there wasn't really anybody on hand who could advise me about what to do

–(Demery et al. 2012)

4.8.2 Symptoms

The participants in the included studies all mentioned stress levels experienced whilst studying at university, along with their symptoms of mental ill health. The participants in the Chew-Graham et al's. (2003) study experienced two types of stress: stress caused by

the transition of moving away from home and stress caused by the course itself:

If I had done medicine at home, I would not have to worry about other things like housing and finances; I do my own shopping for food and travel; travel is a lot. So all those things would be absent, so I think I would have been able to concentrate more on medicine than everything else.'

- *(Chew-Graham et al. 2003)*

Study stress was also a theme that became apparent in the study by Tinklin et al. (2005) and Demery et al. (2012). Here, the constant striving to achieve led some students to experience suicidal thoughts and reduced cognitive functioning, leading to a decline in academic performance:

... exams were the worst times for me really because the added pressure of knowing that I had to perform at a certain standard in order to get through to the next phase, um meant that that added stress meant that my sleep and my moods would bounce around a lot during those times.

- Demery et al. (2012)

In the study by Tinklin et al. (2005), students expressed what their mental health problems were and how their symptoms fluctuated from time to time:

'The depression is there all the time, but it's not so bad at the moment. It kind of gets worse and then gets better. I've had to go on anti-depressants recently ...as I had a tiny relapse, nothing so major as it was when it first started'

– (Tinklin et al. 2005)

4.8.3 Awareness of support provision

The next theme explored access to support. Participants in Byron et al's. (2022) study where not always aware of what support was available. Similarly, Tinklin et al.'s (2005) study found that a lack of information articulating what support was available negatively impacted access. Likewise, according to Chew-Graham et al. (2003), students had limited knowledge of what support was available for them in their medical school and the wider university:

'I don't think there is much help for us. Not medical students in particular. There might be help for students in general but, I would not know where it is and, whether I would go and take time to seek it or not is a different story because again, instead of seeking help you could be trying to revise, just try and get more information in there.

-(Chew Graham et al. 2003)

Quinn et al. (2009) also found that although many services were available, the lack of knowledge on accessing them overshadowed this. However, participants from Demery et al. (2012) and Quinn et al. (2009) also found that knowing a service was available was

sometimes enough to help; other students acknowledged that they knew 'something' was there but did not necessarily reach out to get help:

Just knowing there are services available so if you're not coping, if you're in a lot of stress, there are people you can go and talk to, not making it into a huge issue ...just making it like, you know, people get stressed it's no big deal ...if you feel like this there is someone who can help you ...it's when it's not talked about, you have a stigma to it, then people are like, oh I can handle it, I can deal with it myself and that makes it worse

-(Quinn et al.2009)

4.8.4 Experience of support

The personal tutor role was cited in all the included studies. This was identified as a person whom participants went to for support with their mental health needs. The value of academic tutor support was mentioned by participants in Oates et al.'s (2020) study, as participants felt that having regular contact with the same academic tutor enabled them to manage the emotional aspects of their degree. Participants in Freeburn & Sinclair's (2009) study also spoke of finding solace when seeking support from their tutors:

'. . . they [personal tutor] just felt that they wanted to do something.'

-(Freeburn & Sinclair, 2009)

Whereas the experiences of seeking support from academic staff by students with mental health problems in the Tinklin et al. (2005) study were negative. Participants identified that they felt a lack of support and that staff had little understanding and were dismissive of their mental health needs. Some participants felt it was challenging to get help and needed student services to get involved to ensure their needs were met (Tinklin et al., 2005):

'I couldn't stand the thought of presentations and when I did finally have to do one last year, it was terrible, it was awful. I've never had such a terrible experience, and that tutor [said] ...'' Oh, you'll be fine ...you'll get through,'', but the thought of it was just turning my stomach. I also received a fairly bad mark for it. It wasn't until after the experience that I managed to get my point across. I did try and tell him before the presentation, but he took it as a normal nervousness. He's accounted for that now and says he's sorry that he didn't listen in the first place, which was nice to know.'

-(Tinklin et al. 2005)

Similarly, Quinn et al.'s (2009) participants felt that staff required training and noticed a difference in attitudes towards physical disabilities and mental health from academic staff. One student felt that they had to get their community psychiatric nurse (CPN) involved to validate their mental health problem at university to be supported:

They [the Disability Service] are communicating with my community mental health team, so I don't need to go to them, get letters and

stuff ...that's made a massive difference ...I've been put on a community care programme, and my CPN was talking about inviting someone from the Disability Service along once a month

-(Quinn et al.2009)

Likewise, Demery et al. (2012) found that students reported that academic staff were only sometimes aware of reasonable adjustment plans and that work between student services and the academic departments needed to be more cohesive. These experiences are echoed in other studies included in this review, with participants highlighting that staff require more training and support to deal with their mental health problems (Demery et al., 2012; Quinn et al., 2009; Tinklin et al., 2005):

You hardly have any contact with an authority figure ...I haven't seen my advisor of studies since the first day, so you don't know who you're supposed to be contacting

-(Quinn, et al.2009)

The included studies also described student experiences with student support services, including mental health advisors, counsellors, and unidentified roles. Quinn et al. (2009), Demery et al. (2012) and Tinklin (2005) all reported participants' positive experiences when accessing different staff members from student services. Participants in Quinn et al.'s (2009) study reported having a plethora of services available within student services to support mental

health needs, but having this much support required a high level of coping. Demery et al.'s (2012) participants commented on the role of the mental health advisor (MHA) being a positive experience. There was the acknowledgement that MHA was a new role, but the concept was practical and positive. The MHA's aim was around achievement, which helped students stay well and achieve in their studies:

... I was very lucky the warden got me to the doctors; he got my mum to come up he could just see I was out of control really. That was the first bit of help from the university, that was really an individual being kind, than a network.

-(Demery et al.2012)

However, one student in the Demery et al. (2012) study did not return to the MHA and then wondered if she should go back but did not. Some views were also less positive - participants claimed a need for more consistency with the counselling service, and two participants described it as ineffective (Demery et al., 2012). Likewise, the Quinn et al. (2009) study participants felt that support should be increased during exam time and that liaising between this service and the academic departments could have been better. The Tinklin et al. (2005) participants also expressed that the environment of the university, the course design and 'unsupportive lecturers' added to their mental health problems. Participants in Byrom et al's. (2022) study also had mixed experiences with staff too.

4.8.5 Family and peer support

Freeburn and Sinclair (2009) found that their participants recognised the need for mental health support from family and friends while studying.

However, some of the participants in Tinklin et al.'s study reported negative experiences; students expressed feeling alienated, which on one occasion related to their partner speaking poorly about them and then ending the relationship. Other participants in this study shared that people had been mean towards them and had felt patronised by their peers:

'It depends on who I'm talking to and why ...if you're just talking to everyday people you don't really let them know the depths of your problems as such, do you? ...I mean, I know it's serious, but I don't sort of, as I say, I don't tell people really, you keep it to yourself

-(Tinklin et al.2005)

Demery et al. (2012) described that participants were cautious about making friends and were found only to have a small circle of friends. Some participants only spoke to close friends and family about their issues, rather than university staff or professionals, for fear of repercussions.

My brother and his wife have always been mega supportive, and they are the ones I stayed with in Orkney. Um, and you know [names

sister-in-law] even like made a little painting of things to do when to keep yourself calm and things.

-(Demery et al.2012)

4.8.6 Barriers to seeking help

Awareness and accessibility of what was available were issues identified within the studies by Byrom et al. (2022), Chew-Graham et al. (2003) and Oates (2020). Yet participants in Chew-Graham et al.'s study (2003) reported needing more awareness of the support available from student services. They elicited that they would be not as keen to attend this service for fear of stigma and their medical records having mental health information on them:

'But if you have even the slightest hint that it might not be kept confidential then students wouldn't go. So confidentiality is a big thing.'

-(Chew-Graham et al.2003)

Similarly, in the Tinklin et al. (2005) study, students failed to disclose having a mental health problem or show any willingness to seek support for their mental health problem due to the perceived stigma. They also found that students appeared fearful of stigma, embarrassed to seek help, feared it would be perceived as a weakness, and possibly affect their career if mental health was to appear on their medical records. Similarly, Quinn et al. (2009) and Chew-Graham et al. (2003) both reported that their study found that

stigma was the main reason students did not seek help for their mental health. Additionally, the Demery et al. (2012) study found stigma was a big issue for students with a mood disorder as it sometimes stopped those students from accessing support. It was found that students would only disclose mental health problems to university staff and peers if they were confident there would be no adverse effect on their university experience or job prospects.

'There is a lot of stigma and there's a lot of shame in it and there shouldn't be really but there is. And I don't know how you'd remove that. Sometimes I think you've to turn it round and kind of educate people and say that they're probably actually being stronger if they go and seek help rather than keeping it bottled up.'

– (Chew Graham et al.2003)

In addition to stigma, the university's culture towards mental health was also a barrier to accessing support. Culture was reported in several of the included studies and from different perspectives. Tinklin et al.'s (2005) study participants experienced a 'not cool to care' culture and felt student services needed to change their image to increase accessibility. One student felt that his peers lacked mental health awareness and felt that they did not need to look out for their fellow students. One participant mentioned that he 'disappeared from the class' and that this went unnoticed. He felt that the nature of higher education exacerbated and potentially created mental health issues.

Likewise, participants in the Quinn et al. (2009) study reported a culture of accepted reluctance to seek help. Meanwhile, students in Chew-Graham et al.'s study (2003) found that students worried that their disclosure would not be treated as confidential due to the culture.

'Well, it must make you a better doctor to have gone through some problems and come out the other side. That's what I think. I guess not everyone shares that view. I guess I'd be careful who I told. I wouldn't want it on my CV (resume´) or their records.'

- (Chew Graham et al.2003)

4.9 Discussion

Help-seeking behaviour was the first theme discussed here. All the seven included studies made some reference to help seeking behaviour. Some participants felt more comfortable speaking to peers and family members over contacting University services; however, others found that speaking to university mental health services was a better option for them. It was also noted that a certain level of confidence was needed to speak out and seek help.

The symptoms that some of the participants experienced were then explored. Not every study gave an explicit description of what mental health problems the participants were experiencing. One study by Demery et al. (2012) focussed solely on students with a mood disorder, whereas the rest of the studies did not interview participants with a specific diagnosis, the participants just needed to have any kind of mental health problem. The findings from the themes showed that

students experienced a range of mental health difficulties, including stress.

The next theme related to participants' awareness of support provision. Again, the experiences differed. Participants either were or were not aware of the available support, while others felt that once they were aware that support was available, this was enough to support them.

Experience of support was the next theme, and the experiences varied. Some participants described having a positive experience with university wellbeing staff members and academic staff members, as other participants found that the support was damaging. Some participants even considered that the degree itself exacerbated their mental health problems.

Family and peer support was the next theme. Some students felt comfortable approaching family members to support them with their mental health needs, and other participants found that speaking to peers would be helpful in the first instance.

Lastly, barriers to seeking help were explored. Stigma was one of the main issues that prevented students from accessing help for their mental health needs. Awareness of what was available was another key barrier.

4.9.1 Summary of key issues

This review found a paucity of research into the experiences of students who have struggled with their mental health while studying at university. These six papers varied in their methodological quality and

overall provide clear justification for further research to be conducted. This review identified that several questions remained unanswered, including

- What is the lived experience of having a mental health problem and seeking support from university services?
- What was unique about receiving support from university services?
- What was the meaning of having a mental health problem while studying?
- What needs to change to enhance the student experience of having a mental health problem whilst at university?

Therefore, my study was designed with a lived experience focus to help address these questions and provide an in-depth exploration into students' help-seeking behaviours and experiences of seeking support.

4.10 Conclusion

This review has presented what is currently known about students experiencing mental health problems at university. These insights identified whom students sought support from and their experiences, such as the mental health and stress of being at university, access-related issues, and cultural barriers to receiving support.

The chapter provides a comprehensive oversight of how I conducted the systematic review. The robust and systematic approach has helped to show what evidence is currently available in this research area and highlights how my study is required and unique.

The chapter concludes with a list of questions to ponder and highlights the current literature gap: it highlights that this area still needs to be researched and is worthy of exploration. The next chapter explores my theoretical positioning.

Chapter 5 | Theoretical positioning

5.0 Introduction

The previous chapter provided a review of the current available evidence on university students' mental health experiences. This chapter presents the theoretical positioning of the research used in my study. I represent the aims of my project then provide insight into the epistemology, ontology and axiology underpinning the chosen approach. I provide a brief overview of other methodologies that were potentially suitable but dismissed. I explain my reasons for using van Manen's approach and why this was appropriate to answer my research question. The chapter also provides a rationale for the study's suitability of a hermeneutic phenomenological approach.

From there, I discuss the key contributors influencing Max van Manen's (1990) work, a leading academic who, with others, including Bas Levering, at the University of Utrecht, developed a hermeneutic phenomenological reflective framework to aid interpretation and writing (van Manen, 1990).

This chapter is structured using Crotty's (1998) scaffolding approach, which he suggests can help ensure the robustness and value of the research.

5.1 Aims of the Research

My study aims to comprehensively understand what it is like to be a student with a mental health problem and seek support from university services. I wanted to explore in depth what students experience in their journey to receiving support as well as their experience of support.

5.1.1 The research question

The research question is far more than the title of a study; it clearly articulates what question will be answered (Green & Thorogood, 2014). The research question should sit within an epistemology, theoretical perspective, and then the method chosen to help ensure the research is taken seriously (Crotty, 1998); therefore, the research question for my study is:

What is the lived experience of having a mental health problem and seeking support at university?

5.1.2 Hermeneutic phenomenology

Hermeneutic phenomenology is the underpinning philosophy of this study. Hermeneutics, loosely translated from Greek, means ‘interpreting’ (Chang & Horrocks, 2008). It originates from Hermes; the Greek God associated with transmuting what humans cannot understand into understandable content. Hermeneutics is a process of bringing understanding to a particular concept (Heidegger, 1959).

Thus, hermeneutic phenomenology focuses on subjective experience, aiming to reveal the world as experienced by a person via their story and for the researcher to interpret these experiences with their preconceived knowledge (fore - sight) (Heidegger, 1962).

Hermeneutic phenomenology has descriptive and interpretive aspects; phenomenology uncovers meaning, and hermeneutics interprets meaning (Zalm & Bergum, 2000). Hermeneutics and phenomenology are often used interchangeably despite being epistemologically and ontologically very different (Chesterton & Jack, 2021). Benner (1994) adds that hermeneutic phenomenology is best suited to 'how and why questions' of a person's experience and cannot aid prediction or be generalised as the lived experience is idiosyncratic to each person. The following paragraphs will explain how I decided to use hermeneutic phenomenology as the methodology for this study, aided by the scaffolding model which Crotty (1998) suggests as a framework to ensure that a robust approach underpins the research.

5.1.3 Epistemology, ontology, and axiology

Research philosophy is a set of beliefs and assumptions about knowledge development and how our beliefs and assumptions affect our choices (Saunders et al. 2019). The way a researcher views their world (ontological assumptions), what they consider is acceptable for knowledge (epistemological positioning), their values and ethics (axiological positioning) all constitute and shape how a researcher understands research, questions, methodologies, and findings

(Saunders et al., 2019; Crotty, 1998). These three concepts are explored in further depth as follows.

5.1.4 Epistemology

Epistemology is the theory of knowledge which can be viewed on a continuum, positivist at one end and interpretive at the other. At the end of this section, I present a visual comparison of positivism and interpretivism adapted from Saunders et al. (2019). The table (table 6) compares the two philosophical approaches, highlighting their key differences and implications for research design and outcomes.

This phenomenological study is interpretive as the experience of individuals is subjective. Interpretivism emerged in the mid-twentieth century in Europe, notably in hermeneutics, phenomenology, and symbolic interactionism (Crotty, 1998). Interpretivism aims to create a new understanding of social worlds and contexts (Saunders et al., 2015). It is more concerned with creating depth in meaning with the assumption that humans cannot be explored like physical phenomena (Helmi Allharahsheh & Pius 2020). Its subjective focus is in direct contrast to positivism which is associated with the belief that objectivity is important, that facts are there to be proven and that reality is the same for each person (Ryan, 2018).

Hermeneutic phenomenology is an interpretive approach as it aims to understand individuals' subjective experiences, with the researcher being required to illuminate a rich and profound account of the phenomena being explored rather than proving that something is right or wrong (Cohen et al, 2000). My study, with its interpretive

nature, uses an inductive method that looks at the "what and how" to make empirical observations about a phenomenon of interest and to form concepts based on them (McEwen, 2018). Again, this differs from the deductive approach aligned with positivism, which entails starting from a theory, deriving hypotheses from it, testing those hypotheses, and then revising the theory accordingly (McEwen, 2018).

5.1.5 Ontology

Ontology concerns the nature of things that exist (Williams, 2016). It looks at ‘how things really are and how things really work’ (Guba & Lincoln, 1994). The underlying ontological perspective of this study is based on constructivism and interpretivism. Constructivism concerns the constructions of reality and knowledge and contrasts with positivism, which believes there is one reality to be discovered. Constructivism looks at what brings knowledge into being and describes human subjects engaging with objects in the world and making sense of this (Crotty, 1998).

5.1.6 Axiology

Axiology is the study of judgments about value; acknowledging personal values during each stage of the research process is essential for adding to the credibility of the research (Saunders et al., 2015). The choice of philosophical approach reflects the researcher's values, and understanding the role of values is central to contemporary philosophy (Ward, 2021). This led me to reflect on my values before deciding on

my research design. Hence, hermeneutic phenomenological studies, including this one, are laden with the values and beliefs therefore appealed to me as being value laden enabled me to examine what the participants find meaningful in their experiences.

	Ontology	Epistemology	Axiology	Typical methods
Positivism	One actual reality exists. External Objective	Scientific method Observable and measurable Facts Law like generalisations Numbers	Value free The researcher is detached. Researcher remains objective	Large samples Typically, quantitative
Interpretivism	Complex Rich Socially constructed via culture and language Multiple meanings and realities exist. A flux of processes, experiences and practices.	Focus on narratives, stories, perceptions, and interpretations. New understandings and worldviews as a contribution	Value bound research Researchers are part of what is being researched. Researcher interpretations are critical to the contribution. Researcher is reflexive	Typically, inductive Small samples In-depth investigations Qualitative methods to analyse. The range of data can be interpreted.

Table 5 A comparison of positivism and interpretivism adapted from Saunders et al. (2019) provides a detailed comparison of the two philosophical approaches, highlighting their key differences and implications for research design and outcomes.

5.1.7 Consideration of theoretical perspectives

A range of approaches were considered before determining the best approach to meet the aims of my study. I considered both Grounded Theory and Narrative Inquiry as possibilities and provide a rationale for why these approaches were not best suited to this study's aims. I then provide a rationale for choosing hermeneutic phenomenology.

5.1.8 Grounded Theory

Grounded Theory is an inductive approach that uses symbolic interactionism to generate and advance theories and explain social processes (Charmaz, 2006). Symbolic interactionism allows the researcher to determine what meaning comes from language, clothing, and gestures for groups of people interacting with one another (Cutcliffe, 2000). It uses non-probability sampling, an approach that relies on the researcher’s judgement rather than random selection, therefore, has no limits for the number of participants or interviews; the interviewer stops when nothing new is presented (Cutcliffe, 2000).

I did consider this approach, but due to the requirement of data needing to be saturated, and because I was interested in achieving an in-depth understanding of the lived experience of a few people, it would not meet these criteria; additionally, I was not looking to make a new theory.

5.1.9 Narrative inquiry

Narrative inquiry was also considered as this describes personal stories. Narrative inquiry researchers look to understand, and then present, real-life experiences via the stories of their participants (Clandinin, 2006). It was appealing to see that narrative inquiry can use voices that may otherwise go unheard, plus the required collaboration with the participant was interesting to me, along with the requirement to continually discuss the story with the participant (Wang & Geale, 2015) However I chose phenomenology as it is uniquely positioned to look at the lived experiences of people (Neubauer et al., 2019). Moreover, it aims to understand and create knowledge (Koch, 1999).

5.2 Justification for using hermeneutic phenomenology.

These explorations of alternative methodologies, neither Grounded Theory nor Narrative Inquiry offer the approach to exploring the lived experience that would meet the aim of this study. Hence, I identified the phenomenological approach as the best design for this study for two reasons. First, it meets the aims of the study. The principal value in using phenomenology is that it is a human science that uncovers a person's thoughts, feelings and perceptions and provides an account of an experience from the perspective of 'being-in-the-world' (Heidegger,1962) to unveil the lived experience (Whitehead et al., 2016). Phenomenology reveals the experience and focuses on the experience as ‘lived’: it focuses on subjective experience and attempts to illuminate the meaning of the world as experienced by the person (van Manen, 1990).

Second, mental health nurses have been found to gravitate to more qualitative methods (Cutcliffe & Goward, 2000): phenomenology seeks to understand others' experiences and is ideally suited to nursing research (Cohen et al., 2000). It has been used across several disciplines in healthcare research and has provided rich insights from patients who have in turn helped to improve care (Thomson, Dykes & Downe, 2011) Although this project is not specific to nursing, I am a mental health nurse, so I have been drawn towards this methodology. Moreover, as mental health nursing itself seeks to understand a person's lived experience so has influenced the way I think and understand (Dibley et al., 2020). It also offers a lens to encourage researchers to look beyond the ‘taken for granted’ assumptions and acknowledge how their own view of the world can impact the research process. Phenomenology also aligns with my values, epistemological and ontological positioning, as described earlier in the chapter.

5.2.1 Hermeneutic phenomenology

Understanding the philosophy of research adds further dimension; therefore, I sought to understand how phenomenology had developed over the years and what philosophers have influenced van Manen (1990) to develop his reflective interpretive approach (including Husserl, Heidegger, Gadamer and Merleau-Ponty). Van Manen & Van Manen, (2021) highlight that Husserl, Heidegger, and Merleau-Ponty are the best-known phenomenologists and that their original writings and offer fundamental insights into the philosophy of phenomenology.

5.2.2 Edmund Husserl (1859-1938)

Edmund Husserl has been described as the father of phenomenology (Zahavi, 2018). He developed his work as a philosopher in Germany before the First World War. Husserl defined phenomenology as the essence of pure experiences and postulated that phenomenology wants to establish itself rather than concern itself with fact or reality like psychology does (van Manen, 2014). He wanted to develop a rigorous human science to investigate how knowledge comes into being. Husserl's aim of phenomenology was a rigorous and unbiased study of things as they appear to human consciousness to arrive at an essential understanding (Valle et al., 1989). Husserl's phrase "Zu den Sachen" means both "to the things themselves" and "let's get down to what matters!" (van Manen, 1990, p. 184). It signifies Husserl's focus on the essence of things, to understand them as they are, without any preconceived notions or biases.

Husserl introduced the concept of the 'lifeworld' (Lebenswelt) in 1970, a fundamental aspect of phenomenology. As Laverty (2003) points out, it represents the world of lived experience, which is experienced before it is analysed and conceptualised.

Husserl's approach prompts us to question everything we know about a phenomenon. He introduced a method called 'epoche' (Moustakas, 1994), which posits that intentionality is the fundamental property of consciousness. By suspending our judgements through epoche, we can study the phenomena in its purest form (Peoples, 2021). Epoche, a Greek word meaning to refrain from judgement or avoid the everyday, commonplace way of perceiving things

(Moustakas, 1994). It is a key epistemological feature of Husserl's descriptive phenomenology, in the natural attitude, individuals hold judgemental perspectives of what they encounter and experience, but the epoch requires a fresh way of looking at things (Moustakas, 1994). Epoche involves individuals' bracketing' or setting aside their preconceived knowledge and assumptions to intentionally describe objects, events, or experiences as they appear in their consciousness. The intention being that truth can be found by bracketing subjective variations to reveal its fundamental essence (Chesterton & Jack, 2021). This process, known as phenomenological reduction, was proposed by Husserl, rejected by Heidegger, and reinvented by Merleau–Ponty (Moran, 2000).

5.2.3 Martin Heidegger (1889-1976)

Phenomenology was further developed by one of Husserl's students, Martin Heidegger. Heidegger is considered one of the most gifted and recognised philosophers of the 20th century, as he profoundly impacted the field of phenomenology with his unique contributions (van Manen, 2014).

Heidegger's views on lived experience mark a departure from Husserl's approach. He advocates using hermeneutics as a research method, believing in the ontological view that lived experience is an interpretive process. This novel approach to understanding lived experience is a key aspect of Heidegger's work (Racher & Robinson, 2003). Heidegger's rethinking of the foundations of science, arguing that science occurs in structures that have already been worked out by fact and experience, is also a significant contribution (Chang &

Horrocks, 2008). Heidegger emphasised that all knowledge is interpretation and that we are not stand-alone objects (Chesterton & Jack, 2021; Heidegger, 1962).

Heidegger did not believe that one could bracket their own experiences from interpretation, as we are always in the world with objects and others (Peoples, 2021: Heidegger 1962). In contrast to Husserl's requirement of bracketing our pre-understandings of phenomena, Heidegger believed that understanding is always there and, therefore, cannot be disconnected from one's thinking (Smythe et al., 2008). Preunderstanding is essential to grasp the meaning of our ilfeworld (Benner, 1994). Pre-understandings guide questioning, understanding and responding (Gadamer, 1976). To appreciate being-in-the-world, it is necessary to understand Heidegger's interpretation of Dasein, emphasising its importance (Crowther & Thomson, 2022).

Heidegger proclaimed that before we understand anything, we, as human beings, must understand what it is to ‘be’ (Chesterton & Jack, 2021), so using the adopted word ' Dasein'. Heidegger used the term ‘Dasein’ to refer to us as human beings, and in its literal translation means ‘being here’. Heidegger explains that we all exist in a world that we are intrinsically connected to. This fundamental interdependence is also known as ‘being-in-the-world’ (Heidegger, 1962). Being-in-the-world acknowledges that we all have pre-understanding of our social situations and, we cannot separate ourselves from this understanding (Heidegger 1962). Dasein interprets and understands via its fore-structures as part of the hermeneutic circle (Cucen, 2017) – discussed in more depth below.

5.2.4 Hans Georg Gadamer (1900-2002)

Gadamer, a student of Heidegger, made a unique contribution to hermeneutic phenomenology with his practical approach, as outlined in 'Truth and Method' (Gadamer, 1975). Gadamer's philosophical hermeneutics, rooted in Heidegger's ontological structure of understanding, posits that hermeneutic (i.e. interpretation) arises from text and human interaction with the world (Austgard, 2012). Understanding is not a passive act but is actively derived from personal involvement. This involvement initiates a reciprocal process of interpretation that is inextricably related with one's being-in-the-world (Spence, 2017). Gadamer's work extended Heidegger's thoughts to transform the hermeneutic process into a dialogical method, bringing together the interpreter's horizon and what is being studied.

5.2.5 The hermeneutic circle

The hermeneutic circle, first developed by Heidegger (Heidegger, 1962), is a cyclical movement of interpretation and reinterpretation to develop new understandings (Chesterton & Jack, 2021). It is also a metaphor for the cyclical movement of interpretation and reinterpretation between the whole and the parts (Chesterton & Jack, 2021). Within the hermeneutic circle, Dasein interprets and understands something in terms of its fore structures - no interpretation is pre-suppositionless. In van Manens interpretive structure (that is explored more in depth in section 6.11), 'balancing

the research context by considering parts and whole' (van Manen p.30 1990). This process is used to achieve understanding; narratives are simultaneously viewed between the parts and the text as a whole. The circular aspect is generated when further narratives are made and become 'parts' themselves. Therefore when the researcher enters the hermeneutic circle, they are required to revisit all the texts' parts, to compare meaning in a none linear way (Crist & Tanner, 2003). As meaning emerges, the circle continues whereby new meanings are generated and challenged.

5.2.6 Maurice Merleau-Ponty (1908-1961)

Merleau-Ponty, a significant figure who also influenced van Manen's approach, built on Husserl and Heidegger's work and was interested in perception. His seminal text, 'Phenomenology of Perception' (Merleau-Ponty, 1962), is a cornerstone of phenomenology. It aims to fundamentally reshape our understanding of experiences, preventing us from relying solely on reflective experience (Moran, 2000). His work is transformative, offering a new perspective on the world. Merleau-Ponty's interest in 'lifeworlds' was theoretical and had practical implications. He believed that 'lifeworlds' were the contexts in which we experience the world, and the four existentials; lived space (spatiality), lived body (corporeality), lived time (temporality), and lived relation (relationality)-were fundamental to their structure. These concepts are theoretical and practical tools for writing, reading, and questioning in a phenomenological manner (van Manen, 1990). van Manen (1990) refers to these lifeworlds as

existentials and advises that they help guide reflection in the research process. This connection between lifeworlds and the four existentials will now be further explored.

3.2.7 The Dutch school

The Dutch School significantly contributed to the international phenomenological movement (Levering & van Manen, 2002). This 'school' was developed post-World War II and led by the chair of psychiatry, Henricus Rimke, at the University of Utrecht. The Dutch School included scholars from various disciplines, including psychology, education, sociology, criminology, and law (Levering & van Manen, 2002). Rather than viewing phenomenology purely as a philosophy, these academics were interested in it as a reflective and practical method applicable within their respective fields (van Manen, 2007). Prominent scholars from the Utrecht School have published extensive literature on phenomenology, which continues to serve as a helpful resource for phenomenologists. The work of the authors who formed part of this school is unique as it demonstrates the practice of doing phenomenological research to better understand the aspects of professional life (Van Manen & Van Manen, 2021). Today, the Dutch School is seen as a collective of thoughts and ideas stemming from its founders. The most influential figure in refining phenomenological methods based on understanding the experiences of everyday life is Professor Max van Manen.

5.2.8 Max van Manen (1942- present day)

van Manen's hermeneutic phenomenology blends Husserlian and Heideggerian underpinnings and the four lifeworld existentials developed by Merleau-Ponty (1962) to provide salient guidelines for researchers new to interpretive phenomenology (Benner, 1994).

van Manen's approach is designed to interpret the lived experiences of particular life events, situating these experiences in a fundamental self-world perspective where factors such as emotions, social, historical and cultural elements are in play, and providing a flexible framework to aid interpretation (van Manen, 1990). van Manen emphasised the value of the four lifeworld existentials to explore a lived experience. These lenses are described as four fundamental structures that make up our lifeworld. van Manen (1990, p.101) describes them as 'helpful guides for reflection in the research process'. They encompass how we experience the lived body (corporeality), lived time (temporality), lived space(spatiality) and lived relationships (relationality). van Manen (1990, p.102) adds, 'Spatiality, corporeality, temporality and relationality are productive categories for the process of phenomenological question posing, reflecting and writing'.

Using van Manen's (1990) reflective approach also offers different lenses to aid with interpretation; these lenses can help illuminate the essence of what is being said. van Manen considers that a phenomenological question can arise during an experience that prompts us to pause, reflect, and bring a sense of 'wonder'. For instance, a simple experience like watching a sunset can prompt a

phenomenological question about the nature of beauty and our perception of it (van Manen, 2014). van Manen's exploration of the phenomenological attitude and his proposal of hermeneutic reduction are enlightening. He advises us to reflect on our pre-understandings, frameworks, and biases and practice 'radical openness' to the phenomena. This is achieved reflexively by turning to our preunderstandings (van Manen, 2011). Embracing the phenomenological attitude makes us wonder what matters most (Crowther & Thomson, 2022). How I used this approach for my study is explored in the next chapter.

5.3 Conclusion

This chapter has provided an exploration of the theoretical underpinnings of this project. It has given the context and rationale of other methodologies and provides a rationale for adopting a hermeneutic phenomenological approach to meet the aims of this study. The research design is informed by the work of Crotty (1998) and Saunders et al. (2015) to ensure a thorough and rigorous research methodology. An exploration of the history and development of phenomenology has been presented too. In the following chapter I present the applied methods.

Chapter 6 | Applied methods

The previous chapter presented the theoretical underpinning of the chosen methodology. It explored the historical context and evolution of phenomenology and provided my justification on why van Manen's hermeneutic phenomenology was the most appropriate methodology to answer my research question.

6.0 Introduction

This chapter illustrates the process I followed in conducting the study. Each step taken and the decisions I made throughout this process are articulated and justified. Obtaining ethical approval, data collection, interpretation of the data using van Manen's approach, and how I used thematic analysis is also presented.

6.1 Ethical approval

Robson & Robson (2015) stress the importance of giving serious thought to the ethical aspects of what is being proposed early in the process, and state that ethics is a process and not a stand-alone one-time pursuit. The importance and impact of ethical principles are held in high regard (Page, 2012). Therefore, before even starting my study, I considered ethical issues. My research question looked at the lived experience of students seeking support for a mental health issue, so given the sensitivity of the issue and potential vulnerability of the participants, University ethical approval was required. Thomas (2023) emphasises the importance of being ethical in research extends to the conduct of the work, rather than just a process to gain initial approval.

This chapter discusses my ethical decision making throughout the whole process to align to this.

On completing an ethics application that answered concerns about participant safety, data handling, informed consent, and anonymity The university ethics committee granted ethical approval . A copy of my ethical approval letter can be found in appendix 1. The four principles of autonomy, non-maleficence, beneficence and justice, as crafted by (Beauchamp, 2006; Beauchamp & Childress, 2001), have been influential in medical ethics (Page, 2012). The guidelines for ethics can be vague, allowing the researcher to interpret them to fit their research needs and prompting them to take a situational relativist approach (Robson & Robson, 2015). Moule et al. (2017) claim that the first ethical question to be asked is whether the research is worth doing. My literature review clearly shows a gap in this area, therefore, aiding my decision to conduct this project and believing it is worth doing. The following paragraphs explore the ethical considerations I considered before embarking on this study.

6.2 Participant safety

Risk can be described as potential dangers (Arnoldi, 2009). While collecting data, psychological harm is possible due to the emotional experience of sharing information with researchers (Anderson & Corneli, 2018). This was an ethical concern for my study, as interviewing people about their mental health problems could evoke an emotional response. Participants were excluded from the study if

they were hospitalised or deemed high risk to themselves or others, on the university's wellbeing risk rating system. A high risk categorised as ‘red’ would indicate that a student would need higher level intervention from outside of the university: therefore, not well enough to participate in a research project. The level of risk formed part of my exclusion criteria for participants.

The ethics committee needed to see that no intended harm would come to the students if they participated in the study. Having a student hospitalised with their mental health or deemed high (red) risk would compromise this, so developing this as an exclusion to participation reduced this possibility. Furthermore, to ensure students could access all the student support and wellbeing services, should they become distressed or unwell while participating in the study, they needed to be actively enrolled at the university. The ethics committee were interested to know how I would manage the potential issue of a student becoming unwell or being unwell at the time of consenting to participate. I made it clear to the participants that my role was a researcher, but that I am also a registered mental health nurse who was active in clinical practice and could be sensitive to their needs. I also clarified that the student wellbeing team could support them if necessary. An informal distress protocol was established which included actions such as signposting to support networks, to inform the wellbeing team of any risk-related incidents or call for an ambulance.

The participant information sheet provided my university-based contact details and those of my director of studies and second

supervisor, as well as the ethics office should the participants want to speak about or express any concern about the study.

Interviews were conducted in the counselling rooms within the wellbeing building, or in a pre-bookable library room. Both venues were private enough to maintain confidentiality, but also visible enough to be easily located. This helped navigate participants to the venue to avoid them struggling to find or becoming worried about finding unfamiliar places. Students' awareness of familiar UCLan buildings enabled a sense of safety to be established. This also allowed the students to be reassured that all health and safety regulations from the university would apply to these buildings. To add to the predictability and sense of safety and security, I made the room bookings before the interview and confirmed these individually via university emails.

6.3 Informed consent

Informed consent is the pinnacle of ethical research (Hardicre, 2014) and required for ethical research. Agreeing to participate in a research study is based on easy access to information about participation (Parahoo, 2014). I followed these principles, by creating a simple yet informative study information poster. The poster had a brief overview of my study, and who the intended participants were (appendix 7). It included my work contact details for further information and expressions of participation. The poster advertising the study was placed in communal areas and bathrooms across the university campus. I included multiple tear-off strips that provided my contact details for easy access.

Once a potential participant expressed interest in participating, I emailed them a copy of the participant information sheet (PIS) see appendix 2. This email also offered the opportunity to ask questions and be assured that it was completely up to them as to whether they took part or not. I prompted the participants to read the PIS before consenting to the study and offered further time to answer any questions. Once the students had made an informed choice to participate in the study they emailed me to confirm and subsequently an interview time and location were scheduled at a mutually convenient time.

Informed consent protects autonomy and allows a person to know what can and cannot happen to them when participating in research (Anderson & Corneli, 2018). Therefore, participants were greeted during the interview and welcomed into the private pre-booked room. At this point, a hard copy of the PIS was given to the participant, along with the participant demographic sheet and consent form (appendix 6). Time was given for the participants to read and sign the consent form, before the interview started. This also allowed further time for them to decide if they did not want to participate also. I ensured the participant was happy to proceed before any interviews were commenced and recorded. All consent forms and participant demographics were filed onto the university's secure cloud account, and the original hard copies were disposed of in the university's confidential waste service. Anonymised demographics were collected and can be found in chapter 7, appendix 4 identifies what demographic data I asked participants for.

6.4 Researcher safety

Risk in research was historically only a concern for participants, and particularly in psychology and health research where it was necessary to have codes of practice (Dickson-Swift et al., 2008) Whilst it is essential to protect patients from harm, there is a growing awareness of the potential harm to researchers also. They include psychological harm, accusations of misconduct and physical threats. Therefore, to help reduce these risks, all communication with participants was conducted via my university student email address, including an email signature clearly stating who I was. Furthermore, interviews were conducted at either the university's main campus or their satellite campus, within the core working hours of 9-5, should I require additional support or assistance. This also allowed for the health and safety requirements of the university to be used.

From my own wellbeing perspective, I had access to my supervisors, who were available to support me should I need it. I was also aware of additional sources of support should I become distressed. I did not require any debriefing or support, but I explored the possibility before embarking on any interviews to ensure my safety. I also used my reflexive diary to help me process and reflect on the experiences I had heard (see section 14).

6.5 Power balance

Power balance was another ethical issue I considered. Anderson & Cornelia (2018) claim that exploitation is possible

whenever a researcher has a relationship in a hierarchical organisation; for me, this was being part of the wellbeing service, as I was employed as a mental health advisor for the first 18 months of the study.

I considered how I would manage this given the sensitivity of mental health conversations, and I made the decision not to have any participant who had ever been on my caseload participate in the study. No one from my caseload contacted me to participate, but being ready to have a conversation with anyone who may have been interested, prepared me to handle this with care and consideration. Furthermore, I ensured the participants knew I was employed in the wellbeing team before conducting any participant interviews. As I left this post during the interview phase, I made the later participants aware; I once worked for the service but was no longer associated with it, just for transparency.

6.6 Inclusion and exclusion

Inclusion and exclusion criteria for participating in the study were established to capture what was being investigated and to adhere to ethical approvals. The table below details the inclusion and exclusion criteria.

Inclusion criteria:	Exclusion criteria:
Current student Have experience with a mental health problem, either diagnosed or not. Have accessed the student wellbeing service at UCLan.	On interruption of studies Have left the university Currently in crisis or categorised as a red on the wellbeing 'RAG' (red, amber, green) risk rating system.

Table 6 Participant inclusion and exclusion criteria for eligibility to participate in the study.

6.7 Recruitment

In contrast to quantitative research, the sample size had no required number; ultimately, the sample size was based on gaining sufficient information (Moule et al., 2017). As I investigated the lived experience, which was unique to each participant, I was not pressured to get a fixed number of participants. Purposive sampling was used as the sample can be logically assumed to represent the population required (Battaglia, 2008). Specifically for phenomenology, purposive sampling allows access to participants who have the lived experience of accessing the student wellbeing service to be interviewed (Crotty, 1998). Demographic information about the participants was collected. Peoples (2021) advocates collecting this to demonstrate the correct type of participants are being approached. Participant pen portraits are available in chapter 7 (Section 7.2), to illuminate the background of the participants and as a reminder that they are people with lived experience, yet so much more.

Participants were university students who had actively sought out support from the Student Mental Health and Wellbeing service. They were a mix of undergraduate and postgraduate students from diverse backgrounds, both demographically and culturally, as identified in Table 8 in Chapter 7. All participants were recruited from the same HEI.

I approached the participants using posters placed in high-traffic areas, including the library bathrooms and around the student support and wellbeing centre. The posters included a summary of my study, who was eligible to take part, and what participation involved. My contact details were also provided (using tear-off strips at the bottom of the poster) for participants to request further details of the study. This approach was designed to encourage participation by providing individuals with time to consider their involvement and the opportunity to contact me at a later stage. In addition to this, I met with the other wellbeing team members to brief them on my study and to enable them to direct potential participants to me.

Once participants had read the information on the poster, they contacted me by email, and at this point, I provided them with the full participant information sheet, consent form and the opportunity to ask any questions. If there had been no contact after a week to my email, I sent a reminder email. Once they agreed to take part, we organised a mutually convenient time and date for the interview.

At the start of the interview, we reviewed the consent statements, and the participant was ask to sign the form. At this stage I also offered the opportunity for them to ask further questions before

we started the interview. Throughout the process, I made it clear that participation was entirely voluntary and that they could withdraw at any time without affecting any services they received.

During the recruitment phase, I was employed as a mental health advisor within the Mental Health and Wellbeing service. In my welcome email I explained I was a member of staff in the wellbeing team (appendix 5). I also reiterated this at the start of the interview as I was checking consent. The relationship I had as a service provider had both strengths and weaknesses. The strengths included my access to participants. I also had a contextual understanding of the service and relationships with some service users and all the staff members. The fact that I had a background and understanding of student mental health and wellbeing may have made participants feel more comfortable opening up and sharing their insights. My professional knowledge of this service also helped me interpret the participants' responses.

The limitations of my dual role as a clinician and a researcher may have introduced the potential for a power dynamic to occur, potentially influencing participants to respond in ways they thought I wanted to hear. Furthermore, there was a potential risk of role confusion where participants might have expected something more therapeutic than solely engaging in a research project. Hence, I needed to guard against heightened bias and ethical concerns. To overcome these issues, I set explicit inclusion and exclusion criteria. First, all participants who were interested in participating in the study had to be actively enrolled students, as this meant that they

could have full access to all university services. Students who were on an interruption of their studies1 or had left the university were ineligible. As I was actively working in the service at the time of recruitment, one of my exclusion criteria was to not interview anyone I had supported. Thankfully no one on my current or historical caseload wanted to participate, so this risk was alleviated. I also reiterated that they were free to raise any issues, and that all information would be strictly confidential, unless there were any safeguarding concerns. I kept a reflexive journal throughout the whole process. After conducting the first few interviews I left working at UClan and was employed elsewhere. In the interviews I conducted after leaving UCLan I informed participants that I had recently left working in the wellbeing team.

6.8 Data collection: Interviews

Interviews were chosen as the data collection method because they fit the study's epistemological stance, aims, and objectives and would yield the best available data. van Manen (2014) also asserts that the type of interview should be determined by the question, that prompted the need for the interview in the first place. Additionally, qualitative research interviews should explore the insider perspective, to capture the words of the participants (Holloway, 2005). As Alvesson (2023) explains, a semi-structured interview in qualitative research, with a low level of structure enables new and unexpected views to be explored. Furthermore, people's experiences cannot be investigated via quantitative methods, due to the subjective nature of lived experience.

Finlay (2011) postulates that participants need to feel involved, and this is achieved by building a relationship with them to gain their trust. This is also why I offered time with the participants at the start of the interview to re-visit the PIS, rather than rushing straight into the interview. I was grateful for the participants wanting to be involved in my study and being open to sharing their experiences. Therefore, I felt it important to use their time effectively rather than just having a set of questions to ask and rushing them for answers. I did not prompt anyone to speed up during the interviews or use unnecessary questions to try and extend an interview.

6.9 Data handling

Audio recordings were captured on a Dictaphone and started at the commencement of the interview. Following the interview, all data were downloaded to a secure UCLan-approved, password-protected networked account. This required two passwords before access could be gained. Audio recordings from the interviews were saved and given a pseudonym simultaneously. All identifiable data was made anonymous on the first upload to the password-protected network account. Robson and Robson (2015) confirm that giving participants anonymity when reporting on research is the norm. Therefore, I followed this ethical guidance. As the researcher, only my supervisors and I had access to and listened to the recordings. All other identifiable information was anonymised during the transcription process. The paper consent forms were also scanned and stored on UCLan's

secure network account, and the original paper copies were destroyed using the university's confidential waste system.

6.10 van Manen's six research activities

As mentioned in the previous chapter (chapter 5), Max van Manen developed six methodological steps for hermeneutic phenomenological research (Guimond-Plourde, 2009) drawing on the works of established phenomenologists such as Husserl, Heidegger, Gadamer and Merleau-Ponty and working with others at the University of Utrecht, notably Bas Levering (see section 3.2.7).

The emphasis is on the person who experiences a phenomenon, their lifeworld. This framework or 'six research activities' offers the opportunity to look more closely at the existential dimensions of the lived experience (Guimond-Plourde, 2009). van Manen (1990) clarifies that although this presentation appears to be a step-by-step approach, the order is not implied, it is more of an organisational method that highlights separate points, that allow the research process to work intermittently or simultaneously.

6.11 van Manen (1990, p. 30) recommends six research activities:

- 'Turning a phenomenon which seriously interests us and commits us to the world'.
- 'Investigating experience as we live it rather than conceptualise it'
- 'Reflecting on the essential themes which characterise the phenomena.'
- 'Describing the phenomena through the art of writing and re-writing '

- ‘Maintaining a strong and orientated pedagogical relation to the phenomenon. ‘
- ‘Balancing the research context by considering parts as a whole ‘

6.11.1 Turning a phenomenon which seriously interests us and commits us to the world.

van Manen (1990) advised that phenomenological enquiry is driven by this commitment of turning to an abiding concern. Parahoo, (2014) also adds that a phenomenological question reflects a researcher’s lifelong interest in the phenomenon. In this study, investigating an experience as it is lived by students accessing support for their mental health needs was an interest to me, developed over the years working as a mental health nurse and academic. Lived experiences gather interpretive significance as they are gathered and given memory to them via conversation, daydreaming and other interpretive acts (van Manen, 1990). Therefore, turning to this phenomenon is the start of engaging with step one.

In this first step van Manen describes the importance of developing a question to be investigated then rather than just raising a question we ‘live’ the question and ‘become’ the question (van Manen 1990, pp39). He goes on to explain that the problem with phenomenology is not always knowing too little. As influenced by Heidegger and his belief that understanding is always there (Smythe et al., 2008), van Manen rejects Husserl’s use of ‘bracketing’ as Husserl suggests taking hold of the phenomenon and placing it outside of one’s own knowledge (Husserl, 1970). van Manen suggests it is

‘better to make explicit our understandings, beliefs, biases, assumptions, presuppositions and theories’ (van Manen 1990, p. 47).

How I applied this to my study

In relation to ‘living’ and ‘becoming’ the question, I had an interest in student mental health due to my background working as a mental health nurse and as an academic teaching mental health. In addition to this, working in a university wellbeing department ignited my passion of working with students and their mental health as previously mentioned in section 1.4.

With such a large portion of my life involved me being immersed in mental health and university students it would be difficult for me to unlearn everything I know about students and mental health. Similarly, as Heidegger and van Manen, Gadamer (1975) argues bracketing is almost unachievable, but a happy medium can be achieved by his concept of the ‘fusion of horizons’ as this recognises integrating our backgrounds with that of what we are trying to interpret this becomes a process between the person interpreting and the text therefore is shaped by both perspectives.

Considering this I engaged in a reflective activity due to the number of assumptions I had made given my background and early information gathering I had conducted to apply for this course of study. This activity allowed me to highlight my preconceived ideas about this topic. The purpose of this was to draw forth my own stories so I became more mindful of the assumptions and prejudices I carry as

advocated by Smythe (2011). This continued throughout the research journey and became a reflexive journal.

6.11.2 Investigating experience as we live it rather than conceptualise it

As explained by Merleau-Ponty, turning to a phenomenon means re-learning by re-awakening the fundamental experiences of the world (Merleau-Ponty, 1962); this makes us turn to the 'things' themselves. Van Manan explains in phenomenological research the emphasis is always about the meaning of a lived experience, the whole point is to borrow other people's reflections on their experiences to allow us to develop a better understanding and deeper meaning of this human experience (van Manen, 1990). To achieve this conducting a phenomenological interview will help keep the researcher orientated to the task of questioning what is the nature of the phenomena.

How I applied this to my study

This step was achieved by conducting interviews with the participants and collecting data from what they voiced. This study used semi-structured interviews to find the balance between flexibility and structure, allowing it to focus on ontological concerns (Walker, 2011). Semi-structured interviews also assist the researcher in obtaining the required information, giving the participants the freedom to talk at their own pace (Morse & Field, 1998). I created an interview structure to use as a crib sheet as Smythe (2011) recommend crafting questions

to allow participants to recount their experiences as close to the experience as possible. Knowing what my learning style and learning needs are, having this crib sheet as a prompt allowed me to stay on track and focussed on the phenomena during the interviews.

The types of questions I asked during the interview included.

- What is your experience of using our wellbeing services here?
- Do you feel having a mental health difficulty has impacted your experience at university?
- Were there any challenges that you would like to tell me about?
- Were there any effects outside of uni that the service was able to help you with impact your life both personally and academically?
- Was there anything particularly helpful about the support you received from the wellbeing service?
- And anything that was unhelpful?
- Would you like to make any suggestions about how we could do things differently to support people with a MH problem whilst studying at Uni?

In keeping with phenomenological methods, my crib sheet was used as a guide rather than a script and allowed me to ask questions to allow the participant to speak about their experiences. A few additional probing questions were used are available in appendix 3.

6.11.3 Reflecting on the essential themes which characterise the phenomena.

Van Manen states ‘the purpose of phenomenological reflection is to try to grasp the essential meaning of something’ (van Manen 1990, p. 77) Rich et al. (2013) explains that there is often tension in qualitative interviews between staying true to what the participant says about their lived experience and establishing the essential meaning of the lived experience via abstraction. To overcome this challenge, phenomenology adopts the concept of isolating thematic statements, this can be done in three ways, van Manen (1990) articulates these activities as; looking at the looking at the text as a whole and finding what phrases may capture the fundamental meanings. Secondly, in selective reading looking at what statements or phrases a particular revealing about the phenomenon. Then thirdly looking at every single sentence and paragraphs and questioning what this reveals about the phenomena being described.

How I applied this to my study

Phenomenological themes are also described by van Manen as ‘structures of experience’ (van Manen 1990, p. 79) Hence, as Merleau-Ponty (1962) articulates 'putting the essence back into existence’ by using four lifeworld existentials as lenses for interpretation. Therefore, I used the four lifeworld existentials to help interpret my data by looking through the lenses of temporality, corporeality, speciality and relationality, as a basis for interpretation as these are described as belonging to the fundamental structures of lifeworld (Merleau-Ponty, 1962). This allowed me to see, as van Manen (1990 p.90) describes

phenomenological themes are like ‘knots in the webs of our experiences’ by adopting the guidance on how to isolate thematic statements.

Coding was then completed using the Nvivo software platform, and it was here that the essence of the participant's lived experience was visually depicted. One by one, transcripts were read and recording listened to again to explore how the participants lived this experience through their bodies, lived time, space and relationships. Crowther & Thomson (2022) indicate that the data analysis is collected via description and interpretation whilst remaining reflexive, attuned, and open to interpretive leaps.

6.11.4 Describing the phenomena through the art of writing and re-writing.

Van Manen articulates the importance of phenomenological writing requires the ability of being sensitive to the subtle undertones of language (van Manen 1990, p. 111). He adds that ‘phenomenological texts succeeds when it lets us see that which shines through, that which tends to hide itself’ (p. 130). This therefore allows the researcher to step back and apply thought to their writing.

How I applied this to my study

Being wholly immersed in the data allows for re-writing and re-writing to be explored and performed. I conducted several pilot interviews and on re-listening to them, I noticed I had conducted mental health interviews rather than focussing on the lived experience.

This allowed me to fine tune my interview style, to ensure I was capturing the lived experience.

Once all 19 interviews had been transcribed, I listened to the recordings to re-live, re-hear and re-write what had occurred, to capture the essence of each interview. This allowed me to take that step back and provide space between what I heard in the interview, what I then transcribed and what I was now listening back to. This allowed me to go from transcript to transcript, back and forth, rereading and rewriting whilst reviewing the themes both individually and contextually as a whole. Engaging in the act of reading and writing that insights emerge is claimed by van Manen (1990) and is how I felt I found my codes and themes from the data that I had collected.

6.11.5 Maintaining a strong and orientated pedagogical relation to the phenomenon.

Hermeneutic phenomenology is a more reflexive and critical philosophy, that moves beyond descriptions and experience to uncover meaning (Crowther & Thomson, 2020). Van Manen (1990) explains that phenomenological research is demanding for the researcher and unless they remain strong in their orientation to the research question. It is not surprising that attention can drift or interests to be side tracked. Therefore, van Manen advises that to be ‘orientated to an object means that we are animated by the object in a full and human sense’ (van Manen, 1990 p. 33).

How I applied this to my study

To uncover the meaning and stay close to the research question I engaged with the ‘hermeneutic circle’ as further explored in chapter 5 (section 5.2.5). Data analysis does not align with phenomenological enquiry (Peoples, 2021). However, in the hermeneutic circle, the 'parts' are undividable. Using the hermeneutic circle requires reading, reflective writing, and interpretation (Laverty, 2003). Due to utilising a phenomenological approach within this study, I was drawn to the concept of the hermeneutic circle (Heidegger, 1978), because of the deep level of context that is created by its use, and the concept of how I influence and how I interpret other 'parts'. The hermeneutic circle indicates that a greater context influences how we understand a phenomenon, and how our views and opinions change the more we reveal from others (Zimmermann, 2015). When a researcher 'enters' the hermeneutic circle, they are prompted to revisit and re-evaluate to interpret meaning in a continuous and non-linear fashion (Crist & Tanner, 2003).

In line with Heidegger’s philosophy (see section 5.2.3), I applied the hermeneutic circle to my study by examining the parts to understand the whole. For Heidegger, the hermeneutic circle emphasises the complex interplay between parts and the whole within the process of understanding (Heidegger,1962). Using the hermeneutic circle, acknowledged that any interpretation was only possible within the context of my pre-understandings. My interpretations of the findings initially began during the interviews; as I sat back and listened to the participants, I reflected on the overarching meanings – with these thoughts later recorded in my reflexive diary.

This process continued throughout all the interviews, from re-listening to the recordings and transcribing them to analyse the data. It was an ongoing process of examining the "parts" as I carefully considered the tone of voice, body language, and the content of what was said, taking the time to listen, read and reread multiple times. This practice allowed me to engage deeply in the hermeneutic circle.

During this process, the "whole" began to emerge by considering all the parts collectively. This approach illuminated the inherent meanings evident within the stories and helped me to craft a structure reflecting the students' pre-encounter, encounter, and post-encounter experiences. Through this iterative cycle, I developed new insights and a deeper understanding of the lived experiences of students facing mental health problems and seeking support at university. Reflexivity, openness, and depth facilitated this thoughtful engagement with the data. My interpretations evolved, shifting my initial assumptions and leading to new meanings, thus revealing the existential dimensions of interpretation and the importance of context in shaping meaning.

This embodies reflexivity, as it requires the researcher to engage with reflexive engagement to seek out what it means to be human (Crowther & Thomson, 2020), therefore keeping us close to the phenomena. This was used in the data collection, transcription and data analysis stages of this project. As noted by Gadamer (1975) it is not just the text that helps find new meaning, the spoken word also presents a role in interpretation, therefore me listening and re-listening to the recorded interviews helped me stay close to the phenomena

and as van Manen (1990) advocates ‘balancing the research context by considering parts and whole’.

6.11.6 Balancing the research context by considering parts as a whole

Van Manen explains that there is a danger of losing sight of the end of phenomenological research; he describes this as getting so involved in chasing the ‘What is it?’ (Ti estin) (van Manen 1990, p. 33) that the revealing power is lost. This means the study design needs to be measured against the parts and to periodically step back and look at the total, to see how all of the parts contribute to the whole (van Manen 1990, p. 33). Although van Manen proposes these six reflective activities to help conduct research as different steps, he does highlight that despite each activity being presented this way, it would be artificial and awkward to use them as individual steps. He, therefore, acknowledges that these being used in the research process would work simultaneously.

How I applied this to my study

As van Manen suggests, using this six-step approach as a recipe for conducting a phenomenological research project would be artificial and awkward. At first, I thought this would be a nice method to follow, but as each step is explored, it becomes clear that there is so much that cannot be separated and other aspects last from the start of the project and throughout, staying orientated to the phenomena being the prime example of this.

Van Manen (1990) then goes on to highlight to the structure of a research study, He advises that not having a clear blueprint can be frustrating, so to get out of this predicament, he suggests to ‘try to keep the evolving part-whole relation of one’s study in mind’(p. 167). He suggests comparing this approach of using wide brushstrokes to the overall sense of the project as a ‘painter preparing a canvas for the imagery it is to serve’ (p. 167). In light of this freedom to ‘work the text’ I organised my writing by using Merleau-Pontys (1962) four lifeworld existentials.

6.12 The Four Lifeworld existentials

As van Manen (1990) states, lived experiences can be studied using existentials as themes that are part of the fundamental structure of our lifeworld; these include spatiality, corporeality, temporality and relationality (Merleau-Ponty, 1962). These existentials form an intricate unity that makes up lifeworld we can study each existential in four separate aspects, whilst also appreciating that these four existentials cannot be separated. Reflecting on the existentials can provider a richer understanding of the experience and as mentioned briefly above. The thematic statements that show themselves in the data ‘Metaphorically speaking they are more like knots in the webs of our experiences around which certain lived experiences are spun and thus lived through as meaningful wholes, themes are the stars that make up the universes of meaning we live through’ (van Manen, 1990, p. 90). Therefore, I adopted this approach with my data to help illuminate the rich understanding required.

van Manen (1990) states, ‘phenomenological human science research efforts are really explorations into the structure of the human lifeworld, the lived world as experienced in everyday situations and relations’ (van Manen 1990, p. 101). As mentioned in chapter 5 (5.2.6), van Manen was influenced by Merleau-Ponty's existential themes as guides for reflection. He identifies four existentials that are particularly helpful as guides for reflection in the research process. These existentials are central to understanding human experience from a phenomenological perspective and are intertwined with perception (Talero, 2005). Therefore, I used them to aid my interpretation of the interview data.

How I applied this to my study

I used a Merleau Ponty's four lifeworld existentials as a framework to aid my interpretations. Van Manen (1999) states that all phenomenological research explores the structure of the human' life world' and as recurring issues concerning time, space, relationships and bodily perceptions were recurring in the dataset, it felt relevant to use these four-life world existentials to underpin the final interpretations. This approach prompted me to consider and read around the various existential pillars. By doing so, I could explore and unveil the meaning of the participants’ lived experiences, allowing me to ground the interpretations in fundamental pillars of human existence. This process allowed me to understand the participants’ sense of time, their engagement with their environment and connections with others (from a bodily, emotional and social

perspective) to offer a more holistic and deeper understanding of their experiences.

6.12.1 Spatiality, live space

This concept can be described as ‘felt space.’ As van Manen (1990) points out, while we frequently think about the dimensions of space—length, height, and depth—our experience of space often exists before we can articulate it. Merleau-Ponty examines our interconnectedness, focusing on the lived experience of space rather than the space itself. Spatiality cannot be separated from individuals; we are spatial beings who live and interact within space and are socially connected (van Manen, 1990).

In our daily lives, we encounter what can be termed ‘oriented space’. This means our bodies intuitively understand directions such as up, down, in, and out without requiring conscious evaluation. We engage with the space around us through a living relationship with ‘points of anchorage’ that provide our body's spatiality (Madison, 1992). The 'points of anchorage' are familiar elements that help us orient ourselves in the world and navigate our spatial environment (Berendzen, 2023).

On the other hand, situated space relates to our understanding of space and emphasises embodiment. The participants in this study experience space while seeking help for their mental health needs. The therapeutic landscape represents the situated space and the points of anchorage that form part of the interaction between the student seeking help and the person providing mental health support.

6.12.2 Corporeality lived body.

This is another central concept to Merleau-Ponty's works. He argues that perception is embodied as we perceive the world through our bodily presence (Merleau-Ponty, 1962). As students in this study navigated themselves to get help, their bodies would have reacted and responded to the emotions and physical space they experienced, making their bodies central to their experience. Participants reported feeling a range of joy, relief, and frustration. Embodied experiences impact our emotions and, therefore, shape our experiences. ‘I consider my body, which is my point of view upon the world as one of the objects of that world’ (Merleau-Ponty, 1962, p. 74).

6.12.3 Temporality, live time

This can be described as ‘subjective time’ rather than ‘watching the clock time’. This includes past events that have impacted present experiences and hopes for the future (van Manen, 1990). This indicates that the dimensions of time, the past, present, and the future, will impact our experiences.

A brief interaction in time that has significance can have a lasting effect on a person, and this was a key feature of the participants' experiences in this study. University courses are typically three years in length, and yet some of the participants had significant experiences for their mental health needs during this time. These dimensions of how people relate to time enable a deeper understanding of a person's experience (van Manen, 1990). Again,

this is another reason for using these four lifeworld existentials as a tool to aid interpretation.

6.12.4 Relationality lived relations.

Van Manen (1990) characterises relationality as the 'lived connection we foster with others in the shared interpersonal space.' For the participants in this study, relationality encompasses their peers, tutors, wellbeing staff members, and family. Additionally, it extends to the everyday individuals they encounter, even those they do not know personally but whose paths they may cross.

How I applied this to my study

Smythe (2011) emphasises that at this point of the process, the hermeneutic phenomenological lens needs to explicitly show itself; she adds that a simple thematic analysis is not enough and encourages novice researchers to look at other philosophers who write interpretively. Furthermore, ‘understanding Dasein is fundamental to grasping the nature of such thinking’ (Smythe 2011, p. 44). I listened intently to the participants in their interview, as Merleau-Ponty points out that we continuously make sense of the world. Furthermore, reflexivity was also important to ensure I was taking that step back to dwell and ponder the data. This clearly demonstrates that van Manen’s approach is not sequential.

As the participants started to speak about their experiences during the interviews I used a Dictaphone to record these interactions. This allowed me to sit back and really listen to what the participants were saying and as mentioned above, use my crib sheet to ensure the

interviews were staying close to the research question. The more I listened and the more interviews I conducted it was inevitable that the analysis was already taking place. This was unintentional but by listening relistening and speaking with different participants it was becoming clear what themes were starting to generate. As I had already decided prior to starting the interviews that I would be using Merleau-Ponty's four lifeworld existentials I did find myself thinking about these four existentials and therefore thinking of these in an interpretive way with what I was listening to.

As part of this final stage of van Manen's six reflective activities suggests the organisation of the findings can be presented using the four lifeworld existentials, however there were three major themes that were illuminated as I started to interpret all the interviews. So, although I used the four lifeworld existentials as lenses of interpretation, I structured the findings chapters on the three themes that were reflective of the temporal moments that the participants experienced in getting help for their mental health needs these included pre-encounter, encounter and post-encounter.

6.13 Establishing rigour

Qualitative research always prioritises rigour and truth (Cypress, 2017). It is important that qualitative research is conducted in a rigorous and methodological way to ensure meaningful and useful results (Nowell et al., 2017). Trustworthiness is one way to demonstrate to readers that research findings are worthy of attention (Lincoln & Guba, 1985). Ensuring trustworthiness is critical in establishing the credibility and reliability of qualitative findings, given

their subjective nature (Dodgson, 2019). The concept of trustworthiness in qualitative research compromises of various essential pillars such as credibility, transferability, dependability and conformability (Lincoln & Guba, 1985).

6.14 Credibility

Lincoln and Guba (1985) suggest peer debriefing as one way to demonstrate credibility. The purpose of debriefing can help uncover taken for granted biases and assumptions of the researcher it also offers the opportunity for catharsis for the researcher. I achieved this by attending regular supervision. Following the interviews with the participants I debriefed with my supervisory team and at this point started to explore themes and interpretations. This debrief continued past the interviews interpretation stages and enabled my supervisors to challenge me on each chapter and each decision I made throughout the whole research project.

Lincoln and Guba (1985) also suggest prolonged engagement in the field being researched. Having worked in the wellbeing team, being a mental health nurse for 16 years and an academic for over ten years, I already had prolonged engagement established with this area of interest. I kept myself up to date with what was going on in the field of student mental health to help me gain and maintain a broader understanding.

6.15 Transferability

Transferability refers to the studies ability to be applied in other settings to the point another reader can derive meaning from it and

their own experiences (Lincoln and Guba, 1985). They advocate including ‘Thick descriptions’, this refers to providing detailed accounts of experiences and then puts them into context as a way of achieving external validity as it enables a phenomenon to be described in sufficient detail and provides a sense of how this could be applied in another setting. This was achieved in my study via my interpretations of the data providing additional context to demonstrate transferability to other settings.

6.16 Dependability

Dependability was demonstrated by my constant decision making from the start of this project, all decisions I made had been discussed with the supervisory team and had been noted down and then written up as part of this project. In addition to this, a reflexive exercise was undertaken along with a reflexive diary throughout the research journey. I have kept various drafts of my decisions and changes along with rationales so I can refer back to them to ensure I understand why I made the decisions and to also make sure this project demonstrates dependability.

6.17 Conformability

Lastly conformability this requires the researcher to be explicit in how interpretations have been generated (Lincoln and Guba, 1985). In this study this has been achieved by me presenting large extracts from the interview transcripts to enable other readers to see how I have interpreted the quotes that were transcribed verbatim. Furthermore, me engaging in a reflective activity illuminates my preconceptions and therefore demonstrates the impact this could have on the data.

6.18 Conclusion

This chapter provided a detailed account of the steps and decisions I made throughout the time I conducted this study. I provided insight and explanations of how I used the mainland's six reflective activities along with Merleau-Ponty's full lifeworld existentials used to craft this research project. The next chapter is the start of the findings.

Chapter 7 | Introduction to the findings

7.0 Introduction

The previous chapter provided details of how this study was conducted. Ethical approval, planning and implementation were all presented. It also explored the utility of van Manen's (1990) six-step reflective approach and how this was adopted for my study.

This chapter introduces the findings, revealing the lived experience illuminated in the interviews using van Manen's (1990) reflective approach. I explain how and why I have structured the findings across four chapters. I provide a diagram of the themes that were illuminated across the interviews. I then briefly describe the students' journey in getting support for their mental health issues at university and display this as a Venn diagram (fig 14). Participants' pen portraits are then presented to allow me to describe them individually and their journey of seeking mental health support. The participant's demographics are presented in Table 8, followed by a conclusion.

7.1 Structuring the following four chapters

As mentioned in chapter 2 (Section 5.2.6) Merleau-Ponty's (1962) four lifeworld existentials can be articulated as four distinct concepts yet cannot be experienced separately (van Manen, 1990). I structured the presentation of findings according to three distinct moments in time as they were experienced. This chapter presents an overview of the following three chapters under the themes of pre-encounter, encounter and post-encounter, which turned out to be the

pivotal temporal moments in the student's journey to accessing support. Data organisation must be as close to a participant's lived experience as possible to illuminate their truth and genuineness. The three themes were a key feature of phenomenology, as they resonated with lived time (temporality) and allowed me to reflect on the underpinning philosophy and participants simultaneously. The three periods include the pre-encounter to getting help, the encounter of getting the help, and the post-encounter to what happened following the help received. Merleau-Ponty's (1962) four lifeworld existentials have been used through which to interpret the data via the lenses of lived time (temporality), lived environment (spatiality), lived body (corporeality), and lived relationships (relationality) (van Manen, 1990).

‘Dasein’ as mentioned in chapter five (section 5.2.3), is a key Heideggerian idea (Heidegger, 1962) which directly translates into English as 'there-being,' meaning 'being a human in a situated contextual world" (Dibley et al., 2020, p. 20). Being-in-the-world is echoed here in the structure of these chapters to truly reflect the lived experience. It embraces the hermeneutic circle (see also section 5.2.5) as Ironside (2005) identifies that remaining within the hermeneutic circle throughout the process allows for more dialogue generated from existing knowledge and understanding whilst illuminating freshly revealed data from the research.

Figure 12 illustrates the themes (and sub-themes) developed from the findings and structured using the three temporal moments It illustrates the student's journey from realising help was required to the

aftermath of receiving help. The three-time frames of pre-encounter, encounter, and post-encounter are visible in the diagram. In the circles are the subthemes that I used. Some of the names of the themes are quotations from participant interviews to emphasise their authenticity. The arrows represent that some students returned to the service multiple times and that their experiences were not all uniform and linear. This is presented here in preparation of the following three chapters.

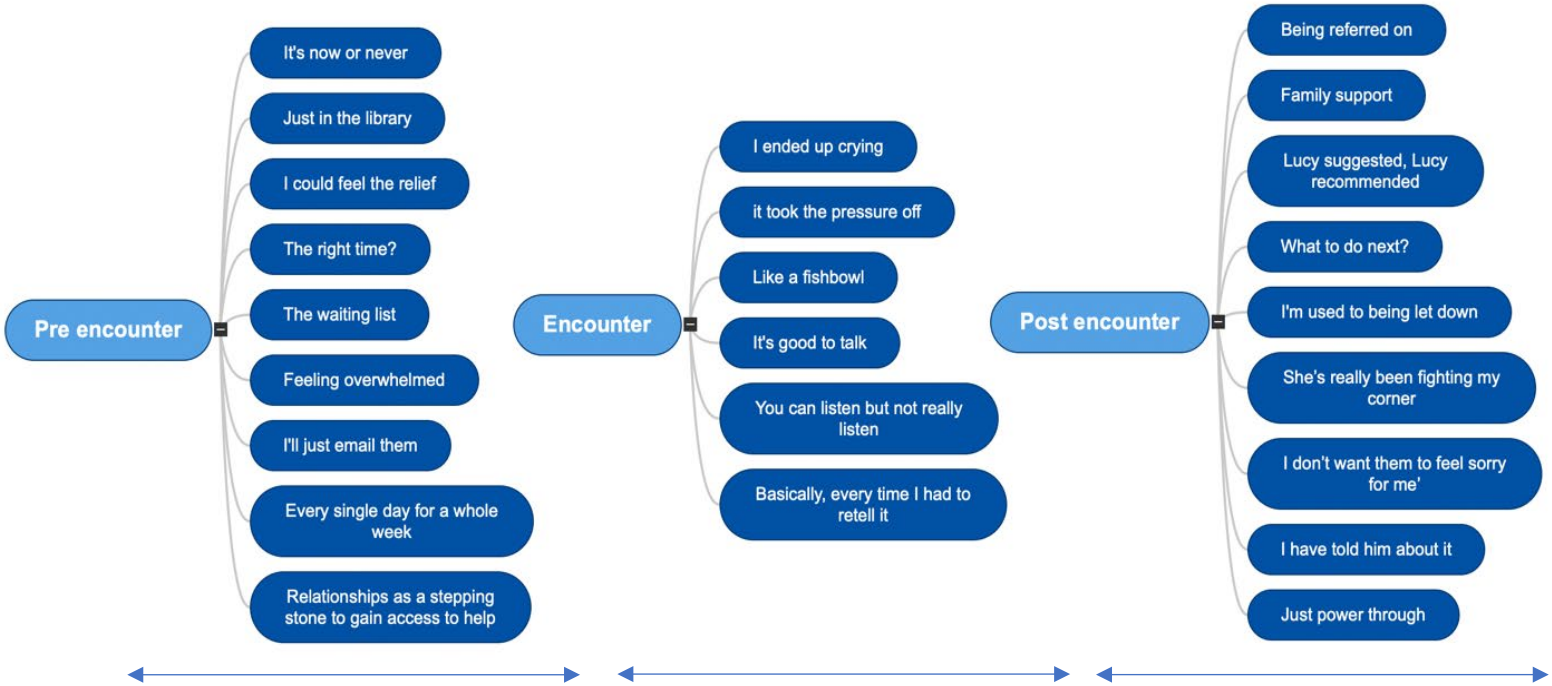

Figure 12 Overview of themes and subthemes

7.2 Participant pen portraits

Here, I present an overview of each participant along with a few brief reflections from conducting the interviews with the participants. All the participants were from the same university and had access to the university's student wellbeing services. Participants were aged between 19 and 50, and their mental health issues span the extent of the mental health spectrum. Some participants had used the service once and had then been signposted. Others used it and attended follow-up sessions with the wellbeing team and/or counsellors (see Table seven participant demographics). Some participants had received help elsewhere and outside of the university.

Thirteen participants engaged in 16 interviews; Jamie, Maggie, and Stella returned for a second interview. Fourteen interviews were used in the study; two were excluded as they did not focus on lived experience. This was due to my interview style, which defaulted to a familiar mental health nurse mode. Therefore, it led me to conduct a mental health interview rather than a research one, which asked them about their lived experience of using the service. I learnt from that and conducted further interviews to capture their existential rather than their mental health history.

The duration of each interview varied from 10-38 minutes, but this did not concern me, as the aim was to allow the participants to share their experiences at their own pace, time, and depth. I also needed to adhere to what I had the ethical approval for and not push participants to give more time or in-depth answers, as their wellbeing

may have been compromised. All participants were aware of the option for a second interview if they liked, and three participants chose to do so.

Participants must be enrolled and actively engaged in a course to access the wellbeing services. This also meant that the service was available to them should they become distressed beyond where I could support them. University regulations stipulated that university-based services would be unavailable if a student left the course or took an interruption of study.

Here I present the participants:

Alan

Alan was an undergraduate student who had moved from India to Scotland to study; after four years, he left Scotland to study at UCLan. Alan was in year three of studying fire safety and engineering. Alan had never taken any interruption of study due to his mental health, but he did not finish his first degree in Scotland due to not enjoying it. Alan had previously struggled with his mental health, so he had seen a psychiatrist. Alan had two months of support at his Scottish university but did not find it helpful. Alan had anxiety and depression and was not overly keen on taking medication. He felt afraid, to be honest about his mental health problems but was able to seek support from UCLan's wellbeing service following speaking to his tutor.

Annie

Annie was studying mental health nursing in her second year of studies. She accessed the wellbeing service due to becoming

overwhelmed financially, to the point that she experienced a decline in her mental health. When she went to finance, she was already on the waiting list for the NHS local talking therapy service and had access to an online CBT platform, 'Big white wall', so she felt there was nothing else she could access. The finance team advised her of the wellbeing support available at the university, which prompted her to contact them. During her studies, which included a foundation year, Annie struggled with her mental health and had to appeal to stay on her course due to not achieving what she expected. Since returning to the course, she had thoughts of wanting to interrupt her studies because of her mental health problems but overall has benefited from the support from the wellbeing team.

Ashish

Ashish was an international student from India. He was due to complete his sports degree later in the year and was looking to find work in the UK. Ashish was planning to get a working visa to stay in the UK following his studies. I later learnt that Ashish had moved back to India as he could not find work as a in the UK. Ashish had struggled with his mental health since childhood and had some support in India. At age ten, he suffered a head injury, was made to leave his British school in India and was told he would not achieve anything. This pushed Ashish to complete school, move to the UK and obtain a degree. During the interview, Ashish was on track for a 2:1 classification.

Imogen

Imogen was an international student from Italy. She was studying English literature in year 1 of her undergraduate degree; she had multiple types of support back home and in the UK for her mental health. She reported having a strained relationship with her dad, with whom she lived. Imogen often felt homesick for her family in Italy, particularly her grandma. Imogen had experienced something 'bad' the day before starting university; she never disclosed what this was and was still actively engaged in getting support for this issue at the time of the interview. Imogen did express struggling with her mood and sleep, on top of the stressful home life and homesickness.

Jamie

Jamie had a long history of schizophrenia and had been involved in NHS mental health services since he was 17; some of this time included prolonged stays in the hospital. He was known to the wellbeing team and the disability service. He had also set up a service user group for people with mental health problems to be included in university events.

Joanne

Joanne was the oldest participant at age 50. She studied community and social care in year one at the undergraduate level. Joanne had struggled with her mental health 'for years'. When she accessed the wellbeing service, she was only getting three hours of sleep at night and was suffering from anxiety that she felt 'had come back'. In addition to her anxiety, Joanne had undergone multiple major surgeries, the earliest being at just three days old, leading her to lose

most of her bowel. She describes the most significant surgery in the middle of her degree. This added to her anxiety as she wanted to achieve her degree, but her physical health would hinder this. She had previous experience losing a job she enjoyed because of her physical health issues, and this fear had never left her.

Maggie

Maggie was a year one undergraduate studying neuropsychology; she started university in a walking frame. Still, she had managed to recover enough to be free of it at the time of the interview. She had moved to Preston with her partner, but they had since separated, meaning she had to find alternative accommodation. She did so, and this was with others who had physical disabilities. Maggie had a diagnosis of emotionally unstable personality disorder and felt this diagnosis accurately summarised her experiences. She was very involved in both the NHS and private services. Maggie had tried to end her life following receiving a 'bad grade'; this had a traumatic effect on her as a friend had copied Maggie's work, and both parties were penalised by the university.

Robbie

Robbie was studying English and creative writing; he was in year two at the undergraduate level. He had used the wellbeing service a few times and had received support for his mental health during his college years, both from the college and the NHS. Robbie had accessed the wellbeing service following a drunken episode, described as 'ending up being in quite a mess'. He described this as a traumatic time for him, as he had woken up at a bus stop covered in blood with

no memory of what happened. He had moved away from home to Preston as he did not like home too much; he experienced 'bad thoughts' and had periods of violent behaviour. Robbie also had a history of cannabis use but had quit some time before our interview.

Sammy

Studying medicine at the undergraduate level year one was Sammy's second attempt at her medical degree; she was repeating year one due to her mental health problems. Sammy had struggled with her mental health in school and college but did not feel she could get much support due to her Pakistani culture. She had poor sleep, panic attacks and very vivid dreams.

Stella

Stella was teaching English as a foreign language course in year two of her studies. She had a history of anxiety and only visited the wellbeing service once. Stella's anxiety had been affecting her sleep and so her performance on the course. She had a family history of anxiety and depression and felt a connection with her dad because he, too, had similar difficulties. Her parents supported her at university with her mental health once they realised it was more than just exam stress.

Zena

Zena was a year two paramedic student who accessed the wellbeing service due to struggling with her Islamic divorce and having a phobia of dogs that affected her clinical placements. She was already on the NHS waiting list for high-intensity CBT, but the waiting list was

over a year. She reported having no friends and having issues with trusting people.

Below is a table of the participant demographics. It lists the participants gender, ethnicity, age, year and level of study, involvement with mental health services and length of interview.

Pseudonym	*Gender*	*Ethnicity*	*Age*	*Subject*	*Year*	*Level*	*Duration of using service*	*Previous MH help*	*Interruption of study*	*Length of interview*
Alan	M	Asian	25	Fire safety	3	UG	5 months	Psychiatrist	Y	17.56
Annie	F	White British	22	Nursing	2	UG	2 sessions	NHS	N	17.24
Ashish	M	Indian	21	Sports journalism	3	UG	'few'	In India	N	12.28
Imogen	F	Italian	22	English literature	1	UG	Ongoing	None	N	25.53
Jamie	M	White British	44	User experience	1	PG	5-6 years	NHS since age 17	Y	39.53 28.38
Joanne	F	Mixed afro Caribbean	50	Social care	1	UG	Ongoing	With a charity	N	28.38

Maggie	F	White British	20	Neuropsychology	1	UG	1 session	Private and NHS	N	13.55 24.44
Robbie	M	White British	24	English & creative writing	2	UG	2 sessions	NHS	Y	17.27
Sammy	F	Pakistani	20	Medicine	1	UG	Ongoing	None	N	31.52
Stella	F	White British	19	TESOL	2	UG	1 session	None	N	10.40 41.18
Zena	F	Pakistani	21	Paramedic science	2	UG	2 sessions	NHS CAHMS	N	27.03

Table 7 participant demographics. Here is a table of participants gender, ethnicity, age, year and level of study, their involvement with mental health services an length of interview

7.3 Conclusion

This chapter set the scene for the findings and discussion. An overview of the methodology used was revisited, and then the chapter's structure and proceeding chapters were discussed to reflect the temporal moments of the student's journey.

A pen portrait of each of the participants has been presented to provide contextual being-in-the-world perspective of the study sample. Diagrams were made to help visualise the themes, how they are structured, and how these were evident in the students' journey of accessing support. The following three chapters present the findings of the study.

Chapter 8 | Exploring the findings – the ‘pre-encounter.'

8.0 Introduction

The previous chapter presented the pen portraits of each participant and a rationale for using the structure adopted to interpret the findings. This chapter is the first of three findings’ chapters that capture the lived experience of having a mental health problem and seeking support. Each chapter draws on lifeworld existentials to illuminate the participant’s experiences. This chapter describes the pre-encounter phase of the experience. This phase includes everything from the discussion to seeking help, then making the first contact with student wellbeing services, to getting help. It presents the themes ‘it’s now or never’, ‘access to help’, ‘just the library’, ‘relief’, ‘timing’, ‘waiting’, and ‘being overwhelmed’. The theme titles have been taken verbatim from the transcribed interviews, to remain authentic to the lived experiences approach of hermeneutic phenomenology methodology.

8.1 ‘It’s now or never’

Around half of participants reported a sense of urgency that ‘pushed' them to seek help. There was a sense that 'it's now or never', like they had given themselves one chance to find help, because of how difficult things had become with their mental health. When interpreting these experiences via the lived time (temporality) lens, time proved to be a significant pillar in getting help, as described by Alan. Alan found his mental health had deteriorated enough that he

was compelled to get help, so he emailed the wellbeing service. The notion of Alan talking himself into getting some help illuminates his sense of inner conflict. His need for help and his internal dialogue proved to be the pivotal moment for Alan, leading him to access help for his mental health, as he states below.

"Erm coz I was sitting like the other night, and I was just telling myself that I need to speak to someone like it's so bad, I just want to say what I feel you know so erm I decided just to email them you know and then yeah I've emailed them, and they said that yes we can make an appointment."

– Alan

Similar to Alans experience, during the interview with Jamie, the physical movement of leaving one space and placing himself in a new area reflects this feeling of support being needed imminently, as Jamie articulates in the quote below. Focussing on Jamie's words regarding his urge to self-harm, Jamie's despair was apparent because he had not self-harmed in 10 years. Nevertheless, whilst at university, he struggled so much that he felt self-harm was needed to alleviate his affliction. The notion of lived body was evident in the palpable physical distress that Jamie described when wanting to self-harm as a behavioural response to his distress His help seeking reflects his need to be fixed rather than use coping mechanisms he has, rather he projects his frustrations and lack of coping strategies on the person taking the call. Jamie stated;

"I was stressed out because I'd come out of my class; I couldn't even go into class. I'd rang them up, and they'd put me under such immense stress… You can't tell me that's not deliberate, that's not me being paranoid. She said she'd put me through [on the phone] said she knew how stressed I was. I felt like self-harming for the first time in 10 years."

-Jamie

Additionally, in the quote below, Jamie describes moving with pace and at length. These insights from Alan and Jamie reflect the corporal agitation and distress encountered. When viewing this distress through the lens of temporality, Jamie both felt an overwhelming sense of urgency to access support and displayed an inability to use coping strategies he himself had built up over the years of having a mental health problem, he added:

“I can still remember Suzanne my support mentor here. I was pacing up and down all night in my flat, I lost, I did 240 miles walking in a month ….It just got to the point where I was walking over 6 miles before I even came out the front door overnight. But that's how obsessive I got because of the stress that was going on.”

-Jamie

This resonates with Alan’s description of “telling himself that he just needs to speak to someone because it is so bad”. Whereas Sammy articulates a desire to reach out to someone familiar to get help in their time of need, illustrating an existential need for relationality.

Sammy spoke of ‘needing it’ [support] and even considered calling the Samaritans charity, a national phone line for people struggling with their mental health. However, she opted for the counselling service because she found it more familiar; this made it her preferred option and illuminated her desperation to seek help. Sammy felt lonely and had no one to talk to. Having a relationship with 'anyone' helped Sammy, as well as other participants in their time of need. Sammy articulated:

“I just felt like I had no one to talk to. I was just struggling so much, and I was either thinking of calling Samaritans or counselling, but counselling sounded more familiar and, therefore, easier to do. But I was also hoping to get a drop-in appointment or something. And yeah, she (the duty counsellor) just like, I think with here I just needed it. She spoke to me for a good 15 minutes, which I really appreciated. She just asked me what was going on and sympathised and gave me advice as well.”

-Sammy

Likewise with Jamie, he found that talking with 'somebody' was just what he needed. The sense of urgency allowed for ‘anyone’ to be that person for support due to the desperation felt in that moment of distress. Jamie felt reassured by speaking with others, as he mentions in the quote below, he had no prior experience with “Lyn’ as she was new, but having the time with her in his time of need really helped him. This demonstrates that this was enough for him at a time of distress. Despite having friends and family, speaking to someone external and

informed was important for Jamie, and he also appreciated knowing the person's experience.

“And there's a struggle in society. I see it all the time; there's a struggle with those who are there and those who are trying to make their way in life. Sometimes you just need to talk to somebody, and that's what Lyn and Becky gave me [mental health advisors]. The best thing that helped was not because Lyn was a brand-new nurse, she’d done nursing a few years, so was able to speak to me from experience. And that’s what I need. That’s really what I need. I need someone who isn’t gonna go, oh had you seen mental health services, who have you talked to? I needed someone to talk to me!”

-Jamie

This sense of wanting belonging also reflects the existential desire for relationality, as also expressed by Sammy. The realisation that help was needed and the importance of communication with someone, was experienced physically by Sammy. She could pinpoint a moment in time and recall these feelings of being helpless, which has had a lasting imprint on her recollection of seeking help:

"I just felt helpless at that point."

- Sammy

Equally, Joanne was able to recall the physical sensations of her body physically shaking during the encounter that she felt at the time. The 'it is now, or never' scenarios is really emphasised here with the participants as Joanne’s impulse had unlocked the same feeling of

urgency felt by these participants before they were provoked to access support. Joanne states;

"Like I felt like I was shaking because I was that anxious and crying... Erm, so I do remember it was quite early when I rang [Wellbeing]; I thought if I don't ring now, I'll not ring, I'll talk myself out of ringing. So I knew that I was feeling like I'd felt with previous anxiety when I was going through all that, and I knew I was aware that I didn't want to get that bad again 'cause I couldn't go out and things like that."

-Joanne

The quotes above have collectively explored and interpreted the 'it's now or never' subtheme. The participants had an inner urge to seek support once they had got to a point where they were feeling so desperate to get help, it was now or never and with anyone who would listen. It was common that once participants had realised that they were needing support for their mental health, they started to seek out and access help that was available to them. This section now explores this.

8.2 "Relationships as a stepping stone to gain access to help".

Most participants described how they had accessed help, although via different experiences. Some participants had no knowledge that a wellbeing service existed, whereas others were aware of the service and what it offered. Some participants were referred by staff, and some referred themselves.

Looking through the lens of relationality, Annie only found about the wellbeing service via the finance team. In the quote below, there is a sense of Annie feeling overwhelmed when she stated, ‘and everything’ as her perceived needs were supported through her relationship with the finance team. Her interaction with the finance team subsequently enabled her to communicate with the wellbeing team. This captured her perception of ‘everything’; because her needs at the time included finances and mental health, and the fact that both were being attended to led her to have a positive experience. There was a sense of entitlement at the time she booked the appointment, as she described wanting to know what other services were available for her, despite not articulating if she felt she had any other needs to be addressed. Annie stated:

"So, I got told to go like book and make an appointment because I was struggling with my finances and that and everything and struggling with like the general practitioners sorry I’m really quiet, trying to get through to them and like and I went to see someone and I was given some really good advice like, my financial situation and what to apply for and also what other services were available for me."

-Annie

This experience was similar for Sammy too, who described how an established relationship with the academic advisor enabled access to support from the wellbeing team. As the academic advisor usually

stays as the same person for the duration of the degree, this constant relationship is a pillar throughout the student's degree. This conversation between Sammy and the academic advisor enabled her to self-refer to the student wellbeing service via the online student relationship manager platform 'Starfish' (see chapter 1). Despite providing her with the support and enhancing her confidence to self-refer. Sammy's academic advisor had also referred her to the same service despite Sammy acknowledging that she had already been referred for support. This resulted in a duplication in referral to getting the same help. This contrasts with Jamies experience of him feeling like he would deliberately put under stress, this demonstrates a higher level of personal responsibility and self-determination here. Sammy explains in the quote below;

"And on top of that, my academic advisor referred me by via, I think starfish or something…So they did that [personal tutor] and then erm I felt really supported, and I was really surprised. Yeah, so just before I went to my, got my pastoral tutor referral, I'd actually referred myself."

-Sammy

Similarly for Joanne, she also went to her academic advisor for support; however, the process differed. Despite Joanne's distress, her academic advisor did not refer Joanne to wellbeing but advised her to seek support by self-referral. This was self-validating, promoted independence and facilitated self-help. In the participant pen portraits

described in chapter 7, a brief context of Joanne's history presented her fight for survival since she was four days old. Joanne's self-referral could be attributed to survival and determination, which she had developed due to physical health problems from birth. Battling against bowel disease had given Joanne the independence and confidence to seek help. Joanne was very pragmatic and strong-minded; despite her anxiety, she waited until she submitted all her academic work before going to her academic advisor and implementing the advice she received. This was not easy for Joanne, as she identified the temporal feelings of her body and mind, which only allowed her to stop once her academic work was completed. Joanne stated;

"Plus, I was trying to work part-time. Each time I got took into hospital, the last time it happened I was actually at work, and they had to get the ambulance. So, each time I was took into hospital I had to reduce my hours [at work], but I still wanted to keep going and going. The one thing I regret was not getting the lady's name who I spoke to that morning, because when my tutor had said to ring Wellbeing, I hadn't done it that day, I think I did do the following week once I knew my essay was in. It was almost like my body and my mind wouldn't let me stop until I'd done it[submitted her assignment] … it was a relief making the phone call, and it took me till the end of year to do it… The day after I finished my last assignment."

-Joanne

Like Joanne's experience, going to an academic who the participants already had an established relationship with, did not help Maggie. Maggie, who also had physical health concerns, was not referred to wellbeing by her academic advisor; she was initially referred to another staff member and then to wellbeing. Noting the word 'little' when speaking of the meeting suggests that Maggie did not acknowledge the severity of her distress or may have been overcompensating for the distress she was experiencing. It could also suggest that Maggie felt this was just part of a 'tick box exercise' rather than being looked after. Maggie had accessed the service following an intentional overdose, that required medical treatment in an emergency department. This 'little meeting' resulted in two people referring Maggie to the wellbeing service; the relationship here may have been put under pressure due to the severity of Maggie's overdose. Maggie described this as;

"Then I approached erm, my academic advisor at Uni, and she referred me to a pastoral support person, and I had like a little meeting with her, and they both referred me to counselling."

-Maggie

Jamie's interaction with his tutor differed. An impromptu passing on the corridor gave him access to help. Jamie declared he sought advice in this passing manner and was advised by the tutor to seek help. Jamie refers to this tutor as a "PhD doctor", indicating a level of respect and admiration for this person, due to their academic standing

and one he trusted. The level of respect was apparent in how he postulated during the interview; Jamie always used people's titles when speaking about other staff members, whereas other participants referred to academic staff mainly by their first names. Respect is significant for Jamie when looking via the existential lens of relationality, as it enabled him to have relationships with people he would not have outside the university. Jamie also had a long history of admissions into mental health units and, therefore, would have been regularly exposed to the medical hierarchy. Jamie has required support from mental health services since age 17. So, for 27 years, he has had this exposure and to institutionalisation.

Here, the lived space is noteworthy, as Jamie uses the word bumped in the quote below. 'Bumped' can be described as a physical movement, whereas here, Jamie did not make physical contact with the doctor yet used the word 'bumped'. Jamie mentioned a personal experience, yet although the person's response appears dismissive, he holds this person in such high regard that he attributes meaning to it. Additionally, as this interaction was impromptu, Jamie was not in control of the situation and allowed this interaction to proceed and showed his dependence on others for support. The fact that this academic had suggested he ‘make a decision’ indicates they are advising him to take some accountability to help himself. Jamie explains;

"I did seek advice from one of the tutors who I'd bumped into, one of the PhD Doctors, and he said, sometimes you've got to make a decision."

-Jamie

The quotes reported here demonstrate that access to getting help came in many ways for Annie, Sammy, Joanne, Maggie, and Jamie, yet all were similar in that they all embraced their established relationships as a stepping stone to gain access to help. Each experience was individual, but all led to help being received. These participants first differed from the remaining participants in accessing help via discussion with academics. As mentioned, participants accessed support in different ways. Annie, Robbie, Ashish, and Alan referred themselves to the wellbeing service without seeing their tutor first.

The next section explores the physical environment of where support was experienced. Once participants had realised that they needed help with their mental health and started to reach out to get support, the next step was physically attending the support session.

8.3 'Just in the library'

Several participants felt that accessing help was easy; for example, as quoted below, Annie had a pleasant and normalising experience. Annie accessed the support via the library. Looking through the existential lens of spatiality, students attending a library is characteristically 'normal' due to the facilities housed there to aid study. Having a wellbeing team based within this set-up 'the <i>' [chapter 1]

benefitted Annie as she was familiar with the place and knew she could get 'everything sorted.' There was also a normalising feel about the library space, as many students use it for a complete range of activities, learning, accessing help, and socialising. Annie stated;

"The access to the service was fine, it was really easy to get an appointment because it was just in the library, so it was easy to get to and everything. Then I got help appealing my course with student support and everything as well."

-Annie

Like Annie, Jamie shared a similar experience. Having ‘the <i>’ the one-stop shop for all queries helped the students receive support for their mental health. Having a familiar space in a physical environment to access help has undoubtedly been an important element in accessing support for some of the participants. Jamie describes a similar case of access to Annie, stating

" I came here. Came here to the library, it was one of the nurses’ mental health advisors, I can’t remember her name. But she was absolutely lovely, just anything that really got me through it, she spoke to me like a human being. She listened to me. I always find that when I’ve met people in the past who have literally, I think I remember the last time I spoke when I met a certain person who I first met and we didn’t get on. She wanted to literally just fill in a form and sign post me places. That’s not what I go there for, that’s not

what I need. I need a connection with people. I didn't feel that she cared."

-Jamie

The ease of access experienced by Annie and Jamie and echoed by Robbie, who disclosed issues with alcohol, memory loss, and anxiety, did not feel concerned or scared of accessing the support via the library. However, describing his access as 'not a big deal' was interesting, as his mental health issues were a significant enough 'deal' to be impacting him, his life, and his studies.

"Yeah the morning after 'cause I'd just woke up, I had like cuts and stuff all over me and I was like, god what's happened? But then initially what made me go out drinking anyway really heavily and alone …it bothers some people but I do everything alone. I'll go to a restaurant alone, I'll go cinema on my own, doesn't bother me, I have no choice really …No it wasn't a big deal [seeking support at the library], it wasn't like I was scared of doing it, I was more concerned about the situation id put myself in."

-Robbie

Whereas Sammy felt walking into the <i>, not knowing who she would be seeing and guessing the person would be from wellbeing, demonstrates a sense of comfort that no matter who it was, help was available. However, not all participants had the same experience in physically walking into the library space to access help.

“There was no counselling available that day. I was initially with one of the teachers, ‘cause I got my results from them. I felt absolutely just shattered, and I was really upset, and I came to the <I> and someone spoke to me. I don’t know what their title would be, but I guess they’re from the wellbeing team. I think wellbeing advisor, and she really helped me. She kind of gave me a plan of what to do. That day was a Friday, and I was worried that like, I would go home, and my dad would be upset at me. Just in general, I needed to deal with it [failing an exam] before I could tell them."

-Sammy

8.4I’ll just email them

Telephone and email were other ways used by participants to get access to support. Despite needing help with mental health concerns, accessing the help via the telephone or computer was the preferred approach for some.

Alan spoke of feeling pleased with the response to his email as it resulted in an appointment, and, fundamentally, this is what he wanted. It is possible that Alan who was studying fire safety would require a person to be pragmatic, calm, and patient. Hence, the skills necessary for the course were also present in Alan's approach to accessing help. Alan stated;

“I just want to say what I feel you know so erm I decided just to email them you know and then yeah I've emailed them and they said that yes we can make an appointment.”

-Alan

Similar to Alan, Ashish's experience of getting access to support via email was simple and effective.

"Erm, I found, I searched for student wellbeing at UCLan, and I got in touch with the team through email and they [a mental health advisor] set me up with a counsellor and I asked for a counsellor."

- Ashish

However, some of the participants had experiences where timing and access were a concern for them. It is commonplace and widely accepted by the public that there is a wait for help unless it is a life-threatening emergency. However, for a student wanting support for their mental health from a university mental health service, the expectations here differ from those in the NHS.

8.5 Every single day for a whole week

Although the participants did not complain about waiting or not establishing contact, there were still feelings of disappointment and frustration during these temporal moments. When Sammy reached out for help, she believed the timing was against her. As stated in the quote below, using the word 'whole' when referring to the week's wait demonstrates that she saw this as a long wait to get her required help.

"Erm, but literally I remember, I was calling every single day for a whole week and I didn't get an appointment. And then on one of the

days, I think it was a Thursday or a Friday, the receptionist was rude to me, and I was having a rough day, and I was just so upset by it."

-Sammy

Crying was also a behaviour that Sammy experienced. The sense of being unable to get immediate help via an appointment led Sammy to cry as mentioned in her the quote below. Focusing on the time Sammy mentions, leads to the ambiguity of whether she cried all day or at just one point. Either way, having waited for help, the lack of appointment availability meant that Sammy could recall her distress when interviewed months later. Crying is explored in further detail in the next chapter too.

"I just couldn't get an appointment, and I called the counselling woman, I ended up crying that day."

- Sammy

Sammy's poor experience of getting help resonated with Jamie's. Despite trying to contact a service that had a 7-day provision, Jamie struggled to get through. Also, referring to the service as a 'thing' suggests detachment from the service. Equally, this could reflect a blasé attitude generated from Jamie's previous disappointing experiences of his call not being answered, reflecting possibly unrealistic expectations of the service response. The situation escalated for Jamie as his high expectations from the service were not met. Despite the effort put in from the wellbeing service, Jamie remained dissatisfied, he describes;

"And this 7-day access thing but they weren't answering….I felt like self-harming for the first time in 10 years. I saw slates on the floor, and I was like I can't do this. I walked away from the classroom I walked all the way up to 118, 119 [room numbers where Wellbeing is housed] I saw Becky; she saw I was stressed; she took me into a room, she rang up the on-duty nurse, mental health advisor whatever, and they got me an appointment via Burnley. They said there was no one, they had to ring up to Burnley, and then they rang up I got an appointment in the afternoon to see one of the nurses"

-Jamie

Relief was the next theme to be unveiled.

8.6 'I could feel the relief '

Notwithstanding the challenges of lengthy waits and lack of continuity reported above, for some of the participants, the point of accessing help provided a sense of 'relief'. The recognition of having a mental health problem and then getting help felt like a big step forward for several participants. For some, the relief experienced from contacting the service, following the realisation that they were experiencing mental ill-health, positively impacted their experience.

Joanne experienced relief when she called, and the response was quick. As she discusses below, this feeling was so poignant to Joanne that she felt she could cry. Joanne could recall feeling relieved from the telephone being answered so quickly. Recalling these feelings in a crisis must have been difficult, yet Joanne could recall this eloquently. Looking through the lens of relationality and corporeality

allows for the feelings Joanne experienced to be highlighted, along with how the relationship she was developing during the interaction also impacted her. The speed with which the call was answered and the reassurance not to rush, positively impacted Joanne's experience, as she states below;

"So, once, when I rang someone answered the phone quite quickly, and I could feel the relief. I think I am going to cry I think just the relief from, I regret not getting her name cause I don't know who it was. I don't think it was the same lady, no it wasn't the same lady that I went to see, but she was very very good, and she was just, said take your time there's no rush. I was trying to talk through sobbing, and she was just lovely, she made, she took away that feeling stupid. That feeling that you're going to get judged, she was just lovely."

-Joanne

This sense of relief experienced with Joanne was also echoed in Zena's experience. Zena also felt a sense of relief from the telephone call. Zena had gone from a phone call to scheduling a face-to-face appointment with one of the wellbeing team, despite never speaking to anyone about her mental health needs beforehand. This relief was limited, however, as Zena's overall experience, unlike Joanne's, was less helpful than anticipated. Her description of never speaking to people also suggested how serious her mental health issues were, and how she was confronting these because she was willing to leave her 'comfort zone'. Zena stated;

"And I think they might have telephone called and spoken to me and then made an appointment to meet them in the building I remember feeling a bit of relief erm because I never speak to anyone so."

-Zena

Relief continued to progress and developed as a theme. Despite only calling to enquire about what help could be offered, Joanne had already started feeling empowered following the call. Joanne also recognised that if she had not called at that point, she would have talked herself out of calling and perceived that not achieving her academic work would make her a failure, she describes;

"Erm, it was a relief making the phone call, and it took me till the end of year to do it... I wish I had gone for it sooner …The day after I finished my last assignment ...I hadn't done it that day, I think I did do the following week once I knew my essay was in… Because what if I couldn't have done it and I hadn't got all the work in, I would have felt a failure to myself… I thought if I don't ring now, I'll not ring, I'll talk myself out of ringing."

-Joanne

Relief also explored via the lens of temporality; Joanne said that because she had called at the time she did, it made the difference between going 'this way or that' for her.

"So, that sort of like, the relief, I got my coat on, went to the park which I love as a wellbeing thing anyway. Now whether, if I hadn't

done the call that day, it's the fine line of slipping back into going downwards or going that way and having that call for me made the difference of going that way instead of that way."

-Joanne

This crossroad that Joane described above had a lasting impact on her experience. The temporal sense of 'now or never' echoes throughout the pre-encounter phase for all participants. However, timing was also evident in other ways across the interviews.

8.7 The right time?

The participants built up the courage to reach out for support and felt relief early in the journey, when they knew they would be getting help. Some of the participants waited until they were in crisis or for all their coursework to be completed before they asked for help, but their interpretation of crisis differed, and was relative to each participant. Sammy and Jamie had multiple interactions with the wellbeing service; they believed they needed to be experiencing a crisis to receive help.

Looking through the lens of temporality having no immediate support when in a crisis, made them feel despondent and upset. Relationality was also evident as not having access to a previously established relationship left the participants feeling negated and confused. Jamie's quote below describes his despondence; influenced by his many years of using NHS services, and relationships that were meaningful to him. Nevertheless, in a crisis, Jamie could not use

coping skills he had developed over the years or any relationship he had established and appeared to accept that he would only get help if he were in crisis. Jamie describes the following;

“It's really sad, I felt that I couldn't talk to somebody. Or they say you've got a support worker, or you're with mental health services, go and see them. Then you ring them up, you ring mental health services they say that person's off today, would you like to speak to duty? Then say, is it a crisis? No, it's not a crisis, but I need to speak to somebody; if it's not a crisis, you don't have to speak to somebody.”

-Jamie

Similar to Jamie’s experience, Maggie, had an abrupt interaction with the wellbeing team, when she called for an update on her position on the waiting list. Maggie's word choice of 'oh' after calling to clarify her position indicates a sense of disbelief. Calling a service to ask a simple question was not straightforward for Maggie, as she did not get the answer to her question; this could have affected her relationship with the wellbeing service, but the way Maggie spoke with a compassionate tone about service demand and waiting times, allowed her to accept this as the ‘norm’.

As mentioned, the participant's perception of crises was idiosyncratic; there was no benchmark to define a crisis other than what the participants felt that this was. What is essential to lived experience is how the participants experienced a crisis, and what is relative to

them. Maggie received help following an overdose of medication with the intent to end her life: Maggie stated;

"Literally, I'm just like, I'm ok for the moment, but I know that when I've been in times of crisis, I called them up once and was like, I just want to know how far I am on the waiting list. You're not on the waiting list, and I was like, oh, I thought I was on the waiting list, you know. Cause I thought when I first saw the advisors that they put me on one, but apparently not. That's ok for now, but then I'm also like, I would quite like to be on one like that would be nice to be on a waiting list like I would wait and I will be patient 'cause I've got other things to keep me going",

-Maggie

When the participants spoke about temporality and the 'right time' for support, there were various responses. For Maggie, her access to the service was not self-directed; she had tried to end her life and was seen at the local hospital, and the hospital contacted the wellbeing team to advise of Maggie's attendance at accident and emergency. This prompted the wellbeing team to reach out to Maggie.

"They were like I know it's really frustrating, and it's really stressful, but it [an application for disables students funding] will help you. I know that, but I was just like I can't right now, so I don't think I ever responded. I've seen her since, and as I say, she gave me the form, and I've misplaced that, so I'll email her and get another one, and then I'll try and get that all sorted out now. But it is annoying cause,

you know it's not like I haven't even tried cause I did try, and then they just literally, I paid £15 for a Doctors' note, which isn't a lot, but it's still £15 for a Doctors note to confirm this person has got BPD, and I'm like well yeah I know that. I can tell them that. You know, it did frustrate me cause they're like we need to know how it affects you, and again, I could tell you that, but you know, that's not really what they need. They need to hear it from a professional, and I understand that, but they could have done that. They could have been like, look, there's multiple suicide attempts on my medical records, and it says a bit about how I'd gone about it and my history of self-harm, and you could have literally put that on there, like I am struggling clearly. I've been to A&E, well, 3 times in like 5 weeks over the summer, like it's a lot. So, it did kind of irritate me, like guys, come on, you could have, like, to the doctors, not to anyone here. They could have done a bit more; my doctors isn't here, it's elsewhere, so I'm not like, throwing bricks at medical centre cause I'm not at that one."

-Maggie

Frustrations about the timing of support have been previously mentioned but here the timing for Maggie was not appropriate, she did not attempt to access help and could not respond to the offer of support even during a crisis. She was not ready to die, but equally, she was not ready to access support either. If Maggie herself had asked for support at a time when she was ready, then maybe her experience of getting it would have been more constructive.

The right time was apparent for Stella too. Stella's delay in contacting the service resulted in her needing the courage to take the first step. Using courage to get help signifies a battle. Stella explained;

"But it took longer, because I had to do that as well as like, I'd already had to get up the courage to send the first email."

-Stella

Once the right time for getting help was overcome, students then had to wait for the help to either be arranged or appointment be attended This is the next phase of the experience to be explored.

8.9 The waiting list

Once participants had started to access help, there were various lengths of time that they needed to wait to get the help. Temporality was evident when participants spoke about having to wait for help, although their experiences differed. Maggie was so overwhelmed with waiting lists, that she was unaware if she was even on one. The repetition of Maggie saying 'waiting' and 'waiting list' suggests she understood and accepted she had to wait while also feeling distressed. Maggie articulated that she was willing to wait and be patient and almost felt she was convincing herself this and seeking validation, that she was ok for now as she has things that will 'keep her going'. Maggie stated;

"Err coz I guess like I know the waiting lists are a long time but I'm sort of about [position] 2 you know nearly double the waiting list now,

so I was just waiting and now I am beginning to think am I on it... It is for a long time you know more than a few weeks you do kind of lose track of how long it has been and just sort of regular updates on you know where you are on the waiting list or if you are still on the waiting list and it doesn't need to be you are in 4th place, it could just be you are still on there...Like that would be nice to be on a waiting list, like I would wait, and I will be patient cause I've got other things to keep me going."

-Maggie

Maggie's views about being on a wait list was a shared experience with Annie. Yet, despite Annie knowing she was on a waiting list for an NHS service, she felt that if she could not wait for the NHS, she would seek help at the university's wellbeing service. This sense of entitlement has been seen earlier with Jamie's expectations. Each participant had a different expectation. Annie felt that one week from requesting help, to be in touch with a counsellor was too long to wait and that this could have been sped up. Whereas for other participants such as Maggie, this was to be expected. As reflected in Annie's quote, she had higher expectations and recommended reducing the time between emailing and seeing someone despite this only being one week. Annie explains below;

"So, I was already on a waiting list to go through to minds matter with the NHS …They've been really good, yeah because she gave me a lot of information, apart from the fact I'm already on the waiting list, I can't be offered a counsellor from university, but that would have

been quicker than the actual waiting list because it's been about a year."

-Annie

Annie's expectations directly contrast with Maggie. Annie empathised with the service demands of insufficient staff to meet all the students who needed help. Maggie had to wait also, but she had a different reaction. Maggie appeared to appreciate that she was one of the many people requiring support, demonstrating understanding and compassion towards the strains of the service. She states:

"In the school, they always say they're really big on mental health; I don't necessarily feel that everyone thinks that they are. Same with the uni on the whole, like, oh yeah, we're here to help you, we're here to listen to you, but people are like, well, we've said this, and you've not done anything, or. And a lot of people are like, yeah, but there's a 6-month waiting list, and you know, I'm like, well, I know that's actually not that bad, but it is if you're in a crisis, and you need to see someone. It is a long time to wait, but they've got too many people who need them, and there are not enough people to support them, right ? Then there are other things, like the student mind, and I know Nikita, who does a lot of that. She is incredible, she really is, and the SU are really big on you know, mental health inclusion, that sort of thing; they really are big on that this year. Moreover, I know it's there; people just need to access other things like that. Like I'm on the psychological society committee, and a course rep and I've said to

people, you know you can come to me whenever, and some people do, some people don't, it's whom they feel comfortable going to. They might not feel comfortable going to student minds; they might want to see a professional because they know it's confidential. They might be on the NHS but on a waiting list and can't afford private. It's difficult, really. I don't know how much of it the university should be responsible for and how much people as individuals should be, but I don't really know what they can do when the funding is so low. The same goes for the NHS. What can they do when a massive problem is rising, but then there's not any money there? I don't really know what they can do to make it better."

-Maggie

What was apparent here was that Maggie was navigating her own recovery. Ashish, similarly, had a positive view on needing to wait. Contentment was evident in Ashish's tone when speaking about this, thus, adding to his overall satisfaction of accessing the service. He stated:

"Erm, what I found good about the service was that I, erm, from the start when I met the mental health advisor to when I was put well, erm, from when I met the counsellor to when I met the mental health advisor, well the time period was really short about only 4 or 5 days which is good really good. And they set up my appointment quickly; I was able to get it resolved and have a nice time at uni."

-Ashish

Joanne shared similar satisfaction with her wait in the quote below. Joanne describes her waiting time as *'days'*. Joanne is assured that someone is getting her support and that this help will be timely:

"I don't know, I just, I felt like at that time for me that conversation was enough, I didn't feel I needed, I don't think I would have been able to talk more if I'd have seen someone that moment face to face …it was a huge relief, the speed at which she got me some support was very quick … I think it was a matter of days."

-Joanne

Despite having a positive experience, the expectations of Maggie, Ashish and Joanne differed from the high expectations of Annie. Jamie and Zena also shared Annie's views by having experiences of access that added to their stress. Jamie felt his telephone call was terminated deliberately. For Jamie, this impacted the relationality element of the encounter. Jamie was left feeling frustrated after being on hold for 45 minutes. While it is unclear if Jamie had been deliberately cut off, his interpretation of the encounter was that he had, which angered him (while also recognising that this could be associated with his paranoia):

"I went to the reception area, and this lovely woman called Becky was there, and she was absolutely fab. She knew I was stressed out because I'd come out of my class; I couldn't even go into class. I'd rang them up, and they'd put me under such immense stress. They kept saying they were going to put me through, then they'd cut me

off, and I'd been waiting 45 minutes on the phone for them, and then I got cut off deliberately."

-Jamie

Zena also experienced dissatisfaction, resulting in her referring herself to an external service. In the quote below Zena explains how she turned to her peers on the course to see if anyone had a dog, to whom she could be exposed to help overcome her phobia of them. Zena gave up and described feeling worse; she took matters into her own hands by asking her peers with dogs for support and making another referral to the local NHS services.

"So, I've referred myself to minds matter, it was a 45-minute telephone appointment erm, and they asked me loads of questions and they said I need the high-intensity CBT. But I called them yesterday to see what place I was, and they said 97th. I was just like, yesterday felt even worse, I'm 97th and I need to get my pad document [practice placement assessment document] signed off and everything. So, I've just, I messaged on the paramedic science group chat erm, and I've asked if anyone has dogs. I've explained the situation and said if anyone's willing, cause I don't really speak to anyone in class either, I'm just a girl who sits at the front."

-Zena

Now that help had been scheduled, the participants started to experience different feelings and anxieties about the help and appointments themselves. The feelings of being overwhelmed and

potentially being judged for having a mental health problem was evident.

8.10 Feeling overwhelmed and judged.

Once participants shared their experiences of waiting, the next theme was the fear of being judged and feeling overwhelmed. This was the final theme within the pre-encounter phase. The participants commonly expressed feeling overwhelmed and inferior, and these experiences are interpreted through the lenses of relationality and corporeality. Joanne worried about being judged as she states in the quote below;

"I think just the relief from, I regret not getting her name cause I don't know who it was [the receptionist]. I don't think it was the same lady, no it wasn't the same lady that I went to see, but she was very very good and she was just, said take your time there's no rush. I was trying to talk through sobbing, and she was just lovely, she made, she took away that feeling stupid. That feeling that you're going to get judged, she was just lovely …Not feeling rushed and it, through a phone obviously, you know I could sense that she was listening and she cared, and for that to come down a phone, well it meant a lot to me at the time. "

-Joanne

This resonated with Alan, who also worried about being judged; he was afraid to open up and be honest with the way he felt. Alan's fear of expressing his true feelings was noted but being vulnerable and

honest with his feelings was crucial to getting the most appropriate support. After having built up the courage to seek help and engage with the person, it was vital that he could be honest about his feelings, to make the most of his experience:

“It was the same thing like what my mental issues you know and er it wasn’t that helpful you know when I was there I dunno maybe because I was just afraid to really say what I felt about you know."

-Alan

Like Allan, Stella also experienced a level of apprehension about how her mental health concerns would be perceived. Stella also worked to negate her problems, by referred to them as ‘not as bad as other people’s’. The relationality lens here illuminates that their preconceived ideas of judgement meant that participants were predicting the content of the appointment, even before it had begun. Stella stated;

“Yeah, and I hadn't slept at all, so I was sort of like when I got in there, I was nervous, I guess. What was the person gonna be like? I'd never met the health professionals before because they didn't have any at school or college, so it was like a new experience, which is also anxiety-inducing… I just didn't know what they would say. I did psychology at A level, and I knew the basics of like the biology, and the chemistry what, ever. But I just didn't know what a person in practice would ask me. And whether I'd be able to answer it in a way to get them to understand what I was feeling, and whether they

wouldn't understand, and I'd just be sent away… Yeah, I guess I was just sort of thinking that, oh, your problems aren't as bad as these people's problems. So it's like, it kind of felt like that's what it would be."

-Stella

Participants also reported the feeling of being overwhelmed. While they had channelled energy into getting help, they then felt overwhelmed to the extent that these feelings almost hijacked the interaction. There were bodily experiences of being unable to think clearly ('not having a clear head'), and increased feelings of anxiety, which reflect the lens of corporeality. Having this experience of an unclear head, as articulated in the quote below, appeared to have jeopardised Stella's opportunity to articulate her feelings and experiences clearly.

"I didn't have a clear head and I couldn't think of what to say."

- Sammy

Similarly with Joanne, she was already feeling the physical signs of anxiety, which added to her concerns about accessing support overwhelming her:

"It made me feel more like, anxious even though I already was… I was, I think overwhelmed to be honest at first."

-Joanne

Robbie also reported physically shaking and experiencing poor sleep. While Robbie had already recounted poor sleep before this encounter, the anxiety of help-seeking added to his tiredness. Robbie explained;

“I think I’d had, not had much sleep at all, I don’t think I’d even had 3 hours. I was, the only way to describe it is probably feeling that sort of, I don’t know is it wired when you’re sort of shaking?”

-Robbie

"Taking me back there" is an interesting phrase coined by Joanne, as she was mentally returning to a previous situation, and then compared this to the upcoming appointment for mental health support. Drawing parallels between both experiences was repeated throughout Joanne's interview, as she would often refer to past medical appointments and experiences associated with her bowel disease and make comparisons, particularly in relation to feeling judged and misunderstood. Joanne said

"Like taking me back there. Even though I knew this wasn't the same sort of appointment, it's that thing that I haven't met them before …And whether I'd be able to answer it in a way to get them to understand what I was feeling, and whether they wouldn't understand, and I'd just be sent away."

-Joanne

By this point, the realisation that help was needed had been ascertained, and the participants had made the first steps towards getting help and had started to receive their appointments to attend. The data described the emotions they reported and how relief and feeling overwhelmed were featured in this part of the encounter.

8.11 Conclusion

This pre-encounter chapter has identified that experiences started prior to accessing help. There was a profound feeling of 'it being now or never,' indicating a sense of urgency for those who accessed help. Access to help differed across all participants, leading to the array of lived experiences being demonstrated. The participants were experiencing anxiety leading up to their appointments, worrying about judgement, how they would be perceived in the meeting, and how the person facilitating the meeting would be towards them. The next chapter will illuminate the encounter phase of the experience.

Chapter 9 | Exploring the findings - encounter

9.0 Introduction

The previous chapter presented the findings from the pre encounter phase experienced by the participants. This chapter uses the same structure to explore the participants' encounter with attending student services for mental health support. The key themes presented here are 'I ended up crying', 'relationships as a stepping stone to get help', 'just in the library', 'I'll just email them', 'every single day for a whole week', 'I could feel the relief', 'the right time?' ,'the waiting list', and feeling overwhelmed. These will now be expanded on.

9.1 'I ended up crying'

Describing what happened during the support sessions presented many emotions for all participants. Several participants shared their experiences of crying due to issues accessing support (as reported in the previous chapter), whereas for others crying was due to the relief of receiving help.

Joanne found herself crying on the way to and from the appointment. Walking to the appointment prompted Joanne to cry, and the sense of relief she felt when just entering the room was 'massive'. Being soothed by the mental health advisor led her to describe this person as being 'so lovely', and going at her own pace allowed Joanne to feel the interaction was person-centred and positive. Joanne describes;

"I was upset going, yeah… I was upset coming for the appointment…Erm, so I probably cried more then, that was a massive relief to get in the room. Again, she was lovely and reassured me to just take my time. When I was ready, you know very much at my pace and very, what I would class as person centred … Nothing was whatever, or saying, sometimes you worry you're being ridiculous."

-Joanne

The emotional and corporeal charge felt here is echoed in Imogen's quote below. Imogen expressed crying as part of the physical and emotional relief too. She expressed gratitude because she had not cried all weekend following her session; she acknowledged her body was tired, and yet, having cried all through the session, this enabled her not to cry all weekend. Crying, therefore, offered physical respite from her emotions and on her body. She describes;

"Oh yeah, I remember just crying all session 'cause I was just really tired mentally …Yeah and that whole weekend I didn't even cry, like not even once."

-Imogen

9.2 It took the pressure off

The relief experienced when accessing support was also a theme within the appointment itself and can be viewed via the lens of

corporeality. After accessing support and starting to engage in the support that was offered, the feeling of a physical weight being lifted from the participants was palpable. Given that mental health is also felt within the physical body, physical sensations were associated with this encounter: Ashish describes this in detail, by focusing on ‘pressure off’ from his back allowing him to continue his studies. The term 'lifted' is associated with help, as more than one person is usually required when physically lifting. For Ashish to relate this to his encounter with the wellbeing staff member, allows him to give deep meaning to his feelings and the outcome of continuing his studies:

"So in that way, it helped me, took the pressure off my back that's it …Erm, if there as anything, it just felt like a weight lifted off my shoulders talking about it, so for example, if I talked about it, if I met a counsellor on a Wednesday, it helped me because If the assignment was due on a Friday it helped me open up and let into in the open so it wouldn't bother me the rest of the week. So, in that way, it really helped, I took the pressure off my back that's it."

-Ashish

Similar to Ashish, Imogen also used language that portrays the physical body as a descriptor for relief. The image of a chest being cut resonated with Imogen as she described how her support helped her:

"I feel like relief, big weight has been cutting off out of my chest."

-Imogen

Zena, too, expressed a sense of relief in the quote below. When Zena spoke about her appointment, the physical notion of things building up inside was profound:

"So yeah, just speaking to the advisor I think, it made me feel a bit of relief …Yeah cause so much had built up inside me. When that happens, I know what that can do to me because I've been through it before, so I felt better that I spoke to someone."

-Zena

Zenas relief, however, was short-lived and only lasted until she got home; there was a sense of the relief being a temporary fix as she saw no resolution for her fear of dogs. This led her to question what she was doing in her life, and not what she expected from the support she so desperately sought. Zena explains;

"Erm but, after I went home, I felt numb again. I felt the same. So, at that time it gave me relief, but when I went back home, I just thought, what am I doing with my life? So, it was just like …."

This section has explored crying and relief, via the lens of corporeality. The experiences differed for the participants but crying and relief, no matter for how long, were commonplace across participants' experiences. The next section explores the participant's experiences of receiving help through the lens of spatiality.

9.3 Like a fishbowl

On attending the support appointments there was a lot of commentary on the physical environment. The lived space (spatiality) had meaning for all participants. From walking into the library building (that housed one of the two wellbeing areas), the participants felt that they were on show: the waiting area was so open, so everyone would know they were there for their mental health needs. Stella recalled her feelings towards the environment as if she was in a 'fishbowl.' She felt exposed as 'everyone could see', which added to her anxiety. Stella recalled being moved into the wellbeing room quickly. Moving into the wellbeing room allowed Stella to 'breath[ed] it out', suggesting that moving to a private environment allowed her to vent her thoughts, feelings, and emotions in the safety of the private room. The build-up of anxiety of being in the open space impacted her appointment, as she spoke quickly and felt that what she said was not helpful, as stated below:

"Almost like a fishbowl… So, it kind of felt like, everyone would know Erm, well, because they have chairs outside, and it kind of feels like everyone can see you. …but she did get me in the room as soon as she could … I think it just made me uncomfortable. It wasn't like, I wasn't 'gonna leave or anything. But I was just more nervous because I had to go and talk about it after that, and I don't think I had slept that night. So, when I got into the meeting, I just sort of breathed it all out. I was speaking quickly. Erm, so I think that that didn't help, if anything, I guess. It made me feel more anxious even though I already was."

-Stella

Similar feelings of being exposed in the waiting area was evident for Joanne. Reference to the public nature of space adds a sense of vulnerability to the participants' experience. Joanne acknowledged that the location could not change, but recognised it was busy. In addition to the area being busy and open, the room was not ready for Joanne's appointment. The wellbeing staff member repeatedly checked on her, inadvertently bringing further attention to the space and to Joanne. Although this happened during a quieter summer month for the library, there were still enough people around, making her feel nervous. She stated:

"I felt, where it was, was quite public… It's very open in that space, but it's only of them things, it can't be helped where it is …And like in my head, it's like they all know why you're here. I think she was more concerned because there was a bit of a overrun with erm, the room someone else using the room, so obviously she kept coming out to check erm…There wasn't anybody else sat there, but I was aware that I kept crying …and I was aware that she kept coming out you know, to obviously … and I was trying to not look around, because obviously there were people …Erm, so I walk in through the library bits, which because it was towards the end of May, it wasn't as busy as it could have been, but there was still quite a lot of people around…when I got in there I was nervous I guess."

-Joanne

The feeling of being exposed was important for Joanne and Stella, but less so for Jamie. The lived environment was mentioned by Jamie but in a sense that he was able to recall what the floor looked like, even when feeling so distressed. Being able to recall slates on the floor suggested significance to environmental features for Jamie. Also notable was Jamie's memory of being taken into a room – his use of the word 'taken' could suggest Jamie was feeling vulnerable or needed to be taken care of by Becky in the wellbeing service;

“I saw slates on the floor, and I was like I can't do this. I walked away from the classroom, I walked all the way up to 118, 119… I saw Becky, she saw I was stressed, she took me into a room, she rang up the on-duty nurse, mental health advisor whatever and they got me an appointment via Burnley. They said there was no one, they had to ring up to Burnley, and then they rang up I got an appointment in the afternoon to see one of the nurses."

-Jamie

Like in the example provided by Jamie, participants could recall specific details about the environment where they received support. Despite of being in a heightened state of arousal, this allowed for a detailed account of the experience as lived. However, some participants accessed help remotely. This will now be interpreted.

9.4 It’s good to talk

Not all participants had to walk through a building to get support, as telephone appointments from the wellbeing team were also available. Zena used the telephone for her first appointment with the wellbeing team and found this preferable to face-to-face interaction. Using the lens of relationality, Zena explained that she does not usually talk to anyone, so the telephone interaction was much more manageable and accessible. Having the opportunity to speak to someone on the telephone removed the face-to-face barrier and gave her the option to terminate the call, yet Zena continued with the call and was able to arrange an appointment for a face-to-face session;

"So yeah, when I spoke to them on the phone, I felt I could speak more than when I was in person. When I met in person, I felt like I missed out on things that I wanted to say, but when I was on the phone, I remembered what I was saying, and I knew what I was saying."

-Zena

These insights (also discussed further in chapter 8) highlight that having various methods to access help available was beneficial. The length, duration, and frequency of the support sessions differed based on need. Within these encounters, there were a variety of experiences, reflecting the existentials of temporality, corporeality and relationality. Imogen had helpful weekly sessions, as she felt she could explore her week and would only need a week to wait for the appointment; she described this temporal feeling as a 'release’. Having

a release allowed Imogen to let go of whatever had unsettled her during the week leading up to her appointment. She experienced feelings of improvement following each session and found benefit in attending, she stated;

"Every week because I can talk about everything that happened the week before. All the pressure, home…So is it a kind of release having this weekly session… Honestly, every week when I go to the session I feel like better again."

-Imogen

The frequency of support was important for Imogen and Jamie alike. Temporality and relationality were also relatable when Jamie spoke about his support frequency. Jamie's relationship with Helen felt like a lifeline for him. He could recall the frequency of his meetings with her, and the effect of the follow-up emails he received. He found this a positive part of his experience. Describing this relationship and its frequency as a lifeline is powerful in that it alludes to Jamie's distress;

"Exactly, and then the stress that society puts on you, demanding to do certain things to achieve certain boxes. Do you know how many emails I used to get every time I went to see Helen, every time I had to do a satisfaction survey with student services, they've stopped it now. But I went to see Helen 4 times in 5 months, and every time I got an email how happy was I with the appointment."

-Jamie

Each participant experienced time differently. Jamie and Imogen found the frequency of their support helpful and a lifeline to their experiences. However, in contrast, he opportunity to talk to a staff member did not positively impact Robbie. He found talking was ‘useless’ and did not help him. He appeared to have an internal battle with himself, as he questioned this thought by saying, 'maybe it is kind of helpful on some level'. Thus, demonstrating that a lived relationship isn’t always a positive one. Robbie stated;

“I don’t know because I’d had disappointment a while after the incident. I was like yeah, it’s good to talk about stuff, but in a way it’s kind of like, useless. I mean it doesn’t help really … Talking, erm, purpose maybe to clarify that things aren't as bad as they are in your head and stuff like that. Maybe that's kind of helpful on some level, but it didn't change anything so."

-Robbie

Jamie, Stella and Robbie did not feel they were listened to; they felt dissatisfied. Validation for mental health concerns starts with a positive connection with a person who wants to help. Expressing thoughts and feelings to a mental health service took courage, as described in the pre-encounter aspect of the interaction. Jamie felt that there was a 'lack of care'. Care is essential when sensitive experiences concerning mental health are discussed. Jamie had been involved with NHS services for over two decades, so his interpretation of care may differ from what the university offers. This perceived lack of care for Jamie, as reflected in the quote below, points to feelings of loneliness,

despair and rejection, perhaps amplified by a different and more caring experience within the NHS. Jamie felt no one was available to him or listened to, he said;

"Didn't feel that she cared … I remember to coming to see, and I tried mental health services and they weren't listening, literally there was no one available because my worker was off or whatever. They said oh, we'll put you through to duty, who doesn't want to know basically, who doesn't know you."

-Jamie

Likewise, this perceived lack of care, also happened for Stella:

"I can't remember exactly what it was that she [the wellbeing staff] had written. But, I know she'd written some things, I don't know if she just presumed, or common things with people that have anxiety. Like she's written stuff like about my parents, them sort of pressuring me. And I'd said I felt like I wanted to please them, it wasn't the other way around, so. I was like well, I don't know if she's just referring that that's what I mean, cause that's not what I said. So that was sort of, like when I had it, I was sort of like. That part kind of felt like she hadn't really listened to what I said."

-Stella

9.5 You can listen but not really listen

Looking through the interpretive lens of relationality here really illuminated the experiences of the participants. Imogen quoted that you

can listen but also not really listen when referring to her previous experiences of getting help, but here with her experience of getting help from university, she felt that she was listen too. Likewise not being rushed and feeling in control positively affected Sammys experience of getting help. This demonstrates that Sammy felt listened too and therefore could have benefitted the relationship and improved outcomes for Sammy. The content of the interaction was also noted.

"Again, it was when, it was at my pace, if I wanted to do it. She made me an appointment to speak with her the following week."

-Sammy

During Imogen's interaction she referred to how being asked how she felt helped her to feel listened to and understood. She drew on previous experiences of not being. This deeper level of exposure for Imogen came as a pleasant surprise as she reflected that not many people ask this question:

"Not so many people ask you how you are feeling. Most people talk about how they feel, but they never talk about how are you doing, how do you feel?"

-Imogen

Jamies experience of getting support differed from feeling like he was being listened to and feelings of not being listened too. Jamie did have multiple interactions with different members of staff, so it was inevitable that his experiences would differ. On one occasion Jamie

remembered being spoken to like a ‘human being’, and found this to be 'lovely', and more than a ‘form-filling’ exercise. He recalled where he was when this interaction occurred, and how it made him feel. The communication skills of the receptionist were a positive aspect of Jamie receiving help too. Interestingly, reception is the first place a student would interact when walking into the wellbeing area. As clarified earlier, Jamie went to another building that offered wellbeing support and not the library. Getting a pleasant greeting made a lasting impression on Jamie. Every contact mattered, and Jamie felt he mattered during his interaction with Becky [wellbeing staff].

“She spoke to me like a human being…No but she was lovely, but to the point that she actually spoke to me like a human being …So Becky literally, I came and sat outside, and she introduced herself…The person actually spoke to me. And when you’re stressed out thinking someone’s actually listening to you, and not just filling in a form.”

-Jamie

Joanne shared a similar experience to Jamies positive encounters; she explained how her perception of being listened to, made her feel that the staff members cared. Being cared for when feeling vulnerable allows a person a sense of safety and acceptance, particularly when speaking about mental health problems:

"But I really felt like she listened. You can listen but not really listen … through a phone obviously, you know I could sense that she was listening, and she cared, and for that to come down a phone."

-Joanne

Stella also experienced validation like Joanne but from a different perspective. Having familiarity with other people who have similar struggles helped Stella feel validated and reassured. Feeling that she was the only person to have ever struggled with her mood was a concern for Stella, yet the validation she received from the wellbeing staff member who had a shared history allowed her to move forward with hope and optimism:

"It was good to have 'someone' who actually had experience with other people to make you feel like you weren't the only person who had felt like that before."

-Stella

The wellbeing staff member having personal experience of mental health problems was important for Stella and Jamie. Whereas for Ashish, he felt optimistic about speaking to someone who understood mental health. This helped him foster a sense of belonging and connectedness to the university; the validation he felt from the relationship with the 'nice' wellbeing staff members offered him relief. He drew on his opinion that not everybody understands mental health

and compared how this was not apparent during his time with the wellbeing service.

"I found the experience really nice, well, when I say nice, relieving I mean, sometimes people don't believe mental health can be seen, so when you talk about it with someone who understands its obviously better, and I feel more part of the university."

-Ashish

Imogen also spoke of the 'nice' relationship she formed with the wellbeing staff member. Imogen clarified that 'being nice' meant 'being a good listener'. Imogen identified that she often talked a lot but noted that the wellbeing staff member continued to listen, which allowed her to feel listened to. She reflected that being asked how she felt made her cry, because she genuinely felt cared for and not alone.

"Nice is where she is a good listener, she listens a lot. Sometimes I just talk, talk, talk and she just listens, and I think that when you can listen to a person without talking, it's good. And she knows how I feel, she can understand how I feel really … And I remember when this lady asked how do you feel, I started crying, cause like there's someone that cares about me, about what happened, and I'm not left alone here in uni."

-Imogen

Interestingly, Joanne described the wellbeing staff members she encountered in a similar way, but rather than using the word 'nice' she opted to describe them as 'lovely'. Repeating the word 'lovely'

suggests a level of conviction and emotion, it also illuminates the relationality. Joanne was vulnerable and upset and required someone to offer her care; she received this from Lucy and described her as lovely.

"I was trying to talk through sobbing, and she was just lovely…the lady who I saw I think it was Lucy, she was absolutely lovely."

-Joanne

This person-centred approach experienced here with Joanne, continued with Robbie; despite not feeling helped by the service, he felt the staff listened. Robbie felt that listening to him was a good skill from the staff he felt listened to, despite not feeling many benefits from the service. While his interactions with the wellbeing team was positive, it did not change him. There was a sense of being understood, relieved, and receiving help:

"Erm, in general they just listen to what you have to say …Erm, she was good, erm, she listened properly."

-Robbie

Here participants have described their experiences of being listened to and found this a validating and a supportive mechanism. Many emphasized the active listening they encountered and how the empathetic responses helped them to feel understood and respected. This sense of being heard contributed to a stronger sense of connection and resulted in a positive experience of seeking support. The comments here suggest the feeling of being listened to is not just

about the verbal communication but the attentiveness and presence of the staff members.

9.6 But she was understanding about it

In addition to feeling listened too, participants reported feeling understood too. This feeling of being understood allowed the relationship to develop further, as Sammy articulates that she would not have continued to share her feelings without feeling understood.

"But she was so understanding about it…But she actually understood what I was telling her…It was very important to me; cause otherwise I wouldn't have wanted to carry on telling …and she would pick up on things that no one else would realise… Yeah. She just, straight off, I felt like I could open up to her."

-Sammy

Feeling understood resonated with Stella too. Stella felt a feeling of nonbiased support from the staff members which in turn provided her with a sense of control. Having to explain mental health problems exposes vulnerability, but having a sense of being in control helped Stella require support. She stated;

"Cause she's like nonbiased, third party. She can advise me without wanting to lead me any particular way."

-Stella

Imogen expressed similar feelings. ‘Being available’ was important to Imogen, and the tasks they undertook to support her were critical indicators of Imogen's success whilst accessing support. Mentioning care again, Imogen relates this to receiving help during her time of need. Having someone available to Imogen at the time of need helped her feel cared for. Being cared for allows a person to be vulnerable in a safe environment; given Imogen's background as the carer in her family, this role reversal had an impressive ‘ten out of ten’ impact on Imogen.

“Well, I think it’s not the computer laptop or paper, I think it’s not important which ever you choose. I think it’s important how people are like available to you… She was really available to me, like she sends me lots of things. She arranged me appointment with wellbeing team support, so that's important for me. If a person, like if you don't see this person in person, forgive me the term … Yeah. If a person really cares about you, they will do anything I think, we are 10 stars out of 10 for the mentors."

-Imogen

These positive experiences interpreted here indicate that the participants’ relationships with their wellbeing support enabled them to feel connected. This was also clearly described by Jamie who said:

“I need a connection with people… The point is it’s the connection with the person that makes a difference…And it’s literally it’s the connection you make with a person, and when you don’t feel that

way … But it was that connection when I came to speak with you, and when I did it with you, and when I did it with this other lady. I can't remember her name now. She might be called Becky as well … It was just her manor, there was something about her, and this is what you get from people."

-Jamie

He articulated his need for a caring connection with someone. Jamie had a long history of mental illness and required support from both a community and inpatient NHS settings. Similar to Jamie, Robbie felt a shared interest between him and the person from wellbeing too.

The feeling of being understood appeared to be an affirming experience that fostered an emotional connection with whoever the participants were speaking with. Many participants hared that when others demonstrated empathy or acknowledgement of their emotions it created a sense of belonging and trust.

9.7 Basically, every time I had to retell it

Despite these experiences being positive for some, the need to keep on repeating their story was a prominent theme. Continuing with the lens of relationality helped to highlight these insights together with the lens of corporeality. The notion of retelling their story was common for Stella and Joanne. This did not overshadow their thoughts on help, but they reflected on how this felt for them, while remaining optimistic about the help they may receive. For Stella there was a sense of frustration as she described that the more her story was retold, the less value it had. As she describes in the quote below, following her

appointment with the wellbeing staff member, she was given a letter to help her not to retell her story repeatedly. Stella welcomed this intervention, but as some of the information was inaccurate, it was not helpful. Stella stated;

“Basically, every time I had to retell it [her story], I didn’t sleep, even if I didn’t have classes the next day, so it felt like it was putting more stress on me…I feel as though I’m just repeating it now. Like I feel like the first time, it had more of an emotional effect, but now it’s like well is that it? because every time I had to meet new people and it was a new environment, it was stressful all over again basically. …and take what she written down with me, so that I didn’t have to say it all again…And when I took it to the doctors, I had to be like that part[of the letter received from the wellbeing team] isn’t true by the way. So, I did have to partly explain what I’d said. He did make me retell it a bit as well … So that anxiety is building up, I've got to tell my story again to someone different."

-Stella

As identified in the pre-encounter theme and within this chapter, building the courage to access help was important for all participants. Having to re-explain why they needed support was frustrating and potentially re-traumatising – as Joanne reflected on her similar experience to Stella’s, she described

"It's having to explain yourself again and having to explain how you feel. Obviously you have to, to be able to get the support, but

because I had to explain myself so much during that period when I lost my job, you sort of like, it took me right back to that"

-Joanne

9.8 Expectations

Participants had mixed expectations of what mental health support they would receive. Some were pleasantly surprised at how helpful they found the service due to their high expectations, while other participants were pleased with the help they encountered. Robbie's initial thoughts were despondent, but overall he was complimentary of the support he received. His opinion on not wanting to take medication influenced the help he was seeking, but he did find some help by attending the appointment:

"There's not really much anyone can do for me, unless they tell me to go on antidepressants or something like that, but I'm not gonna take drugs to fix things …and yeah, they're mostly quite helpful."

-Robbie

Unlike Robbie, Sammy had high expectations when she went into appointment but then reported feeling [pleasantly] surprised by the support she received. Coming from a family that did not acknowledge mental health problems, and having limited exposure to mental health support, could be the basis for her low expectations:

"I felt really supported, and I was really surprised."

- Sammy

Alan, however, had previous experience of seeking support for his mental health at another UK university and was the only participant who could compare services across two universities. During his interview, he explained that while the support from his previous university was not beneficial, the most recent encounter he described as good. So, although not surprised like Sammy, Alan described this as a good experience;

"And they helped me out, erm to help me like er in a good way…I found everything positive due to my last experience was in Glasgow in the past. So, I don't find anything bad they should just need to keep up the great work."

-Alan

Each participant had their needs addressed to some degree, during the encounter period of their experience. Expectations were either met or exceeded, which added to the overall experience of the encounter.

9.9 Conclusion

To summarise, this chapter has provided an interpretive summary of what participants experienced during the encounter stage of getting support for their mental health needs. The findings reveal that this stage of the help seeking journey was marked by a variety of emotions, the impact of the physical environment and the value in being understood and listened too. My interpretation of the post-encounter will follow in the next chapter.

Chapter 10 | Exploring the findings – post-encounter

10. 0 Introduction

The previous chapter presented my interpretation of the encounter phase of the students' experience. This chapter concludes the presentation of the findings. Here I discuss participants experiences of receiving help after accessing the wellbeing service, including wider support. The themes include, 'being referred' on, 'Lucy suggested, Lucy advised', 'what to do next?,' ''I'm used to being let down', 'She's really been fighting my corner', 'I don't want them to feel sorry for me', 'family support', 'I have told him about it 'and 'just power through'.

10.1 Being referred on

This theme, 'being referred on,' was the first to be identified in the post-encounter phase. Students had accessed the help, attended their appointments in the variety of ways offered, and were now in the aftercare stages of the journey. Within the wellbeing team, there were different avenues of support, as explained in the services overview (Chapter 1, section 1.3) so that participants could be referred within the service itself. Some participants received support from the university's wellbeing service, whereas others were referred to external services.

Looking through the lens of relationality, Imogen felt understood and was happy to be referred to the counselling service. Having a

supportive relationship with her mental health advisor ‘Marney’, helped to foster confidence in the service. Imogen did not question or fear moving away from Marney and onto counselling, where she would need to establish a new relationship.

“Oh yeah, we did like 2 sessions with Marney as well. And she was good as well, but I think she understood as well what I needed was something more deep. In fact, she was the one who said you have to do some session with counselling."

-Imogen

Similar to Imogen, Joanne had established a therapeutic relationship with the wellbeing team member. Joanne was one of the participants who went to see a worker within the inclusive support service. The reassurance of having an initial care package on leaving her first appointment was profound; this made Joanne feel the service was 'brilliant'. This sense of gratitude also motivated Joanne to access the other services offered. Joanne stated;

“So, that was reassuring for me that there was somebody that was going to follow up. And on the back of that, I got referred to inclusive support … No just that as a university, and the support to me has just been fantastic, Brilliant… Lucy straight away on the back of the appointment gave me some websites to look at, one I still use being headspace."

-Joanne

10.2 Lucy suggested, Lucy recommended

A key theme was listening to advice that had been provided. This links with the theme of being referred on, as much of the advice given at the appointments was suggesting what to do next. Participants were referred to services external to the university which are interpreted through the lens of lived space. Robbie for example, listened to the advice from the wellbeing member of staff who suggested he attend the Buddhist centre. Robbie solace in the Buddhist centre despite being despondent with his experience of mental health support. Despite only going once, at the time of the interview, he acknowledged that he would go back as he found it to be a good place for him. Robbie had a negative outlook and low expectations for help, but this acknowledgement of a possible return to the Buddhist centre was positive, he stated;

"She [the wellbeing staff member] also directed me to this Buddhist meditation place, which was interesting, I only went once, I would think about going again really because it was good practice."

-Robbie

For other participants, more mainstream services were suggested. Joanne followed Lucy's [from wellbeing] advice, to attend her GP following her wellbeing appointment. Joanne was on a 'mission' to grasp and run with all the help offered. Joanne had waited until she had submitted all her university course work before accessing help. She accessed everything offered to her, but waiting until she finished her academic work limited the amount of support she was entitled to,

as access to university support ceases on completing the degree, Joanne stated;

"Yeah, and I went, Lucy recommended I went to my doctor which I did. I went, in fact, because I was crying, crying, crying, I went to my doctors on the way home, and they fit me in with the nurse that day there and then So, erm, I was started on some medication which I'm still on, which has really helped me which is great."

-Joanne

Likewise, with Alan, he too took on the advice given by the wellbeing staff member. Referring to this suggestion via relationality as 'one of the things Lucy suggested' represents trust in the relationship as, without question, Alan followed the advice to attend Lancashire wellbeing. He said;

“Yeah, and in the interim period to coming back to uni, sorry I did, I forgot to put it on there, I saw Lancashire wellbeing because that was one of the things that Lucy suggested"

-Alan

The act of receiving advice was a feature across several of the participants experiences. Students possibly came to their appointments expecting to be told what to do, rather than using the appointments to explore their own thoughts and feelings. This pragmatic approach appeared useful to the participants who

experienced it. It also illuminated that students were coming in with expectations to be cared for, rather than to help themselves.

10.3 What to do next?

For some of the participants, and unlike the experiences reported in the theme above that explored participant getting advice and help, there was also a lack of clarity as to what to do next. This theme now explores that lack of clarity some participants felt following their encounter with help. For Stella, there was no clarity or rationale for being referred to so many places, including her GP and the local talking therapies service Mind Matters. Stella did not understand what she needed and was afraid of wasting practitioners' time, but she eventually contacted her GP over the summer. Stella articulates;

"when I went to the face to face appointment erm, she basically advised me on what to do next which I really didn't know what to do so she advised me um to sign up for Minds Matter and go to the doctor and I don't know if I would have gone without being advised because I didn't want to waste peoples time, like especially the doctor you know because I didn't know that I actually had. So I got in touch with them, and over the summer period I had some support with them…and er like after I finished with them I went to see the psychiatrist and she advised me what to do, you know."

-Stella

Like with Stella, when asked, Ashish gave an overview of each service that he accessed. Using a service that was external to the

university enabled him to engage in cognitive behaviour therapy (CBT) as this was not offered in student wellbeing. As Ashish also formally disclosed his mental health diagnosis this opened up further support that included financial support and a mentor via the disability service. Without having a relationship with the wellbeing service, Ashish would not have been aware of his eligibility or how to apply for extra support under disability law. Ashish was in year 1; the timing of these interventions allowed him to have the support he was entitled to, for the remainder of his degree. Ashish felt that he had a resolution that led him to have a great university experience, however, this was still met with the burden of having to repeat himself to all these services. Having to repeat their story featured in the encounter phase too (section 9.7).

"I went to Minds Matter, and then I got a note from the Doctor to give to the university, then I had to tell it to someone at the university like disabled student allowance. Then I got a mentor, and I had to tell it to her as well."

-Ashish

The feeling of resolution described here also helped some of other participants feel reassured, validated, and helped when moving on to other services. These interactions with external and internal services paved the way for some participants to access help, accessing help for one issue often identified further issues. The interaction with the wellbeing service informed participants about their options. Therefore, enabling the courage to access help, supported some

participants in a multitude of ways. However, there were participants who felt unsure of what happens next, such as Stella.

The phrase 'the door being opened' was used twice, by participants with no connection to each other (Imogen and Joanne) when they shared their experiences. A visual of new beginnings and a release of whatever is behind the door is symbolic, when Imogen speaks of opening a door. This spatial feature resonates with the participants' release of thoughts and feelings built up over time:

"It was like a door was being opened for me …so it was a door that was open for me…All the pressure, all the problem, and honestly, the mental support is my only escape."

-Imogen

“Yeah, opens the door.”

-Joanne

10.4 I’m used to being let down

Each participant had their own experiences, some had positive and constructive support, while others, such as Zena felt let down by the service, and drew on her own resources to deal with her mental health problems. Looking via the lens of relationality, it appears that the relationship Zena had with the wellbeing service, added to her feelings of always being let down. Zena pinpoints feeling let down when referring to past experiences. Past relationships impacted participants physically and emotionally. Zena struggled to get help for her dog phobia, lost her best friend, and was going through a divorce at the

time of the interview. The lack of help motivated her to refer herself to a local CBT service, knowing her dog phobia would impact her studies. Zena stated,

“I’m just thinking I am used to being let down. I did kind of wait for the phone call initially, but then I thought well they might not be calling, and I just got on with it … I referred myself to Minds Matter, like I said it’s a big obstacle in my course. My mentor said she might not be able to sign me off if you know, I'm not going into houses where there's dogs."

-Zena

The disappointment experienced by Zena was echoed in other participants’ experiences. Several participants described the feeling of being 'passed around’ by different service providers. For example, Maggie was given a ‘lifeline’ with the disabled student's allowance (DSA), yet accessing this service became problematic, due to evidence of her disability (from her GP) not being accepted by the DSA team. This added to her agitation to the point that she felt passed around, let down and financially affected. The stress of Maggie's DSA application not being accepted came when she tried to end her life. The timing was essential for Maggie; she had insight into how her mental health problem affected her, but the lack of support made her feel overwhelmed and suicidal:

“We discussed everything, and the lady I saw was like, you’d benefit from maybe having an assessment from the DSA and I would need a

doctor's note. I got my doctors note and it literally said yeah, this person has got borderline personality disorder, but they then said ah that's not enough, like it needs to say how it affects you. And at that point, I was like I can't deal with this, and it was just like I don't want to be going back and forth and back and forth and I'd already spent money on that [evidence of her disability], and I haven't got a lot of money erm. And I think I got put on a waiting list for like accessing mental health services. But I have not heard anything back, I'm not entirely sure whether they need the DSA letter for that? Or what, but I have not had much since…I went to A&E in November, and then they got me in touch with CMHT [community mental health team] which I'm in touch with now, which is amazing they're really, really good. Erm, and then yeah, I saw and advisor here, …and she even suggested maybe going to my doctor or going to counselling, and I was so surprised … It's very overwhelming, and again like with everything that'd gone on over the summer, and I was trying to get my doctor's note in and that wasn't good enough."

-Maggie

This sense of feeling overwhelmed and dissatisfaction were also present for Annie. After seeing the wellbeing service over the summer, Annie was given access to the online platform Big White Wall as it took months before the external service saw Annie. She was then discharged on the first appointment and from Big White Wall simultaneously. Her relationship with her wellbeing advisor could have

been built on and developed whilst waiting for the external NHS service, yet she felt that all three services had abandoned her.

"I came to like, the mental health services last summer, and I've only just got through to Minds Matter to get an appointment, which has now been discharged already. So, I've been through the big white wall, and they've discharged me after 1 session, so it's not been the best."

-Annie

Zena had such difficulties that she felt compelled to take matters into her own hands when she was not referred on by the wellbeing team. Zena described trying everything possible, with a tone of desperation. She had already mentioned how her dog phobia impacted her practice placements, and despite trying to get support, she did not feel supported. The temporality notion here was seen in her needing high-intensity CBT and being 97th on the waiting list. Despite doing this independently, she felt worse and approached her peers with dogs to see if she could help herself. Zena found a situation where she pushed herself out of her comfort zone; from not speaking to anyone to actively disclosing her dog phobia: She explains;

“So, I’m just trying to do everything possible. So, I’ve referred myself to Minds Matter, it was a 45-minute telephone appointment erm, and they asked me loads of questions and they said I need the high intensity CBT. But I called them yesterday to see what place I was, and they said 97th. I was just like, yesterday felt even worse, I’m 97th and I need to get my practice document signed off and everything.

So, I've just, I messaged on the paramedic science group chat erm, and I've asked if anyone has dogs. I've explained the situation and said if anyone's willing, cause I don't really speak to anyone in class either, I'm just a girl who sits at the front."

-Zena

While the helping encounter was positive for most participants, not all of them experienced a smooth journey in their search for their appropriate support. Despite having access to the wellbeing service that has a variety of trained professionals working there, participants also found support outside of student services and with their tutors.

10.5 She's really been fighting my corner

Several participants referred to having another layer of support in the personal tutor / academic advisor role: a role that was welcomed and well utilised. The relationality aspect of these encounters was a prominent theme of the post-encounter phase.

Zena established a relationship with her academic advisor and felt comfortable approaching them for support after she had tried to engage with the university wellbeing services. While she cried, which she experienced as weird (with experiences of crying also described in 10.2) this was the catalyst for further support. Being able to cry in front of someone often demonstrates a level of trust and comfort present in the relationship; although employed in an academic capacity, the academic advisor also holds a pastoral role that Zena embraced. She acknowledged that sometimes 'eyes do the talking again', alluding to a

level of trust and rapport in the relationship and the inability to compose herself due to her level of distress. Zena stated;

"I've just seen my academic supervisor today as well and had a bit of a cry at her cause it's really affecting me. I have this dog phobia, and I think next time I go out on placement I'm not going to be scared, then I see a dog and I'm running for my life…Sometimes it just comes out. Your eyes start doing the talking. When you get that feeling it's going to happen and I started crying, it just felt, I felt a bit weird I don't know how to say it."

-Zena

Similar to Zena's experience Annie, too, felt the support from her tutors was beneficial. Additional support from tutors following her receiving help from the wellbeing team resulted in Annie having more contact and check-ups with her academic advisor. Annie accepted all the help, but this relationship with her academic advisor was a great support. As reflected in other stories, Annie described how this support would go the extra mile:

"With the tutors, they've been like, erm. Emailing me and things and make sure if I do need any help with anything, I'd go for regular sessions to see if I needed any support with anything, and talk through everything that was going on, because I was changing through different medications, so she was like understanding how I was feeling up and down, and like I was explaining about the mental health advisor."

-Annie

Imogen provided similar sentiments by expressing the value she held for the relationship she had with her tutors; she had more than one highly regarded tutor that continued to support her after she had been with the wellbeing team;

"I think he and Robert are the only ones that know, and they have been really supportive and still are…I'm, erm, I'm someone, I have a value you know."

-Imogen

The positive relationship with tutors was also evident with Joanne, Maggie, and Stella. As discussed in the pre-encounter theme (see section 8.2), Joanne's catalyst for getting help was her academic tutor. Similar to Imogen, there was more than one tutor with whom Joanne had honest relationships with. She spoke about how she had the confidence to speak with them when upset;

“So, I had spoken with my lecturer, who was very supportive. I had 2 lecturers last year that was very supportive, and I think it was the week before it was due in, I'd got upset with her and she'd advised me to go and speak to somebody at wellbeing."

-Joanne

Likewise with Maggie, using the academic advisor as a source of support was a natural progression for her, as their relationship had already proven valuable. Maggie disclosed that her academic advisor had already been ‘fighting her corner’. Drawing on being seen, even

when she was low, and still finding this helpful, was a poignant moment for Maggie.

"One of my tutors in particular I know she has really been fighting my corner and that's defiantly meant a lot of coz she is not my actual academic advisor but er yeah she saw me when I was really really low and erm has been great."

-Maggie

Jamie had reflected that his relationship with most of his tutors was pleasant and supportive. However, there was also a paradox from participants such as Jamie who felt some academic staff would go the extra mile (as reflected in Annie's quote above), whereas others would not. Jamie felt in one of his encounters that one tutor dismissed him despite him needing help:

"I felt they wouldn't have gone that extra mile …It almost felt like the academics didn't want to know. ..And quite frankly, I wish I hadn't been there when he had been doing that. I wish I hadn't even walked to the door …If you knocked on the door he wouldn't see you without an appointment, he would literally make it obvious you weren't welcome …And when you're obsessive like me, you feel like people don't want you to be there …Yeah, they just don't want to know. And I thought who I can really trust?"

-Jamie

It is made clear here that value of the personal tutor role and how each participant who mentioned it, reported their tutor was a good resource for getting support they needed.

10.6 ‘I don’t want them to feel sorry for me’

From a different perspective to that referred to above, Alan would not approach his tutor; he opted to manage his mental health difficulties with the wellbeing team and not disclose any need for support from his tutors. In many ways, the tutors who offered mental health support could be overstepping their role and blurring the boundaries of pastoral support with mental health-specific support. The fear of being judged in his relationship with his academic advisor was enough for Alan not to approach them, Alan may have felt his privacy was being compromised too.

“Because I don’t want them to just feel sorry for me like just have this mental issue, so I just tried to cope with everything going on around me. ...erm it was good kind of, just for me. I didn’t want to just someone to ridicule me or see that look on his face or her face to feel sorry for me.”

-Alan

Robbie expressed similar views relating his experience and feelings to a quote by Stephen Fry the TV personality to validate how he felt. He also reflected on how previous feelings of being uncomfortable when speaking of his feelings in class influenced his decision not to approach any academic staff member for help. Stigma and shame could be interpreted here too:

"No, I've done that before and it just feel uncomfortable to be in a class when you've divulged that information … Erm, it's just kind of like Stephen Fry once said about his depression, it's kind of funny,

would you show a genital wart to a friend or colleague that you have to face every day, and mental illness is kind of similar."

-Robbie

This section illuminated the participants' varying experiences and attitudes with their academic advisors and course tutors. Some were therapeutic and a springboard to getting help, others did not have enough confidence in the relationship to approach the person and share their mental health problems.

10.7 Family support

Alongside tutor support, many of the participants referred to the reaction experienced by the family. This theme aligns with the lens of relationality for interpretation. Each participant's family setup varied from having no family, to living with a supportive family. There were cultural, stigma and shame revelations and an array of different family dynamics.

Sammy did not live with her parents yet had a close relationship with them; she had a younger sister and felt like she had to do well and be well. Even after seeking support from the wellbeing team, she still did not feel that she could speak to her family about her mental health difficulties. She explained that being Asian and from an Asian family, it would be difficult to understand mental illness:

“I didn’t feel comfortable telling my family. Even though I live at uni, erm, I just didn’t feel like they’d understand, or they’d burden me with questions like why, why? And I didn’t tell them about counselling or

anything …Well, my parents are Asian, and I just like wasn't expecting them to be understanding."

-Sammy

This resonated with Alan, too. He feared speaking to his family, who were also Asian. The feelings that his depression would be negated because it is not a visible illness was also profound to the point where he felt he would be labelled as 'just making it up':

"I can't say anything to my family because erm especially my Mum will be like ok like your still young why are you doing this to yourself? You know and because you know like depression and anxiety is something not visible to people you know so they won't feel it and they may just say well that's by your own you are just making things up….."

-Alan

Culture was also an issue for Zena. She appreciated that her mother might have been more understanding of her situation as she had been born in the UK and socialised to attitudes towards mental health. Despite this awareness of her mother's potential reaction, Zena was worried it might upset her and chose not to disclose her mental health problems to protect her mother and herself. Speaking to her father was unimaginable: she described the relationship with him as different due to him being born in Pakistan. She was fearful of a lack of understanding and judgment from her father.

"I just feel like they wouldn't understand. My mum she was born here, she would understand me, but I wouldn't want to upset her. My dad was born in Pakistan so he isn't understanding anyway… Personally I feel I couldn't tell him anything because I feel like he would judge me more. We'll pray you'll be better or something like that."

-Zena

The relationality of family dynamics was an issue for Robbie as well. Home was unpleasant for Robbie, as he felt conflict with his mother and felt he was treated differently than his siblings, believing that this was due to being the middle child. Interpreting via the lenses of spatiality and relationality helps to bring deeper meaning to this quote. Robbie associated this unpleasant relationship with his mother and voiced not liking the environment, thus preventing him from going back home often or for long periods, despite struggling with his mental health and having sought out support for it.:

"I didn't go back home for the summer, I worked here. It's like a terrible environment, I just kind of feel mistreated by my mum and stuff like that. Not really in an obvious abusive way, but more kind of, just erm, like I'm a middle child, there's a thing associated with that. Yeah, I just don't like being in that environment. I'm still on good terms with my family, I go to events and stuff. I'll most likely be back for Christmas, but we stay together for long periods of time there's arguments and stuff."

-Robbie

Being an international student, Imogen often felt homesick. Imogen lived with her father; they had a tense relationship whereby she felt like she was the parent in the relationship. The language barrier added to her distress. Reporting feeling aged 52 gave a sense of struggling with her identity in having to look after her father.

'Well, about it, it is another country. I am homesick, like always. Yeah, I just mostly cry, but I miss, like, my family and, you know, the routine we used to have, used to have in my country. My grandmother, my aunt. I live with my dad, but I don't get along well… my dad doesn't speak English, so every problem is on me. Everything so I don't feel like I'm 22 or 52 or something like that."

-Imogen

Contrary to Imogen's experience, Stella had a supportive and normalising relationship with her parents due to her father having lived experience of depression:

"My parents are quite good about it. My dad struggled with his own things. So, they sort of understood, even though it's different things, it was different, they came to understand it wasn't because I was just nervous about exams or whatever, it was more than that, biological, I guess. So yeah, when I came into 2nd year, I knew I wanted to start talking to someone at least. That's mainly what I wanted, just to be able to talk about it. I felt that would like, help me to process it I guess, because when you're on your own you don't always see things always, so that's what I was looking for."

-Stella

Stella's father's experience of depression allowed Stella and her family to understand her difficulties, but she first went to the university for support. Although the family took time to understand this was more than exam stress, the relationship progressed sufficiently for her parents to understand; this led her to speak more openly and honestly about her experiences with them.

Relationality from peers and family has been a prominent feature of all of the participant's experience of getting support, but this also expanded onto peer and work-colleague support for some.

10.8 'I have told him about it'

Some of the participants had paid employment alongside their studies, so they had relationships with peers from work. Imogen had a wonderful experience with her colleague and manager, as they accompanied her to her first appointment with the wellbeing team and continued to support her after. Having a supportive relationship at her workplace negated the lack of support Imogen had at home. The colleague accompanied her to get help, and she felt grateful for their support. She could also disclose the feelings and experiences that she was struggling with without fear of being judged. She stated;

"I feel the company I work with have been really supportive with what happened. I must be really like, this true, like, they've been really supportive and kind all the staff. And the manager Nelly, she came with me with my first session with Marney where we talk about what

happened. We just talked about what happened before coming here and, we decided to make appointments for other sessions… you have to talk about someone, but what happens in your household and what happens inside you and your feelings, because I'm always afraid to be judged."

-Imogen

The relationality of friends also featured in the interviews. Sammy also noted that her relationships with her friends was optimistic and attributed this to their maturity. She also found them to be understanding and empathetic, which led to the feeling that they supported each other. However, there was a fear of judgement with her course mates due to a perception that medics would not be as understanding of mental health problems:

“Erm, and they are just very understanding and empathetic, and we actually support each other cause they’re mature… and because I’m doing medicine, I felt like erm, if I have all these issues, they’re gonna see me differently, like my peers will, the teachers will, maybe they will underestimate my capability."

-Sammy

Like Sammy, Stella’s housemates had also been exposed to mental health problems and had been for support to help address them; they found this lived experience helpful to talk to each other once they had been to services to help their mental health. Stella described;

"I live with like 5 people and 4 of us have all got some sort of mental health issue and 3 of us have all been to see the mental health services so we can all like talk to each other a bit."

-Stella

Alan, however, only had one person with whom he could share his issues. Alan's relationship with the person he calls his best friend is notable. He was the only person he could confide in, and this was after a month of being so unwell that he had not seen anyone. Interpreting this via temporality suggests the time that passed was poignant for Alan, as it took him this long to speak out.

“Erm, I have told one guy yes, he is like my best friend, and I have told him about it like er I have got mental illness because he has seen me like I think a month ago I was so depressed I didn’t talk to anyone at all in the class I was just so frustrated you know.”

-Alan

Likewise, Ashish's describes having only a small group of friends, Ashish's relationships were vital to him. However, these friends were not open to discussing mental health needs: they did not understand it, because it could not be seen. There was a need to prove his mental health problems, but an acknowledgement that doing this well was complex and part of the problem with mental illness.

“Basically, I had one old group of friends who weren’t very open to erm, yeah, mental health because they believed if they couldn’t see it, it wasn’t there. I think that is a bit of a problem area. I struggled to

explain that it's still there because you can't say, you can't prove it in scientific terms, so. And it's always a grey area, only the person experiencing it like me can talk about it, but others can't. So, I find talking about mental health can be tough, it can be more tough than talking about more quantified illnesses because you can't really prove it without any erm, well without and scientific proof."

-Ashish

Peer support was a feature of the lived experience of seeking support, yet the individual experiences differed. Some participants had continued support from friends and family, whereas others did not due to the perceived burden this would put on a friendship, fear of judgement, and lack of understanding. For some the course itself provided support, this will now be explored.

10.9 Just power through

The final theme prominent across the participant's experience was the course itself. Despite all the participants being enrolled and attending their course of choice, the course played only a small part in their experience. The urge to complete the course and 'power through' was evident and a driving force for some participants, to either distract them from their mental health problems, or it gave them a focus and distraction from their mental health problems.

The notion of 'power through' can be visualised as a physical body walking through anything in the way, and this is precisely what Annie articulated. She had accepted that she had a mental health

problem and took the support offered to her, and no matter what came in her way, she had the focus to ‘power through’: the thought of starting again was just too overwhelming for her.

"It sounds silly but like, the anxiety of starting again, and new people stopped me from leaving and just power through it."

-Annie

Joanne, too, used this exact figure of speech. Joanne wanted to ‘power through’ no matter what her difficulties were. While at one point, Joanne worried about not achieving her degree due to their mental health problems, her determination to complete the course enabled her to accept an extension to her submission date and manage her difficulties within a longer time frame.

"I just wanted to power through I've always managed...Erm, myself I didn't, I was worrying about not meeting my deadline and I didn't, I was putting myself under pressure, even though they'd said it was fine to get extensions. Even when I was in hospital, eventually I had to get an extension for one of my assignments."

-Joanne

The need to focus on the course to pass was a feature for Imogen, also. Having something to focus on was a distraction that allowed her to block out trauma and distressing thoughts. While distraction enabled her to succeed in her studies, this only helped partially as she reports her evenings were a battle.

"Well because I'm thinking I'm focused doing this, I'm focused doing my assignments so I'm not thinking about when I go to the house you know, in the evening and have a battle."

-Imogen

Alan, too, faced struggles in attending university from time to time. Despite having difficulties with motivation, Alan revised his environment by working at night to complete his studies, whilst still battling his mental health problems:

“Erm you see like sometimes er when I wake up you know I don’t like want to attend the university or just to do my job, you know anything so I leave my studies till late night so I want just to not be with a lot of crowd you know anything so … er so I kind of managed erm to just do just my assignments and everything at night-time you know.”

-Alan

Zena, however, felt her course was the only thing that kept her going. Using the term 'hanging on' demonstrates Zena's sense of desperation; she had tried to get help yet had been passed around and put on long waiting lists. So, she found herself having to approach course mates to help her overcome her dog phobia. Zena could have left the course and returned when feeling better, but the course meant so much to her that she was ready to use her motivation to improve and achieve her degree and qualifications:

“This course is literally the one thing that’s in between me and me getting like, I’m hanging onto this it keeps me motivated and keeps me wanting to do my best. Which is why now I’m tryna run round like asking everyone do you have a dog that I could come and accompany you with?”

-Zena

Imogen recognised that she could not have remained on the course without the support of the mental health and wellbeing team. The process of studying also helped in providing a form of escape from her mental health problems. Moving back to Italy was an option for Imogen if factors got too difficult for her in the UK. However, because of the support, she felt able to stay despite feeling conflicted about how difficult life could be when still wanting to achieve her degree:

"Yeah, cause without mental support I would totally decide to go back to Italy and don't come back here anymore. But I need to graduate, but sometimes when the pressure is too hard, when things are up at home you know, dysfunctional relationships just feel like I can't do this. Can't stay here, I don't want to stay here."

-Imogen

The course played a small part in the experience, despite all students attending university to achieve a degree. There was a range of experiences and relationships with the course, varying from the students feeling the course was the only aspect that kept them going,

to other participants not mentioning their course or the impact their mental health problems had on their studies.

10.9 Conclusion

This chapter presents the themes identified within the data from the post-encounter phase of the student experience. The six themes that were illuminated by using van Manen and Merleau-Pontys work resulted in: listening to advice, being referred on, tutor, family and peer support and the course itself all being explored. The next chapter brings the synthesis together by discussing these findings.

Chapter 11 | Discussion

11.0 Introduction

The previous three chapters provide my interpretations of the interview data, which examined students' experiences with mental health problems seeking support at university. The chapters were organised to reflect the three temporal moments in the participants' experiences: the pre-encounter, encounter, and post-encounter. This chapter presents my discussion of my research project. Here I contextualise the findings of this research within the broader literature. I revisit the study's aims, summarises the key findings, and offers a discussion guided by van Manen's reflective framework and Merleau-Ponty's lifeworld existentials. The chapter includes a critical interrogation of my findings in light of existing research along with a similar interrogation of the existing research.

11.1 Purpose and nature of my study

Peoples (2021) advises that researchers should revisit the purpose and nature of their study, summarise their findings, and facilitate a dialogue informed by the systematic review and data from the study while also considering the broader literature and philosophical context. This chapter responds to this advice by synthesising the emergent themes to illustrate the existential experience of seeking mental health support.

My study aimed to look at the lived experience of university students who had a mental health problem and sought help for it whilst at university. The purpose of my study was to contribute new and

original knowledge to the topic of student mental health. I achieved this using a phenomenological approach, as phenomenological research aims to illuminate their lived experiences (Smythe et al., 2008; van Manen et al., 2016). One to one interviews were used to capture rich, in-depth accounts of the participant's experiences and to give the participants a voice to shape future mental health support for others. Below I provide a detailed summary of the key findings.

11.2 Summary of key findings

The research findings were framed around three temporal moments of seeking help, drawing on the theoretical perspective of key scholars in phenomenology, such as Heidegger, van Manen, and in particular the existential lenses described by Merleau-Ponty. The findings highlighted that seeking support was not simply via university wellbeing services. The participants needed to be ready to access support; it was only once the build-up to gaining that support had got to the point of where they were driven to act, were they ready to get support for their mental health needs. My findings provide a unique understanding and insight into the students' experiences at university and the impact their friends, family, and tutors all have on their university experience. Here, I provide a summary of what each of the three encounters revealed.

11.2.1 Pre-encounter

The pre-encounter phase of the student journey highlighted that the participants delayed getting help until a palpable 'now or never' moment. Whilst other participants knew that they needed help but needed to find the right time and confidence to seek it out.

Once students had decided that they were going to ask for help, they accessed the help in various ways; these included visiting physical spaces, online platforms and phone calls. The physical spaces where help was sought also shaped participants' experiences. The way that help was accessed mattered to the participants, too. The wellbeing service was used to access help, yet getting help came from alternative routes, including friends, family, and tutors. Therefore, it is illuminating that it is not simply the role of the wellbeing service that impacts students' getting support for their mental health needs. Fear of being judged was an issue for some participants, whereas the possibility of stigma did not put others off, as they were desperate to get help.

11.2.2 Encounter

The encounter stage of the help-seeking journey explored participants' experience of both crying with emotion and crying with relief in the physical environment where the support was provided. The feeling of relief, fear of judgment and feeling overwhelmed were also key findings. The personal tutor's role was emphasised as an important resource for support and was often a gateway into getting professional help from the student wellbeing team.

My study also highlighted the significance of the environment where support was received. There were some anxieties about feeling exposed to the openness of the library area. However, having a familiar and ordinary space, with multiple uses, such as a library, helped participants feel at ease and 'normal'. The therapeutic landscape played a large part in how students felt about going to get

help. It was noted that, at times, the environment felt like a 'fishbowl' as other students may know what they were waiting for when they sat in a specific area outside of the room for the mental health advisors. Therefore, there was also a reported value in having telephone support. Expectations from the participants about mental health support all differed and therefore had an impact on their views of the support that they experienced.

11.2.3 post-encounter

The last temporal moment illuminated in the findings was post-encounter, which focussed mainly on the experiences of being referred on to other services, how the support from relationships the participants had with peers, family, tutors continued after their encounter of support helped, along with the course itself gave some participants the urge to power through. The relationships with peers proved a valuable resource when a participant had required support or assistance in getting help for a mental health problem. Relationships with family members differed as some participants found this invaluable in seeking help, whereas others had no family support.

11.3 Presentation of the findings

As discussed in Chapter 6 (section 6.12), van Manen (1990) proposes that Merleau-Ponty's four lifeworld existentials can guide reflection, given that phenomenological research delves into the human lifeworld. These four lifeworld existentials are guided reflections and serve as productive categories for questioning, reflecting, and writing (van Manen, 1990). They encompass lived space/spatiality, body/corporeality, time/temporality and

relationships/relationality. Therefore, I have re-presented my findings from the study to reflect the four lenses I used for interpretation. There will be unavoidable overlap within some of the themes given the interconnected basis of the existentials.

Throughout the interpretive process, I paid attention to each existential pillar and stayed open-minded about not making the data 'fit' into any themes. There are more than four lifeworld existentials, as mentioned in section 6.12, but the four presented here were the most meaningful to foreground the participants lived experiences. By being immersed in the data, it became apparent that relationality was the more dominant; therefore, I chose to write about this last to ensure each of the existential pillars were given sufficient consideration. In the following lenses/sections, I also critically explore the findings through consideration of the wider literature.

11.4 Guided existential reflection, Lived Time | Temporality

First, I turn to temporality. In phenomenology, this refers to lived time. Heidegger builds on Husserl’s work of temporality by linking it to Dasein. Heidegger states that temporality is fundamental to our Being as it shapes our understanding of ourselves and the world, (see section 5.2.3). Heidegger believed that existence is always oriented towards the future, influenced by our past and experiences in the present (Heidegger, 1962).

In this study, temporality shaped the participant's experience of getting help. It was pivotal in the lifeworld of students seeking support for their mental health, as they had to find the right time for them to

realise that they needed help. Therefore, it felt appropriate to start the discussion with temporality as the first lens for interpretation.

11.4.1 It's now or never

The timing of mental health awareness in universities is important for several reasons: academic success, early intervention, reducing stigma by creating supportive environments, improving retention rates and developing life skills (Sampogna et al., 2017). The findings in my study highlight the timing of seeking support was a fundamental aspect of the journey for each participant. Timing was experienced differently as some participants felt they were in crisis when they received help; others felt there was an urgent need to seek help to avoid getting to a crisis point. In contrast, other participants put their studies before their mental health and waited until their academic work had been completed before seeking help, despite knowing that their mental health was declining, and that this was having an impact on their capacity to study.

The findings of my study emphasise the importance of timely support. This is often underrepresented within existing literature. Brown and Ellis's research (2019) clearly evidence the value of student mental health support, but there is a gap in our knowledge about their experience of the time between their first contact with mental health services and that first appointment. My study highlights how that time is experienced and the momentum that builds for the person. The data suggests that students will often allow their difficulties to build up before reaching out for support. Participants frequently described having the now or never feeling following a period of contemplation.

This challenges the assumption that getting early help is what people want. Of reflection and contemplation before seeking any help. Considering this now or never perspective it must be noted that our limitations to my study. Although typical of phenomenological methods the number of participants I interviewed was small therefore not generalisable.

In addition to discovering the participants' experience of the 'now or never feeling' having an awareness that participants mental health had declined was also described. Awareness of a problem is a starting point; however, the indicators of mental ill health have a more minor role than expected in initiating help-seeking due to everyone not having the same level of insight (Jorm et al., 1997). This temporal, heightened awareness of poor mental health was evident in the current study, as some participants had insight into struggling with their mental health. In contrast, others did not realise it was a mental health problem they were experiencing. The findings in my study resonate with Gorczynski et al. (2017) who found that students often struggle to identify symptoms and know where to seek help. Furthermore, my study extends the work of Oates et al. (2020) who found that several students in their study required a certain level of confidence to enable them to seek support for their mental health. Likewise, here in this study, participants did not always have the confidence or insight to recognise the severity of their mental health experiences therefore delayed seeking support.

Jorm et al. (1997) developed the concept of 'mental health literacy' and explain that this includes recognising the signs of mental

ill health, its causes, treatment, and knowledge of how to seek support. Raising mental health awareness has been shown to increase mental health literacy and has led to positive implications for help seeking and destigmatisation (Haslam & Tse, 2025). Gorczynski et al. (2017) also found that the experiences of UK students' mental health literacy were comparably lower than those of other countries, and they suggested that overall mental health literacy in the UK was low. Yet in my study the main issue was the timing of getting support and building up the courage to go and seek support, rather than being unaware of mental health problems.

Younger people are more inclined to seek help for mental health problems if they have some knowledge about mental health issues and how to seek out help (Clarkin et al., 2024). Kessler et al. (2007) argue that adolescence (including the university demographic) is an opportune time to enhance and embrace mental health awareness and increase mental health literacy, as most mental health problems present themselves before age 20. This resonates with my findings but my interpretation being presented here is about the timing of when people should develop mental health awareness and increase their mental health literacy. Mental health literacy is pivotal in the trajectories of people with mental health problems (Tsao et al., 2008). Therefore, changing behaviours early can help to mitigate other risks to mental ill health later in life (Tran & Silvestri-Elmore, 2021). When considering temporality through a phenomenological approach, we must accept that experiences are affected via the past as well as the future (Merleau-Ponty, 1962) Therefore, implementing mental health

awareness to enhance literacy as early as possible will aid the promotion, prevention and protection of students mental health, whilst also appreciating that a participants past may not have always been positive in relation to mental health.

Although my findings align with Jorm's (1997) framework for mental health literacy, particularly in how participants recognised their own mental health decline, Jorms model was developed from a public health perspective, emphasizing individual knowledge and attitudes towards help seeking. In contrast my data highlighted the significant influence of cultural factors and the structure of the university course on participants mental health literacy and help seeking behaviours. Therefore, whilst Jorm's framework is valuable my data indicates there is scope to expand it to better reflect the experiences of university students with their mental health problems.

11.4.2 Readiness to seek help

As mentioned above, for some participants there was a palpable 'now or never' moment, with participants taking the first step in seeking help. This moment, where the urgency of their situation became apparent, was a pivotal point in their journey of seeking help. Some participants found it difficult to seek or accept that they were either relapsing or showing signs of mental ill-health due to their lack of readiness to seek help. Giamos et al. (2017) note that students differ in their readiness to seek help; some feel they are not entitled to such help. My systematic review (chapter 4) highlighted that students with mental health problems were, at times, reluctant to get help (Quinn et

al., 2009). Yet seeking help is one of the first steps in getting treatment for mental health needs (Tomczyk et al., 2020). These insights also resonate with those by Broglia et al. (2021) who found that once students had gone through a period of pre-contemplation to explore if they needed help, they explored their options and accessed help from university mental health, online self-help, the NHS or peers and family. However, help-seeking is not a simple process of experiencing psychological distress and approaching others for help (Rickwood et al., 2007).

In nursing, clinicians explain a client's unwillingness to change or to comply with a medical regimen as a ‘lack of readiness’ (Dalton & Gottlieb, 2003). Conversely, readiness is about bringing about a change rather than our simply being ready for change, and it can be based on feelings of perceived ability (Dalton & Gottlieb, 2003). Therefore, this creates a new argument as several of the participants in this study were in a pre-contemplation state as they were pondering whether they needed help. This resonates with the transtheoretical model of health behaviour change (Prochaska & DiClemente, 1983), a circular model representing six stages of change (pre-contemplation, contemplation, preparation, action, maintenance, and termination). Whereas other participants had a palpable urge to act and could be placed in the action part of this cycle. It is evident in the voices of the participants that they were in various stages of the cycle of change. Acknowledging these temporal moments could improve the students' experience if interventions targeting mental health awareness to increase literacy were available early in the student experience of

starting university. Therefore, readiness to seek help can be facilitated once students find themselves ready to act.

Students today expect more than merely traditional lectures when attending university; they seek a holistic experience that supports academic experience and expect accessible and targeted mental health support. Therefore, enabling universities to distinguish themselves from competing institutions in the provision they offer to support student mental health and wellbeing. Offering comprehensive wellbeing services not only reflects a university's commitment to student mental health and wellbeing but it also positions them as a forward-thinking establishment. This looking forward in time anticipates the future of student wellbeing services but also allows students to have an awareness of how student wellbeing services can support them during their university journey whilst simultaneously managing expectations of what a university wellbeing service can offer.

11.4.3 Students' expectations

The findings of my study highlighted that students had expectations when accessing support for their mental health needs. One participant in my study spoke of his dissatisfaction of having to be 'put through to duty' as the wellbeing staff member who he had previously seen was not available. Similarly for the academic element of universities, Yang et al. (2020) add that students have high expectations about how course tutors talk to them and believe that tutors should be available outside of class for prolonged periods. The current student age demographic is predominantly those born between 1980 and 2000 (the millennial generation). Of the participants in this

study, all but two were millennials (Joanne and Jamie). Each participant expected access to a suitable level of care when they accessed the university wellbeing service. Managing student expectations has complexities of generational cultures influencing expectations. Ramsden (2008) concede that students' current expectations have led them to assume greater staff availability and high-quality student support services.

Millennials, also known as Generation Y, are reported to differ from previous generations by acting in an entitled way (DeVaney, 2015). Millennials currently make up the second most prominent part of the workforce and have brought both positive and negative changes to the workforce (Ngotngamwong, 2019). This is noteworthy as once students' complete university they usually seek paid work opportunities, so skills obtained at university need to be transferable to employability. Twenge and Campbell (2001) described millennials as having positive traits, including self-esteem and assertiveness. In addition, several employers have claimed that millennials are more demanding regarding the work-life balance (Caraher, 2016). To obtain a work-life balance, one must engage in social activities at work and non-work life, as engagement in multiple roles facilitates high performance (Sirgy & Lee, 2018). These are skills that can be fostered during the student time at university to prepare them for work life balance when working. Therefore, millennials, such as many of the participants in my study, demanding work-life balance could be good for future employers and a strategy that can be adopted at university, given that students are already wanting more than just a degree from

their time at university. This strategy, could in turn, enhance their mental health and wellbeing.

However, Deal et al. (2010) found that older people sense that younger people (millennials) have poor communication skills, act entitled, and are service-focused. They also acknowledged that older generations have a similar view of younger generations over significant age gaps. Traits attributed to this age group contrast with previous generations, such as Generation X being self-reliant, ‘baby boomers’ being workaholics, and the silent generation being patriotic (DeVaney, 2015). However, labelling millennials negatively is oversimplistic and does not reflect the ever-changing education landscape.

This study has revealed a nuanced landscape of student’s high expectations of access to mental health support at university. My study found apparent generational difference between the younger ‘millennial’ students who seemed to have higher expectations than older students who emphasised their self-reliance, privacy, and a "just get on with it" approach. These idiosyncrasies suggest that expectations are shaped by our socio-cultural background. Drawing on Karl Mannheim's theory of generations (1927) helps to understand the impact that formative experiences of childhood differ across generations. For example, the younger generations have grown up with more exposure to mental health awareness and acceptance of mental illness.

In contrast, participants from older generations may have experienced more stigma towards mental health conditions. This generational gap in expectations raises questions about equity and

inclusivity for mental health services at universities based on their previous experiences of how mental health has been portrayed. This study brings new insights that designing services should be accessible to all ages and avoid privileging the expectations of students who have high expectations.

Expectations of university start before students embark on their degrees, and there is evidence to describe student expectations as unrealistic (Hassel & Ridout, 2018). How expectations are generated and managed plays a pivotal role in the university experience, impacting the student's trajectory for academic success (Yang et al., 2020). As mentioned above, university students want more than just lectures. In my study, once participants realised that help was needed, their feelings and expectations became apparent. One of my participants felt ‘let down’ when she described calling the wellbeing team up daily for a week and failed to get an appointment. In contrast, another participant who did have an appointment for her mental health was keen to know what other services were also available for her, just out of curiosity.

The diverse previous experiences of education or hearing about other people's university experiences shapes the expectations of students. Moreover, attending open days, viewing corporate websites, and marketing campaigns also influence student’s expectations (Yale, 2020). As mentioned above, Heidegger (1962) as well as Merleau–Ponty (1962) articulates that the past influences the future. While it is becoming the norm that university services attend open days to showcase what support student can receive at university. The

students' expectations of support underscore the importance of universities managing the expectations of current and upcoming students of different generations, particularly as millennial students may be more likely to complain if support services such as mental health and wellbeing teams do not compare to services outside the university (BMA 2017). Therefore, universities must be equipped to manage the expectations of students of different ages whilst also providing opportunity to develop employability skills, mental health literacy and a wraparound service to manage any other issues that students may experience outside of their course.

Traditionally, the aim of education has been the facilitation of learning, which should be a constructive, tentative change that reflects the current affairs of society (Rogers, 1990). However, education is now falling into the consumerist slant (Norris, 2020). To add to this notion, UK students are viewed as consumers and increasingly pay more for their university fees. In addition to this, students now have higher expectations and exhibit increased consumer behaviour whilst being more vocal about their needs than in the past (Naylor et al., 2021).

The consumerist view depicts education as something to be purchased, and the buyer is therefore entitled to a high-quality 'product' (Morris, 2022). Since the increase in university tuition fees was introduced in 2006 by the Labour government, students have identified themselves as fee-paying customers wanting value for money for their course and overall university experience. University tuition fees have led to increasingly competitive higher education sectors to be more

responsive to students' needs (Jones, 2006). Besides, universities are also businesses competing against one another, mainly due to the government applying capitalist economic principles to higher education (Molesworth et al., 2009). In addition to this there is significant stakeholder commitment from central government and taxpayers who are keen to see value for money. This notion of students as consumers is situated in the broader context of multiple social and policy changes over the past 30 years (Morris, 2022). Universities must embrace this concept to help manage expectations (Jones, 2010) and to entice new and retain current students. Yet here in my study, the findings do indicate a shift in student expectations across generations as mentioned above. Yet the more consumerist relationship with higher education out forward by Molesworth et al. (2009) did not feature in my findings. Effective support and responsiveness to asking for support was included in my findings but value for money was not mentioned. Therefore, the notion of students being positioned as consumers rather than learners did not have as big an impact with my findings than in the work of Tomlinson, (2017) and Molesworth et al, (2009)

Additionally, to students changing expectations, the widening participation agenda, demographic trends and the lifting of government stipulations on numbers have fuelled this competitive drive among universities (Morris, 2022), so managing expectations and students believing they are getting value for money has never been more important. The NSS (NSS; an annual UK wide survey that obtains feedback from final year undergraduate students about their university experience) was launched in 2005 as a framework for quality

assurance for higher education (Arthur, 2020). Students' experiences being measured by the National Student Survey (NSS) adds to the consumerists' approach of assessing satisfaction rather than engagement with their studies (Gibbs, 2010). The NSS provides prospective students with insights into the quality of courses and individual higher education institutions based on current student feedback. In addition to this it helps universities to improve their student experience and enhances accountability as the results are made publicly available (Tomlinson, 2017).

The NSS suggests that student experience is now at the front of UK university strategies, and institutions are aware of the need to respond positively to increasing consumerist views of higher education (Levy & Roberts, 2005). The University experience is not merely about obtaining an education; the additional extras found in accommodation, student support and wellbeing services are also expected, as elicited here in my study too, yet no mention of value for money was evident in my findings. With the increase in mental ill health and low levels of wellbeing among university students (Thorley, 2017), more support is expected from student services. Therefore, embracing early opportunities to showcase and offer wellbeing support to help manage the expectations of students, entice applicants to choose their HEI whilst also supporting the mental health literacy of the student body can only be a positive for student experience, attrition and enrolment. These expectations need to be managed by universities who are juggling quality of service delivery against student expectations and satisfaction

11.4.5 Waiting list

My study found a variation in students' experience of waiting for mental health support. There were inconsistencies in the responsiveness to accessing support, as well as in how students perceived it. Some participants reported timely and seamless access to mental health support, whilst others described delays that exacerbated their distress and led them to seek support elsewhere. The frustration expressed by participants in my study aligns with growing expectations for timely and accessible mental health and wellbeing support. As mentioned earlier, this is heavily influenced by the consumerist views prevalent in higher education. Students now seek a student experience rather than just a university degree, yet they still require mental health support, which universities are offering, albeit with very little guidance. Therefore, the findings highlighted in my study, along with the current picture of students' mental health support in universities, create a new insight that indicates a complex interplay between student expectations, systematic pressures, and a lack of guidance for implementing mental health support.

Universities do accept that they have a role in student mental health, but they cannot do this alone (De Pury & Dicks, 2020). Over the past few years, mental health provision has increased in universities, but public funding was not feasible due to the student numbers expansion; a lot more money was required than the government could provide (Morris, 2022).

Students are often signposted to university support and presume that they would be supported quicker than in NHS services,

despite universities having poor staff-to-student ratios within student wellbeing services (Brown, 2016). My study found that some participants felt their wait for student wellbeing support was longer than the NHS wait times. However, five days to one person was 'really good' but felt like a 'lifetime' to another. According to a report from the Royal College of Psychiatrists (2022) 23% of patients wait longer than 12 weeks to start NHS treatment for mental health issues. Furthermore 43% of patients feel that this waiting contributes to a decline in their mental health and 78% seek help from emergency services. The report also attributes these issues to an insufficient workforce noting that there is only one consultant psychiatrist for every 12,567 people. Additionally reduced funding for NHS mental health services coupled with an increase in demand has resulted in long waiting times raising concerns about the impact on both physical and mental health (O'Dowd, 2017). As a result, while student expectations remain high, NHS service provision is overwhelmed and collaboration between the NHS and university wellbeing teams is limited.

Batchelor et al., (2019) and Broglia et al., (2018) both found that students reported experiencing long waiting times for university support and were expecting to be seen within one week. Further, in 2019, the Guardian newspaper reported that the longest wait time for university mental health support was 7.5 weeks (Campbell, 2019). Yet, here with the participants the perception of a long wait remains nuanced to each person waiting. This resonates with managing expectations, as mentioned earlier in the chapter. My study contradicts the literature that states that waiting times are lengthy as these

participants were offered help in less than a week. The issue appears to be the perception and tolerance of waiting, amalgamated with students' high expectations from a university wellbeing service. Furthermore, there has been a noted increase in the requirement for university mental health services (Hanson, 2015).

In addition, in having to wait for support, some participants were unsatisfied that they had to be referred to other external services when they needed help. Byrom (2014) found that mental health advisors from university wellbeing services expressed struggles and frustration in referring students to specialist services too. They acknowledged inadequate NHS mental health provision for students as a client group and that the NHS were not set up to support students making the transition between home and university.

However, there are links being developed between universities and the NHS, as several universities within the Northwest alone have now teamed up with their local NHS services to help bridge the gap between university support and NHS care to help improve services for students and reduce the burden on GP services. The Greater Manchester Mental Health NHS Foundation Trust created a landmark service for Greater Manchester University students in collaboration with the five universities in the region, the Greater Manchester Health and Social Care Partnership, and clinical commissioning groups. The aim of this network is to provide proactive mental health assessment support and interventions to help students manage their mental health problems. They planned to do this by partnering with the universities' already established student service providers to generate new

pathways between NHS services and HEIs to assist with access issues, waiting times and student satisfaction (Greater Manchester Mental Health NHS Foundation Trust, 2021). These changes reflect the evolution in university mental health provision and expectations from students that mark a temporal moment in the development of education.

These changes also resonate with the university's mental health advisor role not being a replacement for NHS services. However, the relationship between NHS services and universities requires further examination as Broglia et al's (2018) study found mental health advisors had become the second largest form of low intensity support in multiple university wellbeing services. Therefore, establishing good working relationships with NHS services whilst ensuring that services are not duplicated would be beneficial. The findings of my study build on Broglia's work as the participants in my study did not mention that the University wellbeing team was a substitute for NHS provision, they reported it as complementary or a form of interim support to address their mental health needs. This distinction reflects a nuanced understanding of the boundaries between HEI's and the NHS. My participants frequently expressed awareness of, and limitations of, university-based services and were sympathetic to wait times. This challenges the thought that students are coming to university with the consumerist attitude of value for money, a whole university experience and timely high-quality support for mental health needs. Instead, my participant expectations appear grounded with recognition that universities can only do so much and that the NHS services are there

in addition to what the university can offer. Therefore, this creates new insights to explore if universities are inadvertently advertising themselves as providers of mental health and wellbeing care, this is not what students are looking for. Therefore, it is important to strike a balance of being open with what universities can offer whilst also highlighting that they are not a replacement for NHS mental health care.

Guidance for universities in supporting students with mental health problems, although sparse includes a safer university guide and the University Mental Health Charter (Balogun & Garrat, 2022). The Student Mental Wellbeing in Higher Education Good Practice Guide (Universities UK, 2015) also provided guidance targeting senior leaders and managers to help promote mental health and wellbeing support in their universities. Furthermore, since the implementation of the University Mental Health Charter (UMHC), there has been an increase in universities, fifteen in total, that have been awarded UMHC status along with evidence of widespread innovation and good practice since the development of this framework (Zile et al., 2024). Nevertheless, it remains a complex and large task to embed a whole university approach to supporting student mental health whilst also working alongside NHS services to ensure students receive the right care, from the right service at the right time. If this could be achieved, waiting times for both students and the users of public mental health services would improve and therefore lead to better outcomes, better health and higher student satisfaction.

11.4.6 Summary

Temporality has been explored as a reflective theme. The aim was to convey that time is not a fixed entity but rather a fluid and dynamic concept. This perspective on time significantly shaped the participants experiences. Here I have explored that there was a build up from the participants who needed to be ready to seek support and once the time was right, their expectations were high and attitudes towards waiting differed across generations who accessed support. I then explored how NHS waiting times and the frustration of using NHS services impacted the participants experiences. I will now discuss the next existential - corporeality.

11.5 Guided existential reflection, Lived body – corporeality

Corporeality emphasizes the physical experiences of students, examining how their lived experiences while seeking support impact their bodies and influence overall experiences. The embodiment of the experience reveals the ways in which students express their emotions and physical sensations, underscoring the centrality of the body in the lived experience. As Merleau-Ponty (1962) notes, the body serves as a vehicle for being in the world. The data from this study articulates the participants' feelings and behaviours concerning their experiences of seeking support, with instances such as crying with relief being notably described.

11.5.1 A weight has been lifted.

Several participants in my study reported moments of emotional release characterised by crying at various points in their journey to seek help. According to Simons et al. (2013), crying is an authentic

expression of deep emotion. Notably people cry in response to positive feelings such as relief, fulfilment, and happiness (Miceli & Castel Franchi, 2003). Bylsma et al. (2008) further note, that crying is often associated with catharsis, relieving distress, an idea that dates to Sigmund Freud's formulations in 1915 (Nyklícek et al., 2004). This sense of relief after seeking help was evident among the participants in my study. One participant, Joanne, said she felt like a weight had been lifted from her shoulders due to the relief she experienced, signifying the transformative power of this emotional release.

Moreover, crying is an inherent behaviour that calls for caregivers and continues to be a behaviour of attachment throughout life (Bowlby, 1969). Crying can influence people's impressions of a person crying and is often associated with incompetence and weakness (Simons et al., 2013). Likewise, criers may evoke awkward feelings in the observer, leading them to withdraw (Hendriks et al., 2008). Bylsma et al. (2019) further note that a person's response to someone who is crying can impact the mood of the individual crying. This was evident with Zena; she reported that she felt embarrassed that she cried in front of her tutor. Likewise, Sammy was frustrated, and the response of the person she spoke to on the phone led her to cry.

Nelson (2005) emphasizes that the issue with crying is not a lack of emotional control but emotional closeness. Bowlby (1969) explains the act of crying is not just about expressing feelings but also about inviting others into our emotional spaces. They note that crying is one of the attachment behaviours exhibited by infants, keeping

caregivers close and ensuring that their needs are met, therefore establishing and maintaining an attachment bond. This insight is particularly relevant to my study, as many participants reported crying in the presence of, or whilst on the phone with, someone they were seeking support from. Some of these participants already harboured fears of being judged. Therefore, how individuals respond to another person's tears is crucial for enhancing that person's wellbeing, especially without fear of judgement.

My findings suggest that students experienced relief and cried when they received support for their mental health. This response helped alleviate the emotional intensity they had built up, putting them in a crucial 'it's now or never' moment. Rather than crying out of distress, this reaction can be seen as an inherent behaviour. My participants described instances where their tears emerged after feeling validated, understood, or helped. This aligns with the work of Katz et al. (2024), who, from a psychotherapy perspective, noted that crying in a therapeutic context can often signify a turning point in emotional regulation. This suggests that my participants may have also found a release of tension by crying which could have enabled their journey towards recovery.

11.5.2 Self Stigma

The data showed that students feared being judged and expressing their feelings. Robbie described that having shared his experience of depression he felt uncomfortable to be in a class when he had divulged that information. Stigma is one of the most common barriers to seeking help for mental health (Bathje & Pryor, 2011).

Stigma was experienced in this study, but the participants appeared so desperate to get help that it did not stop them. Whilst numerous study's (Chew-Graham et al., 2003; Demery et al., 2012; Oates et al., 2019; Quinn et al., 2009; Tinklin et al., 2005) identify stigma as a barrier to seeking support for their mental health needs, my findings contradict this. Despite it being widely evidenced that stigma can be a barrier to accessing support, participants in my study disproved this as they did not feel stigma was a barrier.

This was a central and unexpected finding in my study as it contrasts with what is so widely known and acknowledged and vastly embedded in wider literature. This interrogation prompts possible explanations and implications for this finding. Firstly, there is an evolving culture of acceptance and more understanding of mental health and wellbeing. Additionally, universities are working hard to implement mental health support, expand their service provision and follow guidance, although limited, on how to foster a whole university approach to mental health. Furthermore, as mentioned earlier, there was a difference in expectations across the generations of students that were interviewed in this study.

From a methodological lens, the participants who agreed to participate in the study had done so on their own volition, therefore suggesting that they felt more comfortable with speaking about their mental health difficulties, opposed to those who struggled to speak about it. As I used semi structured interviews to collect data, I did not explicitly ask about experiences of stigma therefore participants may have underreported their experiences of it. Likewise, participants

largely had a positive experience with the wellbeing service so may have felt uncomfortable speaking about any negative experiences.

My findings also reflect a distinction between stigma and self-stigma. Participants did describe elements of self-stigma. For example, Stella shared her experience of feeling her mental health problems were not as bad as other students' problems, leading her to feel less entitled to help. Self-stigma often originates from societal stigma and can then lead to individuals internalising these stigmatising public opinions (Corrigan, 2004). Self-stigma, therefore, occurs when a person moves from having an awareness of public stigma to agreeing with it and applying it to themselves (Corrigan et al., 2009), in a form of self-fulfilling prophecy. It is a transformation process whereby a person's identity is progressively replaced by a devalued, stigmatised view, known as 'illness identity' (Yanos et al., 2008). Another rationale may be that is participants perceived their mental health concerns as manageable or not as bad as other (as stated by Stella above), stigma may not actually be a dominant factor in their experiences.

Therefore, this suggest that it may just be based on assumption that stigma is still a main barrier to seeking support. If this no longer is a major barrier, resources and research could change focus and be redirected to managing expectations, access and service delivery to support mental health needs.

11.5.3 Identity

Students form their identities in relation to academic success and social belonging. As mentioned above some of the participants in my study spoke of the self-stigma they experienced, this can become part of their self-concept therefore their identity.

Identity is constructed through physical embodiment. The idea of identity has advanced since being developed initially by Erik Erikson (1968). In higher education, the notion of social identity indicates that belonging to a university community is linked to positive wellbeing outcomes, such as increased self-esteem, greater life satisfaction, and reduced levels of depression (Cameron, 1999). Biggs (2001) supports this idea by stating that a student's identity is shaped by their learning experiences, which influence their sense of self and their life choices. Two of the participants in my study, Imogen and Stella, had the added complexity of caring for their dads. So, at the same time as developing their student identity, they also had the caring identity pulling them in another direction, whilst also experiencing their mental health problems.

Wenger (1999) further accentuates that learning is an identity-forming experience that transforms us and what we can accomplish through active participation. Sung (2021) argues that students engage in social relationships with different communities through participation and non-participation and construct their identities accordingly. Nevertheless, in my study, some participants were grappling with extra caring responsibilities and mental health problems whilst also trying to have a university experience during a period of transition. In a

university setting, what was pertinent in this study was students meeting new people, experiencing different cultures, and encountering new experiences, all of which assist them in forming new identities as they navigate the transition to university life, often accompanied by a threatened sense of self.

Therefore, universities offering more support and opportunities than during their studies can help students form a sense of identity with the university, establish these new relationships and experiences and develop their sense of self.

11.5.4 Transition

The findings from my study found that some of the students struggled with transition. Reference was made to previous support received in college and how this different to the support at university. Ashish too also referred to moving universities and commented negatively on his previous experience. Yet in contrast to my study, much of the existing literature focuses on the transition of academic skills such as time management, academic level and preparedness, whilst these are instrumental in the impact of transition, it can overlook the social, emotional and identify aspect of the student transition. Without focussing on these aspects there is little understanding of the complexities experienced by students with mental health problems. Studies are available that identify this is a stressful time (Worsley et al., 2021), yet as identified by (Cage et al., 2021) there is limited work that has captured the experiences of students who do transition.

Yet the transition to university is significant for students' success, confidence, wellbeing and feelings of belonging (Bolton &

Hubble, 2020; Thorley, 2017). As mentioned above, the transition period for some students was unsettling. The relationships students had with their college or school before attending university was explored during the interviews with some participants. They acknowledged the support they received at school or college before elaborating on what they were experiencing at university. Azmitia et al., (2013) explains the transition period of moving to university can destabilise a person's identity as mentioned above. Yang et al. (2020) also asserts that making this transition to the higher level of education can be stressful and impact students' mental health. Broglia et al., (2021) adds that undergraduate students may have left their families and friends for the first time and be exposed to new languages, cultures, and experiences and therefore struggle to adjust. There are also new academic environments, social networks, new responsibilities and personal freedom to contend with.

The existential experience of transitioning to university involves a shift in the student's lifeworld as they encounter new experiences; their Being-in-the-world will now be potentially influenced by new cultures, academic environments and expectations of self and others. Furthermore, new relationships developed during this time can foster or hinder growth and development, Heidegger postulates that our interactions with others (our 'being-with') are fundamental to our Being (Heidegger, 1962). Martin & Atkinson (2020) found that students were trying to reinvent themselves during this transition whilst coming to terms with their experiences; therefore, having positive relationships is essential.

Navigating transitions can be emotionally demanding, particularly in the context of student mental health (Cage et al., 2021). To reduce the negative consequences that can beset a student during their transition to university, it is important to understand their experiences and explore what resources they have available to them. Before a student even starts the transition to university, the wellbeing team, with consent, can liaise with the student's current team to explore how this support can be maintained or transferred.

This principle can be applied to support the transition into university too, offering help and guided discovery of a person's needs before they start can help to establish relationships and socialise an applicant into becoming an enrolled student. Failing to manage expectations of students, who are typically now expecting more, can lead to complications later. Therefore, universities providing support prior to transitions may enhance the overall student experience. As my study mentions the relationships with people who had helped before university were meaningful for the participants transitioning to higher education.

11.5.5 Summary

This section presents my discussion using the interpretive lens of corporeality. It has also provided a critical interrogation of my findings with the current literature. The exploration has appreciated how the lived body is central to the experience of seeking support. The physical sense of relief via crying and the challenges of dealing with the identity changes created by starting university were explored. The participants in my study almost had a dual identity with being a student

and having a mental health problem, and for two participants, a caring identity for their fathers. The issue of identity also led into the issues surrounding transitioning to university too. Next to be explored is spatiality.

11.6 Guided existential reflection, Spatiality | Lived space

Spatiality was another guided theme from Merleau-Ponty's framework for interpretation and analysis that was evident in the participants' accounts. Spatiality refers to perceiving and understanding the physical space and how it is organised, experienced and represented. It is more than just a backdrop for moving around; it also shapes the experience of getting help for mental health needs. Van Manen (1990) describes spatiality as being largely pre-verbal and influencing how we feel and interact with our surroundings. The lived environment played a role in all participants' experiences and was a noticeable part of the lived experience of getting support for mental health problems at university. Where help was sought and delivered mattered deeply to the participants.

11.6.1 A therapeutic landscape

In my study, participants reported they felt like they were in a 'fishbowl' when they sat in the library waiting for their appointment with the wellbeing team; this feeling of being exposed added to the participants' anxiety and perceived vulnerability. Participants in this study could also recall a row of grey chairs that they felt everyone knew what they were for in the 'exposed' waiting area.

Massey (2013) suggests that how we think about space matters as it shapes our understanding of the world, our attitudes and how we

develop as people. Heidegger articulates that we are already physically immersed in the environment whilst interacting with others and objects (Heidegger, 1962). Therefore, a sense of place can be described as the emotional attachment to a geographical space (Banning et al., 2010). Dibley et al. (2020) articulate that a place is not just the where of something; it is the location plus everything that occupies that location seen as an integrated and meaningful phenomenon. A therapeutic landscape is a metaphor that describes a place where the physical environment and human perceptions combine to create an atmosphere conducive to healing (Gesler, 1996). Despite recognising that learning environments can enhance wellbeing, limited research has explored students' perceptions of this (Stanton et al., 2016). Participants here had experiences mainly of the library as their space to access their support.

Strange & Banning (2001) stress that attention to design in learning spaces is indispensable. For example, seating arrangements can either promote or inhibit social interaction; the physical environment can send messages of support and, therefore, bring a sense of belonging, role, value and worth and therefore enhance the ability to cope with educational stress. As a university is a learning environment that offers wellbeing support, a new angle is presented here to draw attention to how a space needs to be a supportive space. McCormack & McCance (2016) highlight that place, as a concept, impacts care experiences.

There are many parallels between health care and the delivery of student services. Attention to place in care relationships is

necessary as space and place are relational, places have deep connections with the 'self', and spaces are embodied. This can be described as a therapeutic landscape. This resonates with Lawson (2001), who confirms that people are acknowledged in space by what they are wearing, how they smell, the manner of their walk, facial expressions, and where they choose to sit.

Participants in my study reported that the university environment played a pivotal role in the support seeking experience. By this point participants had developed the readiness to seek help had the expectations managed, explored waiting list, and actively sought help. Also, although there were some elements of self-stigma participants did feel a weight had been lifted off their shoulders. The identity related risk and the challenges of transitioning to university with a mental health problem had also been acknowledged therefore now I move on to the experience of the landscape where students experienced help.

There is existing literature that identifies environmental factors like accessibility and visibility being influential in help seeking behaviours (Gulliver 2010 and Eisenberg et al 2009). My study extends this conversation by exploring the lived experience of how the environment played a role in obtaining help. Surprisingly to me yet significant in the students experiences the new dimension that my study brings is the physical design of the spaces were help was experienced.

Whilst much of existing literature frames help seeking as a decision-making process with the name barriers tending to be stigma

lack of awareness and motivation (Rickwood 2005). There is limited literature available that looks at the lived experience of seeking support and illumination being brought to environmental conditions that shape student experiences.

11.6.2 The Library

The library has traditionally been viewed as the heart of a university, despite some predictions that online services would reduce demand for physical libraries (King, 2000). Due to the variety of services often offered at a university library, in my study, placing a wellbeing service in a library offered normality, familiarity and anonymity to those waiting in the area to seek help. This 'one-stop-shop' helped participants receive support quickly and they reported less fear of judgment for being there. King (2000) postulates that the library is an integral aspect of the university experience for students Therefore using a familiar and normalising space with multiple uses, such as a library, helped participants feel at ease and 'normal' about accessing support.

The concept of the "third place" was introduced by Oldenburg in 1989 to describe a setting that exists beyond home (the first place) and work (the second place), where individuals can relax and enjoy the company of others on a regular basis. Oldenburg (1989) outlined the various functions that third places serve, including fostering community, welcoming newcomers, connecting individuals with similar interests, a place to assemble, promoting community and diversity, and offering spaces for enjoyment and entertainment, as well as intellectual discussions (Oldenburg, 1997). They often also serve as

informal offices. These locations play a crucial role in facilitating space particularly for university students and help cultivate place attachment or a bond with the environment (Waxman, 2007). Waxman (2006) found that individuals who regularly visited a third place often developed strong feelings of attachment not only to that specific location but also to the broader community.

Su (2018) builds on this to articulate that dialogic spaces are beneficial and are characterised by a sense of the 'at-homeness' and ‘warmth' – thereby conceptualising dialogic spaces as learning spaces due to the warmth emerging from support and mutual concern, as experienced by the participants in my study. Therefore, including a wellbeing service in the library would meet Oldenburg’s description of a 'third space'. This would appear to be a sound choice by universities, as these concepts could easily be embedded into university environments to help provide a therapeutic landscape for those needing mental health support.

Whilst my study articulates that “it is just the library” and students feel more at ease accessing support there a limitation of conducting a phenomenological study is that it inherently limits the generalisability of the findings. As phenomenology prioritises subjective meaning and seeks to understand lived experience it highlights the nuances across each individual experiences. So, when suggesting changes that will affect the whole student body it’s important to recognise that I had a small number of participants that were purposely selected for this study therefore before any changes

are made service users students must be consulted before these changes are made.

11.6.3 Virtual space

Space refers not only to the physical environment but also to the virtual environment. Multiple virtual ways to access help were noted here in my study; some participants preferred telephone calls due to the sense of relief they reported or emailed to get in touch to access support. The anonymity offered by virtual contacts was helpful for Zena, who reported that a phone call was much more manageable and accessible for her. This helps with access issues and the urgency for a safe and non-judgmental space for those seeking help from their chosen environments using their preferred platform (Gulliver et al., 2018).

Bullingham & Vasconcelos (2013) postulated that online environments allow users to present their different 'identities' via physical detachment to make it easier to conceal aspects of themselves that would otherwise be visible in person and suggest this may be Goffman's (1972) 'splitting' during an interaction. In Goffman's framework, splitting refers to individuals separating the various aspects of their identity based on the social situation to manage multiple ‘selves’ for different audiences. Vaast (2007) claims this to be a creation of 'new selves' online. Goffman (1972) penned the concept of 'face and self' and explained that 'the face is something that is located in events for appraisal' (p. 45). He adds that the face never belongs to the holder but to society, and so is a social face. In his seminal work, he claimed individuals perform to project their desired

image using their 'front stage and backstage behaviour'. Having the option and perceived security to use a 'mask' allowed participants to accept the help that they would not have done so if the only option was to go in and have a face-to-face interaction. As mentioned, participant Zena found talking on the phone much more manageable as this enabled the use of the ‘social face’.

11.6.4 Conclusion

Here, spatiality has been explored, both in the physical and online spaces that are now commonplace at universities. Context has been provided into the historical theory of space and how space helps shape participants' experiences. The familiarity and normalness of the library offered comfort and accessibility to some participants. However, the exposed waiting area made the participants feel that they were in a fishbowl and easily identified as someone waiting for the wellbeing team. Furthermore, the utility of having a virtual environment allowed for the concept of face and self to be embraced; this highlighted the ease of accessibility in speaking about mental health problems. Therefore, having both online and face-to-face help for the wellbeing service would be most beneficial for people accessing the service.

The next lens that is presented is relationality.

11.7 Guided existential reflection, Relationality | Lived relationships

Relationality refers to the way people experience their lifeworld through relationships. Here, using relationality as an interpretive lens helped me to look at the interconnections between individuals and

groups and how these interactions share and influence the students' experience. Relationality was the most prominent theme illuminated when interpreting the data. As mentioned earlier, I presented this theme last to allow the three other guided reflections to have sufficient consideration.

11.7.1 Person centeredness

Unsurprisingly, a person-centred approach was a further pivotal point to all participants' experiences and the environment. Numerous participants repeatedly used the word 'lovely' to describe and express their feelings towards the wellbeing staff member they sought support from. Seeking support for mental health was also primarily influenced by the relationships the participants had either made or already had established; it was evident that each participant had some form of relationality embedded in their experience of getting help.

Person centredness is also broadly associated with the value of the therapeutic relationship. Wright (2021) articulates that the therapeutic relationship is central to nursing practice. Like how student services operate, Bordin's (1979) theory on the therapeutic relationship crafted a three-concept model. This model incorporates mutual agreement regarding the person's stressors, a collaborative approach to the tasks set, and a basic level of trust, which is required to help strengthen the relationship (Bordin, 1979).

Person-centeredness has many interpretations due to the philosophical concept of 'person'. These interpretations of 'person' influence how theoretical frameworks are developed and applied (Entwistle & Watt, 2013). This allows for person-centeredness, often

associated with nursing and healthcare, to be practised broadly (McCormack & McCance, 2016). Person-centeredness is closely associated with personhood. As Dasein is characterised by the ability to be aware of its own existence, self-awareness is a fundamental aspect of personhood. Leibing (2008) articulates that personhood is the inner feeling that guides a person; this resonates with Merleau-Ponty's (1989) views on perceiving the body in the world, that no one is a passive recipient of their history, therefore suggesting person-centeredness is always required. Personhood is a set of physical and psychological attributes a person may lose when unwell. McCormack & McCance (2016) offer the example of a person with dementia losing their language skills, thus reducing engagement with living communication and increasing loneliness and isolation. For the participants in my study, this was them being unwell with their mental health and therefore losing their attributes of self, temporally. So, adopting a person-centred approach in university and their wellbeing services can only be positive. This notion of person-centred care being implemented at a university is novel, if adopted by the whole university.

The prominence of joy and satisfaction for person centeredness in my findings is pivotal. It underscores how students experienced seeking support for their mental health needs. The attributes of person centredness prioritises autonomy, agency and holistic care and therefore had a positive impact on the support experienced. Whilst person centredness aligns with mental health paradigms, its utility in higher education institutions is what I am illuminating here in my study. Implementation of person centredness in university may be under

prioritised by systematic pressure, lack of resource, lack of suitable practitioners and institutional culture and rigidity. Therefore, whilst being valuable, its adoption into universities requires further research, my study starts this exploration.

Rogers & Freiberg (1994) describe education as a traditional and person-centred continuum. As universities are primarily teaching institutions, they also have wellbeing services, so here I am creating a new perspective to align the principals of person centredness to be influential in the ethos of wellbeing services. The more conventional type of teaching includes the power balance between the teacher and the learner being the 'one who obeys' (Rogers & Freiberg, 1994, p. 210). This traditional model of education offers a hierarchy that gives power and authority to the teacher whilst the student is expected to comply and learn. Yet as described earlier, the millennial generation now have different expectations of education. However, Rogers and Freiberg (1994) advocate for a person-centred approach whereby the teacher is a facilitator of learning, shifting the power balance to encourage students to take an active role in their own learning. This approach fosters a sense of promise and self-worth, as students want to be respected and trusted; therefore, the learning environment needs to be infused with these concepts (Rogers & Freiberg, 1994).

Fostering a person-centred learning environment that includes the wellbeing service can be achieved by giving students more autonomy and opportunities for collaboration, this can lead to enhanced motivation, deeper understanding and engagement. Rogers and Freiberg (1994) also emphasise creating environments that are

infused with respect and trust. This aligns with humanistic education that prioritises development of the whole person.

11.7.2 The role of the personal tutor

The participants provided insight into the ways they accessed mental health support. For many, their initial approach was to seek assistance from friends, family, and tutors, reflecting a common tendency among other students. This aligns with Macaskill (2013) and Tran & Silvestri-Elmore (2021) who also found that students opted to seek help from family and friends or from the internet before professionals.

In my study, some participants accessed mental health support by being directed to the wellbeing service via their tutor. The role of the personal tutor is controversial due to the lack of clarity over what is required and the blurring of roles, Gardner & Lane (2010) highlighted the need to clarify and establish appropriate boundaries between the personal tutor and the student. Mynott (2016) in her paper that is a self-reflection of being a personal tutor, highlights that personal tutors need clarity of what is required of them, as this role is not defined.

Academic and support staff have identified that they are now supporting more levels of mental illness among students, including self-harm, suicidal thoughts, and psychosis (Hughes et al., 2018). The shift in higher education policy encouraging a whole university approach can also place greater responsibility on academic staff too (Hughes & Byrom, 2019). Yet studies are available that claim interactions between tutors and students play a crucial role in the wellbeing of both academics and students (Kiltz et al., 2020).

Furthermore, students believe that the way lecturers engage with them, their availability, approachability, empathy, and communication skills all have an impact on student wellbeing (Baik et al., 2019; Eloff et al., 2021).

Since their introduction, it is argued that the role of personal tutors has expanded to mentoring and counselling in a pastoral capacity (Price et al., 2007); these roles therefore require additional interpersonal skills of empathy, genuineness, and the ability to act when additional help is required (Luck, 2010). Braine & Parnell (2011) consider that having an effective relationship between student and personal tutor is imperative to learning and progression and should be underpinned by rapport, a sense of belonging and trust. Yale (2020) also highlights that students only appreciated the role once in a crisis and felt the tutor was a 'hero' when receiving support. However, with Jamie's experience, he mentioned that he bumped into a tutor in the corridor and asked them for some help, the advice he received was about deciding for himself rather than offering anything more targeted. This could have impacted their relationship, given the abrupt response from the tutor.

Whilst existing literature (Wright, 2021, Hartley et al., 2020) acknowledges the therapeutic relationship as a cornerstone of effective mental health support, my findings suggest that the tutor-student relationship mirrors the depth of a nurse-patient relationship. Drawing on Peplau (1988) theory of nursing relationships as 'a significant therapeutic interpersonal process' my participants consistently reported the value in the relationship they had with their tutors for

emotional and mental health support. This therefore challenges the traditional view that therapeutic relationships are exclusive to clinical settings thus offering a new lens to consider that educators have a significant role in student wellbeing.

11.7.3 Family and culture

As highlighted in my study, the role of the family was fundamental in students getting support particularly for first-generation university students (Azmitia et al., 2013; Blake, 2017; Palbusa & Gauvain, 2017). Family relationships provide unique resources that can lead to students having higher wellbeing by enabling better stress management, engaging in healthier behaviours and enhancing self-esteem (Thomas et al., 2017). Family support and dynamics were featured in the participants' responses in my study when speaking about the support they had received from their family. The expectation that parents and children have unconditional love, and a strong bond is commonplace (Scharp & Dorrance Hall, 2017). Although important to note that not every student comes from a family that has these attributes.

The experiences of students estranged from their families often includes homelessness, financial issues, mental health, wellbeing issues, and difficulties with studying (Taylor & Costa, 2019). Furthermore, Gale and Thalitaya (2017) emphasise that people from different cultures and communities experience mental illness in different ways, so these nuances need to be acknowledged by those supporting them. These cultural differences were apparent in my data, particularly for some Asian participants; these participants often felt

unable to speak with their families about their mental health concerns. This is important as ethnically minoritised groups tend to be the most reluctant to seek help yet have the highest prevalence of mental ill health. (Rickwood et al., 2007). Thomas et al. (2017) also found variations in family dynamics and constraints by race-ethnicity and socioeconomic status, whereby lower socioeconomic status can exacerbate strains on family relationships.

As mentioned in Chapter 2 (section 2.2), widening participation universities tend to have students from diverse backgrounds and lower socioeconomic statuses, and these students often face more complexities. The Office for Students acknowledged that students not supported by their parents could face additional challenges at university, and the COVID-19 pandemic exacerbated this risk due to heightened estrangement (Office for Students, 2020). Therefore, universities would benefit from ascertaining what support a student has external to them in the early stages of starting their course.

My study offers new insights into the role of family in student mental health by extending existing literature to include the nuanced experiences of first-generation students and ethnically minoritised students. Where previous research (Azmitia et al., 2013; Blake, 2017; Palbusa & Gauvain, 2017) has acknowledged the importance of support from family, my findings illuminate how cultural expectations, socioeconomic constraints and any estrangement from family, shapes the students access to the support. For example, the reluctance among some of the Asian participants had to discuss mental health with their family highlights the need for culturally sensitive approaches

in university mental health and wellbeing services. These insights challenge the narrative of universal family support and suggest that external support mechanisms should be individually assessed.

11.7.4 Peers

Peer support is interlinked with belonging as both contribute to emotional safety, empowerment a sense of community and belonging. Friends, course mates, and housemates were noted to be the first points of contact for getting support for some participants in my study Peer support has been promoted as an innovative intervention to provide a holistic approach to enhance student mental health and wellbeing (Pointon-Haas et al., 2023). This is particularly important post-pandemic when mental health problems increased (Kannangara et al., 2023).

Students with poor mental health are most likely to seek peer support (Byrom, 2018; Rickwood et al., 2005; Cunningham et al., 2017). In Rickwood et al., (2007) study, when asked, 40% of participants said they would talk with peers who had similar experiences to themselves before seeking professional help. Furthermore Batchelor et al. (2019) conducted a study. That asked UK students via an online survey what their experience of NHS mental health services was, and they found that peer support helped to reduce loneliness and to develop friendships, as also discussed by participants in my study. Peer support is advocated as a valuable intervention for a whole university approach as described in the University Mental Health Charter (Hughes & Spanner, 2019).

Contrary to the evidence detailed above, Batchelor et al. (2019) reported that their participants had concerns that peer support was not professional enough and had a high risk of stigma and shame. This suggests that peer support may benefit some students more if peers have appropriate training. Despite this, as found in my study, students are already turning to each other for help. There are concerns here, as there is no formal training. This poses a risk given the sensitive nature of supporting someone with a mental health problem. Therefore, structured evidence-based interventions centred on peer support could enhance the quality of support and student experience (Pointon-Haas et al., 2023).

My study contributes new insights into the role and value of peer support for fostering emotional safety and belonging for university students. Existing literature from Pointon-Haas et al., (2023), Rickwood et al., (2005) and Batchelor et al. (2019) have explored peer support, and my findings reveal that students are already relying on peer support in the first instance for emotional support. This highlights a gap between universities recognition of peer support and its implementation and illuminates the potential risk with peers being untrained in providing mental health support for their peers. This suggests that there is a need for heightened mental health literacy or evidence-based interventions for peers to support peers. My findings are particularly relevant post pandemic where people were turning to each other as untrained individuals for support and guidance. By capturing the lived experiences of my participants my study adds depth to the understanding of peer support and highlights the need for

universities to include peers if they are going to take a ‘whole university approach’ to mental health and wellbeing support.

11.7.5 A sense of belonging

The urge to complete the course and 'power through' drove some participants in my study to complete their studies before accessing help for their mental health problems. While this distraction from distress appears to be a useful strategy for some, these findings suggest that if student services normalised students having mental health problems at university, it may help to increase their confidence in seeking help. Yet mental health difficulties impact students' academic ability and threaten their long-term mental, social, and physical health (Eisenberg et al., 2007; Hysenbegasi et al., 2005). However, enrolling and engaging in university courses also bring a sense of belonging.

A healthy sense of belonging is essential to one's overall psychological wellbeing. Maslow’s (1943) theory of personality and Epstein’s (1990) cognitive-experiential theory of self (CEST) both recognise this (McBeath et al., 2018). The impact of belonging is thought to be more pronounced during adolescence and early adulthood when a strong sense of belonging is crucial for positive social and emotional development (Drolet & Arcand, 2013). There are a variety of benefits to a healthy sense of belonging at university. Doan et al. (2020) also found that a friend and family sense of connectedness is believed to foster a healthy sense of belonging, self-efficacy, self-regard, and confidence. Furthermore Verbree et al., (2025) looked at student differences in sense of belonging and authenticity. They found

that that a sense of belonging and authenticity positively predicted academic performance. Additionally, extracurricular involvement was positively related to students' sense of belonging and authenticity too. Likewise, Pedler et al's (2022) results indicated that students with a greater sense of belonging experienced higher motivation and enjoyment in their studies, while those with a lower sense of belonging showed reduced motivation and enjoyment.

Gopalan & Brady's (2020) study described that feeling a sense of belonging whilst at college led to better engagement and, therefore, more success; students who feel they belong actively seek campus support. Stones and Glazzard (2019) add that empowerment engenders a sense of belonging; therefore, students should be included in the planning and designing of curriculum content and student services provisions. Universities could provide a range of initiatives to support social integration and belonging using a strategic, proactive, and consistent approach. Universities must develop a whole-university approach to social integration and community within curriculum design and development (Zile et al., 2024). Enrolling and undertaking the course itself was a lifeline for some participants, so getting support and further opportunity embedded into the university experience can only enhance students' experiences.

The new insights provided by my study highlight the complexities between academic persistence, help seeking and belonging. Where current literature establishes that mental health problems do affect academic performance (Eisenberg et al., 2007 and Hysenbegasi et al., 2005) my study highlights that some students

actively delayed seeking help and powered through to complete their studies. This suggests their engagement to the university served as a coping strategy, when participants felt a strong sense of belonging with their course. By getting this lived experience my study challenges the notion that help seeking is always immediate and in response to a crisis. Therefore, my findings point towards needing more mental health literacy, normalisation of mental health problems and a change in culture that recognises the significance of the emotional attachment to their course or university.

11.7.6 Summary

Looking through the lens of relationality has enabled a deeper exploration and understanding of the participant's experiences of seeking support. The transition to university has been explored, and the relationships between peers, tutors and family have also been interpreted. This also led to the exploration of the importance of having a sense of belonging and the potential role of universities in this process.

11.8 Conclusion

This chapter has revisited the purpose and nature of my study, it has then presented a discussion of the key findings, to make sense of them and construct new knowledge of the lived experience of having a mental health problem and seeking support for it whilst at university. The next chapter provides the implications for practice, policy and further research along with the strengths and limitations of this project.

Chapter 12 Recommendations and conclusion

12.0 Introduction

The previous chapter presented the discussion by using my data as a platform to generate new knowledge. This chapter includes the recommendations and conclusion. The chapter starts with highlighting the unique contribution to knowledge my study has provided. It goes on to discuss the implications for practice, policy and further research. The chapter then concludes with the strengths and limitations of the study.

12.1 The unique contribution to knowledge

This study makes several unique contributions to knowledge. First, the systematic review revealed a critical gap in knowledge regarding the lived experiences of university students facing mental health issues. This study, therefore, contributes new insights into these students' experiences seeking mental health support at university. It offers a unique and authentic account of their journeys in accessing the help they needed.

Whilst previous studies have looked at students' university experience or mental health among university students, the specific experience of seeking support had not yet been explored. Specifically, my study has highlighted that the mental health support wanted and required by university students does not solely come from university wellbeing services. The course tutors, friends and family had huge relevance in the help-seeking journey of those who required mental

health support. In particular the role of the personal tutor featured heavily in the experiences shared by my participants. Furthermore, contrary to many published works, stigma was not a barrier to accessing support. Stigma was experienced, but more self-stigma from the participants requiring help. The physical environment where help was delivered played a significant part in the help seeking journey; this too impacted on the participants perception of what people would think of students who were sat in a specific, very exposed waiting area. In addition to this, my study also highlighted how the high expectations of younger generations of students are shaping the future of education and how the consumerist approach is adding to these expectations. Universities need to be adaptable to keep up with the raising demands for services by a more demanding student body.

12.2 Implications for practice

Implications for practice, policy and research to emerge from this study are outlined as follows:

1.Make enhancing mental health literacy the starting point.

A comprehensive understanding of mental health awareness enhances mental health literacy and therefore equips individuals to help others. It also enables early intervention to prevent deterioration in one's own mental health. Training courses such as the "Making every contact count for mental health" (MECC) (RSPH, 2024) have proven effective in raising essential mental health awareness.

Implementing mental health awareness training for staff will offer opportunities to boost confidence, improve understanding, and reduce stigma by normalising mental health experiences for the entire university community. Offering mental health awareness workshops from the start of a student's university journey can be more helpful than offering this at the end of their university experience so they have more time to implement what they could learn. Providing training for all university staff and students could offer the opportunity to facilitate the sharing and transfer of knowledge. This training for both parties should be available monthly throughout the academic year, as my study indicates that students need to feel prepared to access support. In addition to this, having this training monthly and facilitated online and face-to-face will allow a larger audience to be captured based on their availability and work-life demands. This approach could enhance learning and foster a healthier culture surrounding mental health through a unified university effort.

Additionally, providing mental health awareness training as a monthly workshop during students' time at university will align with their stages in the cycle of change (Prochaska & DiClemente, 1983). For example, if someone was in the precontemplation stage of seeking help, knowing that mental health awareness training is available may encourage them to move to the action stage before their mental health deteriorates. This initiative will also assist with the transition to and from university. By training all staff and students in mental health awareness, together we can foster a sense of community and enhance the university's overall approach to supporting student mental health.

2. Manage expectations early.

Clearly communicating what students can expect from mental health support at university before they even start at their chosen HEI could be an effective intervention. This communication needs to provide detailed information on the university's course overview, web pages and prospectuses and needs to be reinforced during open days. This will allow for transparency and a clear indication of what support is available to someone who may have a mental health problem or may be worried about developing a mental health problem at university. Targeting this during the exploratory stage of wanting to apply to university will help the future student make an informed decision before even applying. Furthermore, friends, families and carers will also be able to see this information and in turn may be able to support the potential student or find reassurance for any anxieties. Having this transparency at the beginning of the transition to university will help potential students,' peers family members and other professionals understand the breadth of services and support available allowing for a more thoughtful and considered choice of university.

In addition to this, providing clear guidance on how to seek mental health support could also be provided at this early opportunity, as this will facilitate a smoother transition for incoming students. Identifying where students can get help in physical buildings alongside pointing out where on university webpages to look, would also be beneficial. This proactive approach can allow students to assess the adequacy of resources before making the final choices of university, therefore significantly reducing uncertainty and anxiety

about what mental health support is available to them whilst they study. Furthermore, helping to manage expectations early will reduce anxiety about knowing what support is available. Implementing recommendation one, would complement this too, as if all staff are trained in mental health awareness, then they will be better equipped to support someone whilst managing their expectations.

3. Develop better connections with NHS services.

Establishing a more integrated and collaborative framework for supporting student mental health is crucial to improve the connections between university services and the NHS. Rather than duplicating existing services at both the university and NHS levels, creating a synergy would enhance the mental health resources available to students. By fostering collaboration, students will be able to access appropriate mental health care tailored to their needs in a timely and efficient manner. This approach would streamline service delivery, allowing for early intervention and encouragement of self-management techniques among the students. This would therefore help ensure that waiting times remain manageable and do not become oversubscribed, as universities can offer interventions that could be effective before mental health problems become severe enough to require NHS provision.

In addition to this, working in partnership with NHS Mental Health Services could significantly reduce the challenges students face when transitioning between different care providers. This is particularly important for students who move to university and end up out of their

catchment area, from where they have been receiving care. Simplifying the referral process ensures that students will not experience gaps in care when moving from one service to another or from one geographical location to another. Overall, a comprehensive partnership can create a more supportive environment for students, along with a more effective use of time and resources from NHS services. For universities, this would create a more supportive environment and a more targeted approach for students requiring mental health support, leading to better student outcomes.

4. Create a therapeutic landscape within a commonly used environment to seek support.

Seamlessly blending the environment where the support services are housed and waiting area together can improve the overall experience of individuals seeking support. Avoiding making waiting areas into spaces that are clearly and easily identifiable would allow for a more inclusive environment that reduces stigma. This approach allows the location, for example, in my study, to share the waiting area with other services such as student finance, student accommodation, and library queries; therefore, it would indeed be a waiting area but blended with the rest of the university's student service departments. Having one waiting area for all students will allow for enough anonymity to prevent students feeling that they are in a 'fishbowl' and labelled as being there for a mental health problem, but it will also provide enough exposure to reassure the student looking for support was in the correct place.

Striking a balance between anonymity and services being easy to find should be designed in partnership with students, particularly in the location and the design of these waiting areas. Creating diverse and inclusive spaces that are co-designed by students may enhance the overall effectiveness of these environments. Using ‘spaces’ will help enable this as ‘third spaces’ have been described as places that bring people together, can be enjoyed and foster a sense of belonging. Yet to ensure these spaces' continued effectiveness, user evaluation must be part of the process.

Similarly, with online spaces, accessibility and collaboration with students in the development stages are of equal importance. By having students involved in the development of the digital resources, it ensures that they are user-friendly and meet the needs of the students who will be using them. Easy navigation, current and relevant resources, and an aesthetically pleasing platform are essential in re-engaging services. Furthermore, a comprehensive support system that resonates with all students will be created by emphasising collaboration and inclusivity in both physical and digital spaces.

5. Involve family and peers in support.

This was by far the most prominent theme to emerge from the data. The value of family and peer support shaped students' experiences in their help-seeking. Having an open disclosure policy that students can opt into would enable any of the wellbeing staff members to share information with people whom the student has nominated as a point of contact. This would of course need to be in

line with the UK General Data Protection regulation (GDPR) principles. This would be the student's choice rather than a requirement, and, to ensure compliance with GDPR legislation would require written consent from the student. It would allow for information to be shared with the nominated person or persons in times of heightened risk or when a student wants to share the mental health difficulties that they have been too afraid to do so. Having the wellbeing team on board with this approach would allow for risk to be managed more easily as the nominated person may be able to provide some more context to how a student typically presents when they are well and therefore help identify any changes in behaviour or early signs of relapse. Furthermore, if the student is struggling to share their thoughts and feelings with a nominated person, having the wellbeing team support to help them with this will enhance the student experience.

In addition to this open disclosure policy, providing some mental health awareness training for friends, family members, and significant others who support the student outside of the university could be helpful. However, the university should not be solely responsible for providing mental health awareness training to the public, but it can provide signposting information on where the public can get mental health awareness training from such as St John Ambulance (St John Ambulance, 2025), MIND charity, and Mental Health First Aid England (MHFA, 2018). This information should be easily accessible, therefore on the public university website, along with it being advertised at university open days.

12.3 Implications for policy

The University Mental Health Charter is a huge step in the right direction, but more needs to be done to support university students and their mental health. Changing the policy to allow for an open disclosure policy would be a positive step, as it would allow for easier information sharing. Furthermore, by making mental health awareness training and signposting more accessible for students, staff, friends, and family will, in turn, aid in a healthier student and staff environment.

12.4 Implications for further research

As no research is available on having a mental health problem and seeking support at university, more studies can be conducted at other universities to investigate this further. Having more insight into this lived experience can help shape further policy and improve students' experiences at university.

My study here showed three temporal moments echoed across each participant that could be further investigated to better understand the pre-encounter (the build-up to getting support), the encounter (getting support) and post-encounter (what happened after getting support). It could also be repeated to investigate if there were any generational or cultural differences from across the vast demographic of university students. Furthermore exploring the role of the tutor and their lived experience of supporting students with mental health problems would be an interesting project, given the significance of their role in supporting students.

Further studies could be also conducted to look at the experiences of peers and family members who have supported

students with their mental health whilst studying. It would also be interesting and novel to facilitate a research study comparing universities before and after they had a wellbeing service and how this has impacted student mental health.

The table below is a visual summary of the key actions I have recommended for future research. This is presented in a table to help highlight where research is lacking and highlighting why each suggestion is relevant.

12.4.1 Actions and justifications for further research

Recommended further research	Reason for suggesting
More studies should be conducted at other universities to investigate the findings further and assess commonalities and differences.	Each university's unique demographics, cultures, policies, and support systems significantly shape student experiences. Further research can offer a broader understanding of students' lived experiences in diverse contexts. By drawing insights from various universities, we can better inform policy changes by identifying actionable practices and developing mechanisms to share successful interventions.
Future research could replicate this study to explore potential generational or cultural differences with the diverse student population, which were not fully captured due to the nature of this study and demographic of the participants I had.	As different groups may encounter distinct barriers, this could enhance inclusivity by recognising how different generations and cultures experience access to mental health support at university. These insights can help tailor support services to meet diverse needs, to inform appropriate policies for mental health support and to reduce health inequalities.
Exploring the role of the personal tutor and their lived experience of supporting students with mental health problems would be an interesting project, given the significance of their role in supporting students	This would help reveal the complexity of the challenges personal tutors face when supporting students with mental health problems. It can provide insights for staff training and support systems. It will inform policy based on what further studies find.
Further studies could be conducted to look at the experiences of peers and family members who have supported students with their mental health whilst studying	This would provide a more holistic understanding of the demands of this supportive role and highlight the secondary impact of assisting someone with a mental health problem.

	It would inform support strategies by offering a better understanding of the needs based on shared experiences. Additionally, it could help reduce stigma and enhance mental health literacy. This approach would contribute to a comprehensive university strategy for supporting student mental health.
It would also be interesting and novel to facilitate a research study comparing universities before and after they had a wellbeing service and how this has impacted student mental health	This evaluation will assess the impact of having a wellbeing service available to the student body. It will help justify costs, indicate what is working well, and serve as a guide for identifying where investment should be allocated.
Investigating the longitudinal mental health experiences of students as they transition through university could also be considered.	This would help to understand any patterns or significant times that mental health support is required by more students and in turn will help to offer interventions to avoid crisis points.
Evaluate the support that students already receive and look at the effectiveness and accessibility of these interventions.	This would help with resource allocation and to understand what is being effective, what students are engaging with and if there are any barriers to access.
Another approach is looking at what universities already offer, locally, nationally and internationally.	This would provide an in-depth inquiry of what support is already available and to see how the recommendations have been implemented across different universities.

Table 8 Actions for future research

12.5 Strengths

The main strength of this study is that it has not been done before and, therefore, has added to the knowledge by sharing the lived experiences of students with mental health problems accessing support whilst at university. Phenomenology, being a methodology suited to investigating lived experience, is another strength. The methodology chosen was rigorous; there was a structure to guide a robust interpretation thanks to van Manen's work, which was further enhanced by Merleau-Ponty's four lifeworld existentials.

I was able to capture rich in-depth accounts from the participants who had kindly shared their experiences and time. Furthermore, the university's geographical location was multicultural, allowing the sample of participants to be culturally diverse. The data also looked at whether the participants had previously experienced help or mental ill health. The university's widening participation agenda allowed underrepresented groups to be easily included in the study. The diversity among the participants accentuated the essence of lived experience and helped to understand shared resonance across the different participants.

12.6 Limitations

The main aim of phenomenology is to unveil what is already present and uncover new meanings from the participant's lifeworld and their interpretation of reality to enable the researcher to present new understanding and insight (Chesterton & Jack, 2021). However, this could be a complicated process for a novice researcher due to the lack

of a definitive method in phenomenology (Spiegelberg, 1994). Despite this, the correct research methodology must be chosen, along with resonating with the researcher and the phenomena being explored (De Chesnay, 2014).

The small sample size is often cited as a limitation for qualitative studies, more so for phenomenological studies (Finlay, 2011). However, when interpreting lived experience, there is no requirement to generalise the findings. Furthermore, as the interpretation process is lengthy, smaller samples are recommended (Smythe, 2011). Phenomenological researchers do not represent 'sameness' as a lived experience, as no one's experience can be measured as more valuable than another (Dibley et al., 2020).

The participants in this study were representative of a culturally and academically diverse population, and all had access to the same service from the university's wellbeing service. However, this study focused on one university in the Northwest of England rather than nationwide; therefore, experiences and cultures may differ at different universities. At the start of this project, there was limited literature on student mental health. However, due to the publication of the university mental health charter, the last five years have seen an increase in literature and research. It remains limited, so momentum needs to continue to build.

12.7 Conclusion

This chapter has provided a summary, synthesis and additional context to the findings from the study. The intention is that the insight gained here will inform service protocols to make a difference for

students who struggle with mental health during their studies. Overall, this study has provided a rich and insightful interpretation of the lived experience of students accessing support for their mental health from a university wellbeing service. The lifeworld experiences of the participants have been the driving force of this discussion chapter to truly illuminate their experience as it was lived. Using van Manen's phenomenological approach has provided a fluid framework, allowing a deeper understanding of the lived experience. Implications for practice, policy and research have also been presented, and the chapter concludes with the strengths and limitations of the study.

Chapter 13 | Conclusion

This study started with my interest in academia and mental health nursing. Having a role that blended these two areas of interest helped me see how university students are a unique group of people when it comes to meeting their mental health needs. I was instrumental in setting up a student mental health service. Yet, I was baffled as to why students were not being consulted or spoken to about their needs, desires and wants for such an innovative and student-focused service. This enticed me to look further into this and under the structures of a doctoral study.

I conducted this study using van Manen's methodological approach to help guide and structure me through investigating the lived experiences of these participants. This enabled me to gain new insights into what the participants experienced; the intention being that it would identify practice recommendations for future students who would seek support for their mental health needs at university

In total 16 participants shared their story with me. They gave up their time and raw experience to help me in my project. My sole intention was to help them, yet here I am on the receiving end.

Their experiences have illuminated the power and weight of being ready to get help and having the confidence to reach out. Furthermore, relationships with staff, tutors, friends and family are fundamental in the experiences of students and their mental health experience. Similarly, the environment has great significance as too does the person centredness, and sense of belonging.

Universities have a responsibility to the student body, but they cannot do this alone. My study highlights that students, although they have high expectations, they are using further resources to help themselves. When universities get it right, they really get it right.

“it was a relief making the phone call, and it took me till the end of year to do it... I wish I had gone for it sooner …” - Joanne

Chapter 14 | Reflexivity:

Here, I discuss myself as a researcher and the journey this project has taken me on.

Reflexivity is helpful in phenomenological research as it enables thoughts and feelings to become visible. Using a reflective approach allows the researcher to explore different understandings and interpretations of the data. Reflexivity is also a movement between participant and researcher and involves researchers looking at their own preconceptions, values, and behaviours (Enosh & Ben-Ari, 2016).

For me, having no definitive method was something I struggled with. I appreciated the luxury of freedom it facilitated but was apprehensive that I had no fixed direction to follow. This lack of direction made me worry that I would not perform adequately and not do the participants justice with the experiences they had so willingly shared with me. However, having self-awareness also gave me the room I needed to grow as a researcher.

Chesterton & Jack, (2021) also highlight that nurse researchers who are adept in reflexivity and use an interpretive approach offer a way of using core skills and holistic ways to uncover different understandings of another one's life world. They add that using person centred research points toward Heidegger's philosophy as it enables thinking about ways to perceive the world through an interpretive approach. This resonated with me as a mental health nurse because since starting my nurse training, I have had the person-centred approach embedded into my everyday practice. Likewise, the

underlying philosophies of nursing advocate for a person-centred approach with patients; therefore, in my 16 years as a nurse, person-centredness has been at the core of everything I do. This drew me to use a phenomenological research methodology in my project here. Having the prerequisites of being a person-centred practitioner allowed me to understand participants' experiences with curiosity, self-awareness, sensitivity and respect. I believe this, as Heidegger describes aided interpretation of understanding other people's lifeworlds.

Heidegger's concept of the fore-structures of understanding was one of my favourite parts of learning about phenomenology. These concepts are important for nurse researchers as they allow the researcher to stop and think about how their background and experiences have influenced them. Being able to identify and understand my prejudgements about the topic of student mental health was interesting because it is something I have never done before. This curiosity and explanation started before I even registered for the PhD course. I was unsure why I enjoyed working with students or was interested in their mental health. However, I knew I was interested, so once I understood that my fore-structures of understanding were influential, it helped me understand myself and my role a lot more. This is what enticed me to embark on this research project.

I have since learned that this self-exploration is particularly significant in hermeneutic methodology and person-centred research as it allows the researcher and prompts them to examine the prejudgements they bring to the study, and which can influence their

interpretations (Chesterton & Jack, 2021). I am glad I understood this early on in my research journey because, as a nurse, I like to jump in and fix things for people. In nursing, this is helpful because people come to nurses when they need help for mental health. Due to the struggles some patients feel they want quick fixes and quick wins to help manage their distress or experiences that they are finding difficult to manage. However, from a research perspective, jumping in and fixing is not what investigating the lived experience is about.

When conducting my first initial interviews, I had not fully appreciated the difficulty in not conducting a mental health assessment that I was so used to doing and conducting a phenomenological interview; therefore, the first few interviews were essentially a mental health assessment with participants rather than exploring their lived experience. I remained patient-centred and curious about their experience; however, the way I navigated the interview led to not much conversation about how things felt and were for the person. It was more about the current mental state and the impact it was having on them at the time of the interview. Reflecting on this experience, I consciously made a shift, and my interviews became more phenomenological; this is where I realised that being a person-centred phenomenological researcher is achievable.

Once I was aware of my prejudgements, I found that I could use these to help interpret the data. McCormack & McCance (2016) described this as assuring the sharing of power in the relationship between participant and researcher, and by using a non-judgmental approach, both are seen as equal partners: both are valued, and both

are part of the research process. Again, this was important for me because I valued the time and the effort and sharing of stories that the participants offered me. My personal ‘allergy to injustice’ remained a value of mine that I could apply to my research. I wanted to make sure that the participants felt equal or, if not, felt more in control because without them, there would be no study. I did not want the participants to feel like they were second-class citizens or a burden. It was imperative that they felt listened to and heard because, after all, I was looking to see what their experience was and how to improve it.

Epstein & Street (2011) suggest that Heidegger’s work complements nursing and the importance of person-centred care in terms of engagement, respect, and value in the person. Draucker (1999) adds that Dasein’s most basic mode of being- in-the-world with care, therefore suggesting that the nurse becomes involved in that patient's life world. Using the hermeneutic circle to maintain the context of somebody's lifeworld is also important in finding new understandings and interpretations. When I collected the data, it was a privilege to sit back and listen to what the participants were saying, to hear how they were saying it and to see their facial and bodily expressions.

When interpreting the data, recognition of the hermeneutic circle allowed me to think, read, reread and think again to help make sure I had a genuine interpretation of what the participants were saying: fuelled by a desire for the participants to feel valued, heard and seen. My previous experience was in busy acute wards or in unconventional spaces, speaking to people with mental health

problems whilst being pressured by time and workload, therefore leading any interaction to be one that needed something to be fixed. Whereas here, I was able to settle in and listen. This gave me a deep gratitude in that they shared their story, and I could listen and take it all in. I had never had this opportunity before, and I look back now with only fond memories of that time.

Being a nurse and an academic, working with a client group that I enjoyed, I find it difficult to separate and differentiate myself from being a researcher. I had to remain mindful that my role with the students in my study was strictly as a researcher and not as a mental health nurse or academic. As discussed previously above and in Chapter 5, the first set of interviews did not illuminate lived experience, so through the second set, I had to be disciplined to not 'jump in' and 'fix' with suggestions I typically would make as a nurse and or academic.

Likewise, when interpreting my data once all collection had finished, being reflexive helped me understand more about what was being said and how it was said without jumping to conclusions and always being one step ahead, ready to 'fix'. In completing a script of my fore-structures of understanding, looking back now, I feel embarrassed at the approach adopted by us as mental health nurses in student services, in that we were making big decisions with no involvement from those using the service.

These concluding reflections on reflexivity signals the end of the journey I have been on in this study. It feels right to include it here

at the end, as it has allowed me to reflect on my growth and journey through my studies. The amount I have learnt is immeasurable. I now know far more than I ever anticipated about mental health, students, and their mental health, but I have also learnt so much more about myself and the power of lived experience. I cannot unpick precisely what I have learnt, but I know I am a completely different person from the person who started this journey, with lived time being such a factor in all of this. I know I have learnt to listen and not always react and that the power of lived experience can move mountains. I have learnt to 'just be' and 'trust the process'. I have a deep sense of eternal gratitude to the participants who made this study worthwhile and doable.

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Appendix 1 - Ethical approval

09 January 2019

Karen Wright / Lyndsey Hill
School of Nursing
University of Central Lancashire

Dear Karen / Lyndsey

Re: STEMH Ethics Committee Application
Unique Reference Number: STEMH 945

The STEMH ethics committee has granted approval of your proposal application 'An interpretive phenomenological study of the lived experience of using student services to meet mental health needs'. Approval is granted up to the end of project date*.

It is your responsibility to ensure that

- ☐ the project is carried out in line with the information provided in the forms you have submitted
- ☐ you regularly re-consider the ethical issues that may be raised in generating and analysing your data
- ☐ any proposed amendments/changes to the project are raised with, and approved, by Committee
- ☐ you notify EthicsInfo@uclan.ac.uk if the end date changes or the project does not start
- ☐ serious adverse events that occur from the project are reported to Committee
- ☐ a closure report is submitted to complete the ethics governance procedures (Existing paperwork can be used for this purposes e.g. funder's end of grant report; abstract for student award or NRES final report. If none of these are available use e-Ethics Closure Report Proforma).

Yours sincerely

Simon Alford
Deputy Vice-Chair
STEMH Ethics Committee

* for research degree students this will be the final lapse date

NB - Ethical approval is contingent on any health and safety checklists having been completed and necessary approvals gained as a result.

Appendix 2– Participant information sheet (pis)

Study title: An interpretive phenomenological study of the lived experience of using student services to meet mental health needs.

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

What is the purpose of the study?

The study seeks to discover what it is like to have a mental health problem whilst studying at UCLan and the experience of the support offered. The researcher would like to understand what you have found to be beneficial and effective in order to inform what we do in the future. The study is open to all students who have accessed the Mental Health Advisor service regardless of having a diagnosis and or package of care at any time.

Why have I been invited to participate?

You are being contacted because you have accessed the mental health advisor service for support with your mental health needs. You need to be a current student and not be on an interruption of study, but you don't need to be using the services at the present time.

Do I have to take part?

'It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason'. This will not jeopardise your place at UCLan and you are still entitled to the support available with Student support and wellbeing and your studies and access to all UCLan services will be unaffected. Also, you are free to share your own information and discuss this study with others. If you take part in the focus group, I ask that you do not share any information disclosed by others in the group, to maintain their privacy.

What will happen to me if I take part?

You will be invited to attend an audio recorded 1:1 interview or a focus group (group interview) to discuss your experience. There will be a

range of dates provided so that you can attend at a time most suitable for yourself and the interview will be arranged on campus in a confidential setting. You will also have the opportunity to talk to somebody afterwards, if you would like to do so following the interaction.

I expect that the interview will last for about an hour, but you may feel that you need a little longer, which is fine. It is important to me that you have sufficient time to tell your story without being tired or rushed. We could also meet for a second interview if needed, and this also gives you chance to reflect on what you have shared so that you can either add or take away from what you have told me.

Focus groups will be similar to the interview, in that they will last approximately an hour and we will stop when the group agrees, to ensure that no one stays beyond the time they feel comfortable with. However, focus groups will not be re-convened for a second meeting.

If you agree to take part, you are still free to change your mind up to the point of data analysis and without giving reason, and this will not affect any support or care in any way. We can remove your interview data from the study, but your contributions to the focus group will remain within the context of the group discussion.

What are the possible benefits of taking part?

You will have time, in a safe space to articulate your thoughts feelings and experiences on your mental health experience whilst studying at UCLan.

What are the possible risks of taking part?

You may become upset if you have had an unpleasant experience, but as you are a UCLan student yu will still have access to the support from student support and wellbeing. The researcher will also stop if it gets too much and you can withdraw your consent at any time.

Will what I say in this study be kept confidential?

Although audio recorded, once transcribed a pseudonym will replace your name so you are not identified. I do not expect the research to cause you any distress, but if you become distressed at any time in the process then I will be available to support you, along with others from the student support and wellbeing service.

Information will be collected and stored on the UCLan server as this is a secure server. Data generated by the study must be retained in accordance with the University's policy on Academic Integrity and will be kept for 5 years after the study.

What should I do if I want to take part?

Contact me via email LJHill2@uclan.ac.uk and attach the this form to the email. If you wish to discuss your possible participation, we can arrange to meet.

What will happen to the results of the research study?

All information that is collected about you during the research will be anonymised. Only anonymised information will be used in the PhD project, conference presentations, publications and a summary report. If you would like a copy of this that can be distributed by email to your preferred home or email address.

Who is organising and funding the research?

I am Lyndsey a PhD student in the school of Nursing. This project is being part funded by the University.

Who has reviewed the study?

The research has been approved by the University Research Ethics Committee (names to following once approval has been granted)

Contact for Further Information

Researcher: Lyndsey Hill – PhD student – School of Nursing

LJHill2@uclan.ac.uk

Director of Studies – Prof Karen Wright – Head of school of Nursing
KMWright1@uclan.ac.uk

Secondary supervisor – Dr Tony Gill – School of Nursing

TGill3@uclan.ac.uk

If you have a concern or a complaint about this study, please contact:

You can contact me to discuss these, or, if you have a concern about how the study is being conducted you can contact my supervisory team (details above) The research office ROffice@uclan.ac.uk University Officer for Ethics OfficerforEthics@uclan.ac.uk).

Thank you for taking the time to read this, I hope to hear from you soon.

Appendix 3– Interview schedule

I will welcome the person

I will thank them for attending and consenting to be part of the study

I will remind the person re voice recording, and the possibility of stop, edit, delete

Confidentiality will be explained then explain that this interview is going to be like a conversation and that there are no 'right or wrong answers'. The focus of the study is their experience and so it is about whatever is important and real for them.

This study is about the lived experience of using student services to meet mental health needs. I am sure that you will have thought about this before coming to see me, so, the first question has to be:

1. What is your experience of using our wellbeing services here?
2. Do you feel having a mental health difficulty has impacted your experience at University?

a. In what way?

i. Focus on elements disclosed and help the person to give detail.

3. Any particular challenges that you would like to tell me about?
4. Did you ever think about leaving Uni?

a. As you are still here… what/ who stopped you?

5. Where there any effects outside of uni that the service was able to help you with impact your life both personally and academically?
6. Was the anything particularly helpful about the support you received from the mental health advisor service?
7. And anything that was unhelpful?
8. Would you like to make any suggestions about how we could do things differently to support people with a MH problem whilst studying at Uni?
9. Anything else?

Conclude with a thank you

Then ask them student if they would like a copy of the summary report that will be written up afterwards. If so, ask can they please supply an email as well as their UCLan email to enable to do this. I will also remind them that those details will be kept separate from their interview so that their confidentiality is assured.

Appendix 4– Participant demographics

Demographics to be collected

1. subject area of course I am studying,
2. Undergraduate or Post graduate G?
3. year of study
4. age
5. ethnic origin
6. gender that they identify as
7. duration I have used/using the service and
8. if I had previous involvement with other services at

a. educational facilities eh school, college, another university

b. health services.

9. have they had any breaks/ interruptions in their studies due to MH issues [yes no]

Appendix 5 – Email to potential participants

Dear student

I am Lyndsey,

Some of you may have already met me as I work in the student support and wellbeing service. I am also a post graduate student here at UCLan, studying for a PhD

I am contacting you because I am looking to interview students who are using or have used the mental health advisor service. This is part of my PhD study, which seeks to understand the experiences of students who have used the service. I want to see what your experience has been of using our services whilst studying at UCLan.

I have attached an information sheet that gives a full breakdown of what is involved and how your confidentiality will be maintained. There is also a consent for you to read and complete, if you are willing to take part.

Once you have read the attachments, if you are interested in participating, please complete the consent form and say if you want to be part of the interview highlight your option on the consent form and reply to this email as confirmation. If you would like to talk to me about the study before you decide please let me know and we can make suitable arrangements to discuss the study further, your potential involvement and what will happen with the information that I collect.

I would be grateful if you could reply in the next 21 days.

I look forward to hearing from you.

Thank you and best wishes.

Lynds

Appendix 6 – Consent form

CONSENT FORM

Please read the question then initial in the box to the right if you agree.	**initial**
I can confirm that I have read the participant information sheet and have been given the opportunity to clarify anything that I am unsure of.	
I am willing to provide demographic information	
I aware that my confidentiality will always be maintained and that I will be given a pseudonym when transcribed for the research project titled above.	
I am aware that I can withdraw from this study at any point.	
I am aware that my interview will be audio recorded	
I am aware I will be offered a debrief meeting	
I have been given the opportunity to discuss any specific learning difficulty and reasonable adjustments I may require in an interview setting.	
I have the researchers contact details along with her supervisors	
I am aware that an audio recording will be stored as per University guidelines and that the recording will only be used as part of the research project titled above.	
I am aware I may be contacted after the initial interview or focus group if any further information is required, I fully understand I am under no obligation to attend a follow up meeting.	
I would like to take part in the interview	
I would like to take part in the focus group	
I would like to receive an electronic copy of the brief report which is produced when the study is complete. Here are my contact details for this: Email: …….	

Participant signature…….
Date:……..

Researcher signature……
Date:…….

Appendix 7 – Study advert poster