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Narratives of Need: Exploring the Barriers to Help-Seeking in Undergraduate Students

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Contents

Acknowledgements	ii
Executive Summary	iii
Key recommendations:	iv
Introduction	1
Literature review	2
Methodology	6
Analysis	9
Discussion	19
Conclusion	21
References	22
Appendix 1 – full list of aggregated reported issues	25

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Executive Summary

The research explored possible barriers to students submitting coursework on time by scrutinising the narratives they provide on their Exceptional Factors (EF) request forms. This was a mixed methods approach and involved both quantitative and qualitative analysis. The sample, which was randomly selected from the 2014-15 HLSS EF records, consisted of 167 EF forms completed by 145 students. The majority of students (89%) submitted only one request; leaving 11% submitting multiple applications. Towards the end of the sampling, we ensured sufficient diversity of students in terms of key demographic information such as gender, ethnicity, disability and level of study. Also included in the analysis was level of study, accommodation type and when the EFs were submitted (i.e. either early, on the day or late) into the analysis.

The data was coded and inputted into NVivo and SPSS for analysis. Inferential statistical analysis found no significance, possibly an artefact of the small sample. We therefore carried out descriptive statistics on the numerical data. A thematic analysis was carried out on the qualitative data. Students provided a range of reasons for their EF requests: some more serious and longstanding than others (see Appendix 1 for full list).

Exploring the themes that emerged from the data:

Level of study

The time when EFs were submitted is interesting in showing that level 6 students more frequently submitted their request early (48%) compared to level 4 students (25%) and level 5 students (30%). We suggest that one possible explanation for this was because level 6 students had a greater understanding of the institutional *habitus* and were better equipped to navigate its support structures. Conversely, level 4 students more frequently submitted their EF requests late (67%).

Mental Health Conditions (MHC)

- Nearly one third of the EF forms (31%) included accounts of MHC, these included Anxiety and/or depression.
 - 17% of the sample had previously reported a MHC at the start of their studies as recorded on the university records.
- **Level of study** shows there to be a greater number of level 6 students reporting MHCs compared to levels 4 and 5. This might be an artefact of the additional stress experienced when in the final year of study.
- **Gender** was also an issue with more males (36%) than females (27%) reporting MHCs. This is surprising as literature shows that females are more likely to experience a MHC compared to men. One issue might be that females seek more timely support resulting in them not needing to submit an EF form. The masculine construction of resilience and the stigma associated with MHCs might result in males needing to reach crisis point before seeking help.
- **Embarrassment** acted as a barrier to seeking support with some students leaving such requests until they reach 'crisis point' and have no other alternative.

Stress

- Stress was reported in over 20% of the EF forms. Again, level of study reveals that more level 6 students (29%) reported stress compared to level 4 students (18%) and level 5 students (17%). Exploring accommodation type and stress, an intriguing result emerged with those living with parents reporting the higher percentage of stress (27%).

Sleep disruption and insomnia

- Sleep disruption and insomnia was reported in 27% of the EF forms. For some students, this was an artefact of stress such as around exam times or over personal issues. However, 38% of students reporting sleep issues also reported experiencing anxiety and/or depression.
- Gender differences are also observed with more women (31%) than men (22%) reporting sleep disruption or insomnia.
- Accommodation type also revealed some interesting findings with only 6% of students in halls experiencing sleep disruption or insomnia.

Key recommendations:

Peer Wellbeing Mentors - Our key recommendation is to develop a Peer Wellbeing Mentor system. This would involve training the peer mentors to support students across of range of issues. The peer mentors could act as a 'one-stop-shop' in supporting or directing students to the appropriate support available. We suggest that students are better placed to support each other due to the potential stigma of seeking support. This is partially due to the university promoting a climate that encourages independent learners which in itself could evoke a false sense of self-reliance where asking for help is deemed as inappropriate. These Peer Wellbeing Mentors could be level 5, 6 and 7 students who support students while they successfully transition into university life or, when they are experiencing difficult times. The type of support they could offer includes advice or strategies around good sleep practices, time management, social capital building and stress building.

Sleep – develop an awareness initiative promoting good sleep practices across the university. Promote the use of the free mobile apps that remove the harmful blue light from mobile technology via Moodle. Sleep Mentors could be recruited and trained so they can support students who report sleep disruption and insomnia. University policies that may inadvertently promote poor sleep practices such as 24-hour access to the library should be reviewed.

Online Support Portal - Explore how support can be offered via an online support portal. This has the potential to be more immediate and could be staffed by Peer Wellbeing Mentors. They could act as a springboard directing students in need to appropriate structures.

Increase Awareness of Academic Support Structures – This is a complex area, which requires an evaluation of how students' experience support and the possible barriers that exist. There should be a review of how level 4 students can quickly increase their understanding of the support structures. There is a rationale for increased time being spent on developing such

awareness early into the academic year that lasts beyond induction week. We could also explore how we could simplify our support provision.

Student Re-engagement Support – Issues raised on EF forms should be proactively considered with and appropriate support offered at a local level. Additional support is provided to help reengagement with the learning environment and the promotion of good study habits. For instance, a student who has fallen behind might need structured support in time management that will help them catch up. This process could include Peer Wellbeing Mentors who could:

1. Provide a platform for the student to discuss issues about returning to study and help overcome potential barriers;
2. Contact students before scheduled teaching sessions to check they are ready to attend;
3. Liaise with Unit Leaders and student to ease the way back into the classroom.

Introduction

The purpose of this research is to explore possible barriers to students seeking *timely* support when experiencing issues that are preventing them from submitting coursework on time. There can be many reasons that prevent students from doing this: some more serious than others. Support for transient and short-term issues might require nothing more than an understanding of the disruption to day-to-day living (for instance when experiencing a short-term illness). The more serious cases such as when experiencing Mental Health Conditions (MHC) require a greater level of support. Research by Eisenberg et al (2007) showed how upwards of 37% of students experiencing mental health conditions did not receive any institutional support. Recent evidence reported in The Times Higher Educational Supplement (2013) shows an increase in students seeking support from counselling services. The article also points to a growth in online counselling support being offered and used by students.

When providing support to students experiencing some form of crisis, it is extremely important to have the necessary understanding of their needs and of any possible barriers they may face that prevent them from seeking help. To do this however, it is important to consider students in the rich context of their life (Bronfenbrenner 1979). This requires acknowledgement of key differences in support needs brought about by factors such as gender, age, ethnicity, disability and a range of other important individual dynamics. For instance, a level 6 student will have a greater understanding of the institutional *habitus* than a student who has just started at University. Those in the early stages of their academic career might find it more difficult to navigate the support structures on offer. Interestingly, Thomas (2012) reports how approximately 8% of students drop out of HE within their first year of study with a further 33% considering withdrawing. It is therefore important that whatever support structures we provide are developed and delivered through the lens of the student ensuring they focus on their needs rather than our institutional procedures. The purpose of this report is to explore the possible barriers (both personal and structural) to students seeking support at times of personal crisis. The Exceptional Factors records were scrutinised to look for novel approaches that more effectively support students back to a learning equilibrium.

Literature review

Research on student well-being and barriers to study progression is varied but overwhelmingly a key barrier to seeking help revolves around mental health issues. Stewart et al (2014, reporting Kessler, 2007) explains how mental health conditions such as anxiety and depression are more common in 18 to 24 year olds. Similarly, Gulliver, Griffiths and Christensen (2010) state that more than in any other age group across the lifespan, mental health disorders are highest amongst 16 to 24 year olds. Remes et al (2016) found that, disproportionately higher levels of mental health disorders exist in the under 35 years age group. In respect of anxiety and panic attacks, women are identified as more likely to experience these than men with key contributing factors identified as, excessive worry, avoidance of stressful situations, avoidance of social gatherings causing a resultant outcome being a decrease in work productivity (Remes et al 2016). A recent report in the Times Higher Educational Supplement (2013) shows an increase in students seeking support from counselling services with an increased trend for online counselling support.

Depression is reported as increasingly common in university students with further evidence pointing to those from less advantaged backgrounds being more vulnerable (Ibrahim, Kelly and Glazebrook 2013). Research by Eisenberg et al (2007) showed how upwards of 37% of students experiencing mental health conditions did not receive any support. Hunt (2010) in noting that the transition to higher education study denotes a challenging developmental point that can induce anxiety and depression similarly identifies a gender difference, whereby females are again, more likely to suffer from anxiety or major depression while males are at a higher risk of suicide. It seems clear then, that young people have the potential to experience a mental health disorder and those that are in education are likely to require additional support. However, such support relies on students proactively seeking additional support. Literature in this respect indicates that there are numerous barriers to help-seeking behaviour. Evidence shows gender differences exist in help-seeking behaviour (Eisenberg, Downs, Golberstein, and Zivin, 2009). For instance, males are much less likely to seek help or support than females (Oliver, Pearson, Coe, and Gunnell, 2005). This includes delays in seeking help for medical issues. The suggestion here is that masculine construction of independence and self-reliance acts as a key barrier to seeking support (Courtney 2000; Galdas, Cheater and Marshall, 2005).

A key barrier to help-seeking is fear of stigma particularly in respect of ethnicity and class where long-term cultural disposition leads to the avoidance of seeking support, for fear of stigmatisation (Moran 2007). Such learned attitudes and behaviour are particularly problematic when it comes to mental health issues and relate to Bourdieu's theory of *habitus*, which he defined as, a:

...system of acquired dispositions functioning on the practical level as categories of perception and assessment or as classificatory principles as well as being the organizing principles of action (1990, pp 12-13).

Of course, the reverse is also true whereby instead of acting as a barrier it becomes a driver, with students from middle class backgrounds tending to be better equipped to function in higher education institutions and have all the necessary support structures already set in place. For instance, Moran's (2007) research found that students from lower socioeconomic backgrounds reported higher incidences of depression while those students from highly educated backgrounds were less likely to experience depressive symptoms. Concerns can

revolve around help-seeking being viewed as a potential weakness that would influence, career progression and something to be avoided on CVs (Chew-Graham, Rogers and Yassin, 2003).

The perceived need to be self-reliant can also act as a barrier to seeking help. Hunt, (2010) makes the point that failure to seek help starts at an early age. As an established socially learned behaviour, it is perhaps unsurprising that students are reluctant to seek help when they first enter higher education, which as denoted earlier, is a key developmental stage. Stewart et al (2014) suggest that in the first instance student preference is to turn to family members, romantic partners or friends. In respect of the latter, on entering higher education, this relies on students making friends and developing strong socially supportive networks. Putnam's (2001) model of 'social capital' determines the socially desirable nature of building social networks that are, predicated on trust, co-operation and reciprocity. This is a particularly useful framework that in the case of students, who have moved away from home to go to university, highlights the need for students to build strong friendship networks in order to benefit from social support in this time of transition to university life and the loss of pre-university friendship circles. An important aspect of Putnam's work around social capital points to the benefits of these networks in providing information needed to function within a given community. As such, building strong social support networks could be the key to developing the institutional *habitus* needed to succeed in a novel setting such as a university.

It would be naïve to assume that these networks are always best placed to provide the level of detailed information required to support someone's experience, for instance, in the case of anxiety and depression. However, the social support a friendship group can assist in seeking professional help whether that be pastoral care or, counselling or medical support. Gray (2015) points out that the everyday stresses of university life can take on magnified proportions for some students that render them unable to cope and become victim to what appears to be emotional fragility. Upon entering university, students are willingly entering into what can be a stressful environment whereby the standard of the work they produce is to be judged, rated and ranked. Most students find the resilience to be able to cope with these everyday stresses while some do not. Davydov, Stewart, Ritchie and Chaudieu (2010, pp. 479) identify resilience as, 'a defence mechanism, which enables people to thrive in the face of adversity' but the emotional fragility referred to by Gray (2015) finds some students unable to draw on this mechanism. Yet while the term 'resilience' can be found in literature in respect of undergraduate students professionally training to practice in nursing and social work (Thomas and Revell, 2016; Grant and Kinman, 2014; Thomas, Jack and Jinks, 2012), such focus is less commonly cited in respect of more traditional and non-practising degrees.

Everyday stresses can be both academic in respect of study expectations as well as social and personal. Thomas (2012) reports how 8% of students drop out of HE within their first year of study with a further 33% considering withdrawing. Homesickness is an interesting example reported by Thurber and Walton (2012) who highlight some of the difficulties that students experience in negotiating the transition from school to higher education. They point out that if not managed appropriately, the transition has the potential to exacerbate existing mental health conditions or be the trigger to them developing. In recognising the journey into higher education, the University of York has developed an interesting approach that supports students ahead of their arrival. Transition is conceptualised and explained through the 'W-Curve'; the shape of the 'W' illustrating the highs and lows that students will experience as

they progress through their first year. In preparing the students for these transitional phases and making it clear that students will not be alone in experiencing the highs and lows, this model helps new students to better negotiate their new environment. See figure 1 below and for a more detailed account, see:

<https://www.york.ac.uk/students/support/health/problems/adjusting/>

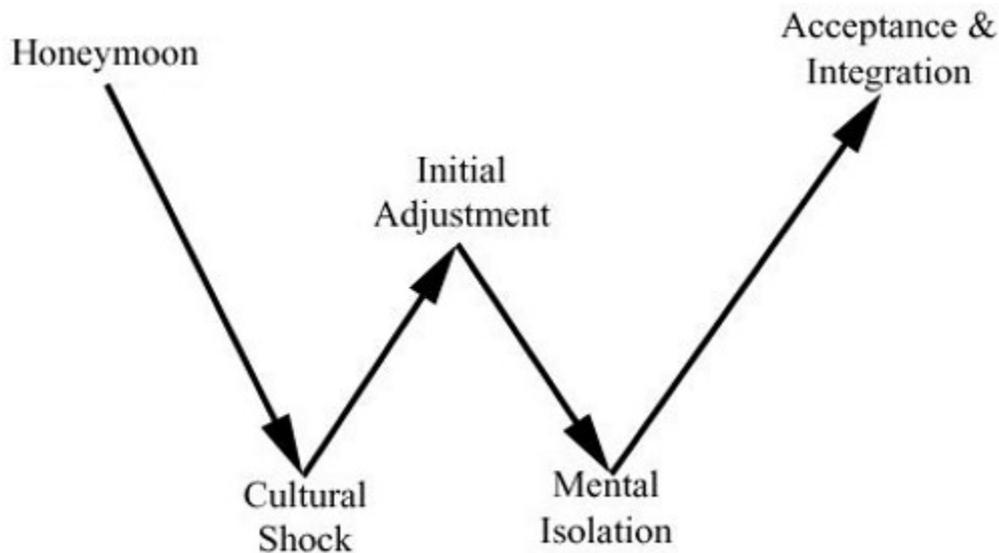


Figure 1 - the W-Curve

The W-Curve is a proactive approach to supporting students in advance of issues occurring. However, when issues do arise, it is important to have the necessary support structures in place where students can seek help for whatever they are experiencing. At Manchester Metropolitan University, we have a plethora of support structures, both academic and administrative. Part of the interest in the current research is to explore barriers for students seeking support. As indicated above, failure to develop appropriate social networks could be one such barrier. Another barrier, in the age of social media, could be the medium by which students are expected to seek support. Ali, Farrer, Gulliver and Griffiths (2015) identify that peer online support is popular among young people although they point out that more research is needed to review its effectiveness. In an article by Stewart et al (2014), they found that 60% of students would consider using phone-in lines, social media sites and mobile applications when seeking support. These participants also valued printed material or being directed to websites to find information. Perhaps one of the benefits of support from social media or online support is how it provides anonymity (Best, Gil-Rodriguez, Manktelow and Taylor, 2016) and feeds through to students' desire to be self-reliant. Universities generally provide a dearth of information about the structure of the university, programmes of study and so on, but specific material developed for self-help consumption seems less common. There are examples where higher education institutions (HEIs) use online support, such as that offered at Kingston University (for more information see):

<http://www.kingston.ac.uk/health/wellbeing-services/>

Here the support is directed at generalised wellbeing that includes self-help guides, stress management, drug and alcohol advice, life coaching, and free condoms. Focusing on wellbeing is interesting as it views the student beyond that of a learner. Using Bronfenbrenner's

ecological approach (1979), it allows us to see the student in the rich context of their lives. For instance, an interesting finding is emerging around sleep disruption and chronic insomnia in students. There are many reasons that point to university life not being conducive to good sleep habits. The new lifestyle of independent living away from home, often in Halls along with the increased freedoms to 'act' unchecked might make it difficult for some students to get into regular sleep patterns. Lund, Reider and Whiting, (2010) found that undergraduate students experience insufficient sleep and sleep-wake patterns that are irregular. Recognising that poor sleep patterns can influence through to mental health, they call for interventions that address poor sleep quality and disruption. Sleep disruption however, may result from rather unexpected sources. For instance, Schmerler (2015) interviewed two prominent neuroscientists; George Brainard and Anne-Marie Chang, both of whom independently advocate that light from mobile devices emit 'short-wavelength-enriched blue light' which then affects the hormone melatonin responsible for regulating sleep. Student lifestyle, mobile devices and LED screens are in regular use so could all be implicated in sleep disruption. There are also reported links between mental health and sleep disruption with a higher than would be expected prevalence of the two occurring together (Choueiry, Salamoun, et al. 2016; Taylor, Bramoweth, et al. 2013). Interestingly, they also report how many students fail to recognise the symptoms of chronic insomnia. The possibility exists that students may unknowingly be experiencing a toxic cocktail of unrecognised sleep disruption, pressures to demonstrate self-reliance and concerns of stigmatization over mental health issues that act as a range of barriers to some students seeking the level of support needed to navigate their time at university.

Methodology

We used a mixed methods methodology (Johnson and Onwuegbuzie (2004) to carry out this research. Taking data from exceptional factors records allowed us to conduct both qualitative analysis on the accounts provided by students, as well as, developing a quantitative coding tree to further analyse key themes with demographic information. The rationale for this approach is that it allows for analytic triangulation by constructing a framework that fuses both the quantitative number of cases with qualitative reasons for the application (Neuman, 2013). One of the key benefits is the ability to take a grass roots approach to develop a narrative from a student perspective. The data was randomly sampled from the EF records and proportionately checked for inclusion of main demographic details prior to completion. The table below shows the breakdown of those included in the current research:

Frequency of identified sample

Of the 145 unique cases, 56% were female and 44% male. The age ranged from 19 to 58 years old with a mean of 23 years, a median of 22 years and a mode of 20 years. The majority of cases (71%) were white with 28% BME students; see table 1 below.

Table 1 - Ethnicity

Ethnic Background of the Sample	
BME	28%
White	71%
Information Refused	1%

Table 2 below shows the spread of cases throughout the level of study. There were more level 4 student records included in this sample at 39% with the fewest being at level 6 at 29%.

Table 2 - Level of Study

Level of Study of the Sample	
4 (1st year)	39%
5 (2nd year)	32%
6 (3rd year)	29%
Total	100%

Table 3 shows the accommodation type. Interestingly, the majority of students included in this study still live with their parents.

Table 3 - Accommodating type

Accommodation type of the Sample	
Halls	12%
House/Flat Share	35%
Living with Parents	36%
Own Home (Owned or Rented)	16%
Total	100%

Data retrieval

The data used in this research is taken from exceptional factors forms that the university requires when students are requesting additional time to complete coursework assignments. From the 2014-15 academic year in the HLSS Faculty, 443 students applied for EFs, on some occasions, students applied more than once. We decided to explore around one third of the applications which were selected randomly. Of the 145 different students, 15 students submitted multiple applications throughout the year. Of these, 11 students submitted EFs twice, 4 students submitted on 3 occasions and 1 student submitted on 4 separate occasions (see Table 4 below).

Table 4 - Number of EF submissions

Number of EF submissions per case	Frequency	Percent
1.00	129	89.0
2.00	11	7.6
3.00	4	2.8
4.00	1	.7
Total	145	100.0

This means that 167 Exceptional Factors records were coded into NVivo from 145 students. In order to explore the accounts of the students and scrutinise this data alongside the demographic makeup of the student, the student accounts were typed into NVIVO from the EF panel database. Using the student MMU ID, we used the MMU university records system to establish the key demographic information of gender, ethnicity, disability, PLP status and accommodation type.

Coding

The data was input into SPSS and NVIVO with each student account being linked to their key demographic data. A full list of reported reasons can be viewed in Appendix 1. In addition to existing numerical demographic information, other quantitative data was numerically coded including reasons for submitting EFs, time when EFs submitted (before assignment due date, on due date and after due date) – see Table 6 below. For the qualitative data, we used a constructivist version of grounded theory (Charmaz 2003) to code the data using the progressive model of open coding, axial and selective coding. This involved careful reading of the accounts presented on the EF form where we allowed free flowing themes to emerge (open coding). This was followed by further scrutinising and merging the coded data to build substantive themes (axial coding). The final stage of the coding involved doing text searches looking for key phrases and terms related to the themes already established (selective coding). The key themes to emerge were:

- Mental Health Conditions
- Contributing factors of stress
- Panic attacks
- Insomnia

Ethics

Prior to the commencement of the research, ethical approval was gained from the HLSS Faculty Head of Ethics. Additionally, permission to carry out this research was approved by the Chair of the HLSS Exceptional Factors Panel.

Ethical Considerations

Dealing with such sensitive information as exceptional factors records meant that ethical consideration needed to be at the forefront of the research. The main issue was our need to obtain further student demographic information from the university systems to sit alongside the reason why the students requested exceptional factors. Student data was given a unique alphanumeric identifier to ensure identity anonymity. The data was then transcribed into NVivo and precautionary, the MMU Student ID was never located with the details on NVivo. Additionally, the NVivo project was password protected and stored on a secure section of the staff hard drive (R drive) where access was limited to only the four researchers involved with the study. However, the unique identifying code was linked to the MMU Student ID on a single Excel file that was further password protected. This was necessary to ensure the researchers could check back on the University student record system. Any other possible identifying features embedded within the accounts were also removed. Any quotes used similarly do not have any identifying features and all data was numerically aggregated to further ensure anonymity but also to facilitate analysis.

Analysis

Exceptional Factors: Setting the scene

The first aspect of the analysis was to explore statistical significance for the key demographic materials included in this research. These are gender, age, ethnicity, disability, PLP status and accommodation type with key dependent variables such as, reasons for submitting EF application. However, as no significance was found, the report will focus on descriptive statistics to explore the quantitative data.

The high numbers of student submitting EFs (and often submitting them late) raises the questions of why are students not seeking support sooner? Table 5 below shows the number of students submitting EFs either before the submission deadline, on the day of submission or late.

Table 5 - when EFs submitted

When EFs submit	Level of study			Total
	4	5	6	
Early	25%	30%	48%	33%
Late	67%	63%	50%	61%
On day	9%	7%	2%	6%

As can be seen, fewer Level 6 students submitted their EFs form late. This could be a result of them having better knowledge of the support systems and processes than those at lower levels of study; or could it be that there is more riding on the year creating the impetus to resolve issues beforehand and leaving less to chance? Additionally, it might also be worthwhile to scrutinise the process of obtaining support ensuring that there are no institutional barriers at play.

Mental Health Conditions – a complex narrative of anxiety and depression

Mental health conditions are recurrent throughout the reports. The most common conditions being anxiety and depression, which as indicated below occurred in 31% of the EF applications (see Table 6 below).

Table 6 -Reports of Anxiety and/or Depression

Reports of Anxiety and/or depression	Frequency (n)	% of Anxiety and/or dep
Anxiety	18	12%
Anxiety and depression	17	12%
Depression	10	7%
N/A	100	69%
	145	100%

Accounts provided by the students revealed the difficulties of studying while experiencing such mental health issues. The discourse builds a picture of 'struggle' 'suffer' or 'dismay' that 'hinders, 'obstructs' or 'delays', students' ability to make progress. For instance, Participant N43, a Level 5 male was experiencing anxiety and depression, which was made worse by an additional health issue:

...to my dismay, the same issues which obstructed my progress throughout the year - recurring depression and anxiety... Frankly, this has been a horrific year for me. I will not disclose to the Panel exactly what is happening to my body, but I will say that it is devastating for a man of my age. It has made me profoundly sad, hopeless, and worried. I hope you can understand that at times my studies have seemed superfluous to this struggle ...

(Participant N43, 23 year old Level 5 Male)

Some students who experience long term MHCs report their condition at the start of university degree and this detail is then stored in the university's records. Table 7 below indicates those students (44% - n17) who specifically reported an MHC.

Table 7 - Disability declared on university records

Row Labels	Frequency (n)	Percent	Valid percent
A disability, Impairment or Medical Condition Not Listed	2	1	5
Blind or Serious Visual Impairment	1	1	3
Disability, impairment or medical condition	1	1	3
General Learning Disability	1	1	3
Long Standing Illness or Condition	2	1	5
Mental Health Condition	17	12	44
Physical Impairment or Mobility Issue	2	1	5
Specific Learning Disability	13	9	33
Not Applicable	96	66	
Not Specified	10	7	
Total	145	100%	

Comparing this with the data on Table 6 above, reveals that 28 students did not report any MHCs at the start of university yet subsequently reported mental health difficulties on their EF forms. Of course, the severity of an MHC is sometimes unclear but is considered sufficient to hinder a student's university progress and act as a barrier to them submitting coursework on time. The majority of students who made the University aware of their MHC (either when starting university or when requesting EFs) went on to receive the appropriate support and progress to the next level of study. For some students, this required them to suspend their studies and start again the following academic year by which time a PLP had been set in place (for instance, this occurred with Participants E08 and E10). For instance, Participant N59 provided several MHCs that acted as his barrier to progression:

The main reason being that I struggle with stress, anxiety and also depression for a number of years which has hindered my progress with the essay

(Participant N59 Level 4, 24-year-old Male).

Exploring the university records for this particular student revealed that he did not declare this long-term health issue at the start of university, but at a later point when he did disclose the MHCs, subsequently a PLP was put in place. Unfortunately, despite the support structures being set in place, (EFs, PLP) he did not complete his first year of study, and sadly did not return to retake the year.

Similarly, there are other occasions when a student declared a MHC either at the start of university or via the EF process but in spite of best efforts of the University support structures being in place, some slip through the net. For instance, Participant N80 declared MHCs on an EF form but did not progress to the next level or have a PLP instigated:

I have been suffering from depression and anxiety with very bad anxiety attacks in particular. It has affected my ability to attend university and I have not been able to concentrate at all for the fear of me having an anxiety attack in Uni and it being humiliating. My depression has caused me to have a severe lack of motivation and a 'what is the point' attitude rendering me currently unable to attend or complete coursework

Participant N80, Level 4, 19 year old Male – no PLP – withdrew).

He, along with Participant E3 (Level 5, 28 year old female), Participant E15, (Level 4, 19 year old female) and Participant N46, (Level 4, 24 year old male) are all students who similarly all declared MHCs and again did not complete their studies and did not have a PLP in place.

You're an embarrassment! The negative side to self-reliance

One barrier to help-seeking is stigma and the embarrassment of divulging the need for help. Student belief in their need to demonstrate self-reliance in itself acted as a further barrier. For instance, the account of Participant N80 above highlights that the fear that having an anxiety attack in front of others can be an acute source of embarrassment. Similarly, embarrassment was reported by two different, 20-year-old, Level 4, female students (Participants E15 and N68):

I was having to deal with intrusive negative thoughts every day which were beyond my control. This continued for months, making me feel suicidal. I considered counselling but didn't have the courage to go as I felt embarrassed

Participant N68, 20-year-old Level 4 Female

The embarrassment was sometimes related to a specific learning need as illustrated below:

Mental health – panic attacks and depression. Dyslexic and didn't tell anyone as (I) was embarrassed to say. So ended struggling to finish it (assessment) in time

Participant E15, 20-year-old Level 4 Female

Struggling with MHC such as anxiety and depression were not unique to level 4 with both Level 5 and 6 students also experiencing such issues. Indeed, Level 6 students report experiencing anxiety and depression more than the other levels with 36% reporting them in their EF forms (see Table 8 Below).

Table 8 - Reports of anxiety and/or depression by level of study

Anxiety and/or depression reported in EF forms	Level of study		
	4	5	6
Reported anxiety and/or depression	32%	26%	36%
N/A	68%	74%	64%

Adjusting to university life

For some students, the MHC arose because they found it difficult to adjust when moving to Manchester from another part of the country. The difficulty of losing socially supportive networks along with the difficulties of making new friends was the cause of stress, anxiety and panic attacks. Participant E30, Level 4, a 21-year-old male provides an account of his experience while living in halls of residence:

I tried to participate in uni life and socialise with my flat mates but I would suffer from what I've found out are anxiety attacks at the thought of making new friends as I was scared of being judged by others. For the majority of the year I have kept myself either in my room in halls or if I've been especially anxious I have gone back home to (home town) and keeping myself in my room

Participant E30, 21-year-old Level 4 male.

It was only through having to explain to his parents the need to resit the first year that the above student received the belated help and support he needed, all of which was instigated by his mother once he had returned home for the summer. A number of other male students at Level 4 provided similar accounts of staying in their room. They suggested that the thought of engaging in social activities was a key factor in inducing panic attacks, stress or anxiety (Participant E21, 27-year-old male; Participant E58, 21-year-old male and Participant E77 – 22-year-old male). The transition from home to university is a developmental journey that takes some students longer than others. Some students find this journey more arduous resulting in them withdrawing from aspects of university life. Others however, maintain strong and persistent links to their home life.

Seeking support - homeward bound

Several students reported how they postponed seeking help until they went back to their family doctor. Participant E13, Level 4, 20 year old male waited until he went back to his home in the North East before seeking support:

Round about late January I started to feel down. I wasn't sleeping during the night due to financial worries over the rent and had a lot on my mind at this point. This started off my problem with attending lectures and eventually leading me to being frightened to turn up due to missing so much and being so far behind

E13, 20-year-old Level 4 Male)

While Participant N07, Level 4, 20-year-old Male waited a few weeks before seeking support:

Last Semester I noticed that my behaviour was changing drastically and after a few weeks of stressing and worrying I went home to visit my GP, he asked me a few questions and told me he believed I had relatively serious depression. I refused medication and resolved to deal with the issue with the help of my friends and family.

N07, 20-year-old Level 4 Male

Their desire for self-reliance is one of the barriers to help-seeking identified in the narrative on the EF forms.

Panic/anxiety attacks

There is also a discourse of panic or anxiety attacks as a reason for needing additional time to complete coursework. These type of attacks are reported at 10% of the sample. Participant N49 and E20 describes having panic attacks and seeking medical treatment:

I am currently experiencing severe panic attacks, these panic attacks are occurring daily and quite regularly. I have been to see my GP about this problem and he has prescribed me Beta Blockers

Participant N49, Level 6, 21-year-old female.

The severity of panic attacks were quite diverse with some, such as the participant above, being resolved by their GP; while for others as illustrated below, required hospitalisation:

I have recently been suffering from severe stress and anxiety, which recently got so bad that I was unable to cope. Due to this, I was hospitalised for three days following an assessment in A&E. I saw a doctor whilst I was in hospital and discharged with an ongoing home treatment plan, which will continue until I am well. The main effect on my ability has been severe panic attacks, which affect my ability to think rationally, stay calm and concentrate. I would not be able to cope with or successfully sit an exam until I am well

Participant E20, Level 5, 20-year-old female.

Of course, all anxiety issues identified are interchangeable as the accounts provided illustrate. Anxiety, depression, panic/anxiety attacks and stress all act as barriers to submitting coursework and disrupt the normal flow of day-to-day life.

A narrative of gender?

There is a wealth of empirical evidence that points to gender differences in terms of ease at socialising; dealing with mental health and ability to seek help at a time of crisis with men fairing less well than women (Eisenberg, Downs, Golberstein, and Zivin, 2009). Part of the masculine construction dictates resilience and self-reliance, which can result in some young men delaying seeking support (Courtenay 2000). In some instance, it seems that they do not have the necessary vocabulary to articulate their support needs. Participant E58 indicates how he had little life experience and struggled to manage the everyday stresses typical of student life. He seems to be at the point of realisation that he is experiencing mental health issues that he attributes to low 'self-esteem'.

As it stands, I am struggling to even articulate my circumstances. Only in the last few days have I begun to acknowledge that I may have an issue that has prevented me from submitting this piece of coursework. I have lost my self-esteem and have felt overwhelmed to a debilitating extent which is why I left it so late to alert the university. I am finding it hard to pinpoint exactly how I feel but I have struggled with most aspects of daily life. (I've never had a job, and have not engaged in any social activities at university or home). Although I have been reluctant to seek help, I am going to seek medical/professional advice as soon as possible

Participant E58, 21 years old Level 4 Male.

It is not until he reached crisis point that he requested exceptional factors, 14 days after the submission date. The above narratives illustrate an inability to seek timely support is more prevalent in males than it appears to be in the narratives provided by females; albeit this is a cautious observation based on this small sample.

Table 9 - Gender by Anxiety and/or depression

Anxiety and/or depression	Gender	
	Female	Male
Reports anxiety and/or depression	27%	36%
N/A	73%	64%

Although not statistically significant, the table above reveals that a higher percentage of men mentioned anxiety and depression (36% n23) than did women (27% n22). This is particularly interesting as reports point to the experience of such issues being higher in women (Hunt 2010).

Contributing factors of stress

A diverse range of stress related issues littered the student EF applications. Academic issues reported were less common but included a lack confidence in educational competence and taking of exams. However, the majority of stress related reasons identified by students were personal in nature. These included, computers crashing prior to coursework submission, parental divorce, family/friend bereavement, or pet illness. Personal issues such as these reported are difficult to minimise and there are support structures such as that we have in the tutoring system to offer support where possible. Similarly, the stress of being at university is also difficult to diminish or quantify as by its very nature, taking exams, submitting coursework can be and is stressful. Again, the tutoring system is in place to provide support those experiencing stress; yet these are not necessary being fully accessed before the student reaches crisis point and needs to submit EFs. As might be expected, those at level 6 report stress more often than those at levels 4 and 5. Table 10 below shows the spread of those experiencing stress by level of study.

Table 10 - Reported stress by level of study

Stress reported	Level of study			
	4	5	6	Total
Yes	18%	17%	29%	21%
No	82%	83%	71%	79%
Total	100%	100%	100%	100%

Level 6 students reported the greatest level of stress at 29%. Clearly, this is understandable due to the pressures of university and the student being in the final year of their degree. The research explored if there were any other contributing factors related to the experience of stress such as gender and accommodation type. Interestingly, there was no statistical difference when exploring gender and the experience of stress. However, while is no significant difference between accommodation type, there is a higher percentage of those who reporting stress who are living with their parents at 27%.

Table 11 - Reported stress by accommodation type

Stress reported	Accommodation type				Total
	Halls	House/Flat Share	Living with Parents	Own Home (Owned or Rented)	
Yes	12%	16%	27%	22%	21%
No	88%	84%	73%	78%	79%
Total	100%	100%	100%	100%	100%

What might account for this higher percentage? On the surface, it might seem the ‘easy option’ to be living still at home with parents while studying at university. However, an adverse consequence of this might be the reduced opportunity to develop socially supportive peer networks that might be better equipped to provide the help and support of each other at times of stress. Interestingly, those students who are living in halls or sharing accommodation with other students report lower incidences of stress. There is also the potential for increased stress due to parental expectations and in some cases, a lack of understanding about studying at university.

Sleep and insomnia – a ticking time bomb?

The importance of sleep cannot be overestimated yet in the current climate of connectedness with much of our social activities being conducted online, we might be in danger of missing how easily sleep can be disrupted and how this can affect our students. For instance, in a recent class exercise exploring percentages, the authors asked the lecture hall of around 150 students how many were experiencing sleep disruption. Over 50% of the class raised their hands. We then asked for those who used handheld technology before they went to sleep to raise their hands. It seems, at least anecdotally, that it was the same people whom as before, raised their hands. Exploring the EF forms indicates that while MHCs are clearly the most prevalent of the issues raised, the theme of ‘disrupted sleep’ and ‘insomnia’ emerged with some intriguing discourses. Disrupted sleep was reported in 27% of the EF forms.

Table 12 - Reports of sleep disruption and insomnia

Sleep disruption or insomnia	Frequency (n)	Percentage
Yes	39	27%
No	106	73%
Total	145	100%

Sleep disruption and MHCs

Some students who reported sleep disruption also reported mental health conditions. Table 13 below indicates that out of the 39 students experiencing sleep disruption, 38% also experienced anxiety and depression.

Table 13 - Reports of sleep disruption/insomnia by anxiety and/or depression

Reports of anxiety and depression combined	Disrupted sleep	No disruption to sleep	Total
Anxiety and/or depression	38%	28%	31%
N/A	62%	72%	69%
Total	100%	100%	100%

Disrupted sleep patterns and anxiety/depression seems synonymously linked within the student narrative of need. For instance, Participant E3, Level 5, 28 year old female points out the circularity of depression and sleep:

I have depression and insomnia; I can't sleep because I am depressed and I am depressed because I can't sleep. I have been on 4 different medications for depression the past 2 years and they haven't really helped. I went 'cold turkey' last October and that just made things worse. My sleeping pattern is awful I used to sleep around 11am and wake up at 9pm.

Participant E3, Level 5, 28-year-old female

What is of note is this student struggled to progress and repeated several years but did not have a PLP due to being rejected on the grounds of the evidence she provided. She eventually withdrew after spending 3 years as a student with us.

When Participant E41, Level 5, 21-year-old female came off her medication for anxiety, the result was difficulties sleeping:

I have anxiety and have recently come off medication. This has resulted in panic attacks more regularly and not being able to sleep.

Participant E41, Level 5, 21-year-old female

Sometimes, the disrupted sleep patterns were the result of external factors such as money worries, partner problems or anxiety over exams.

I have struggled with anxiety for a number of years, especially exam anxiety. It is harder to overcome it when situations are too overwhelming or stressful. During the course of the year, I have found university to be extremely life changing and the experience was not what I had initially imagined. Previously, I was a hard-working and busy individual and routine was important part of my life. However, when I came to university this changed. I have always struggled to sleep well, but I noticed the lack of routine effected my body. As a result, I developed a serious form of insomnia, which left me frustrated and angry

Participant N68, Level 4, 20-year-old female.

Sleep and insomnia was implicated in some quite complex issues such as the account below:

I have been suffering from anxiety when I sleep. Unable to get a decent night's sleep has increased my anxiety further as I feared it was damaging my health. It has affected all my pieces of coursework so far this year. Then my mother had a breast cancer scare along with my girlfriend's parents deciding to divorce. This left me under immense stress and attempting to care for people encountering distress and a difficult time. My coursework that I have handed in late was specifically affected by these two events and my subsequent sleep anxiety. Finding myself too tired to carry out work sufficiently I was late completing the coursework and had no choice but to complete it and hand it in late

Participant, E28 Level 6, 22-year-old male

Clearly, when a student has reached crisis to the point where they need to request additional time to submit coursework, sleep might seem to be a symptom of a variety of related issues.

Sleep disruption and gender

The narrative of gender identified above in respect of MHCs is also apparent in respect of sleep disruption.

Table 14 - Sleep disruption/insomnia by gender

Sleep disruption or insomnia	Gender		Total
	Female	Male	
Yes	31%	22%	27%
No	69%	78%	73%
Total	100%	100%	100%

Of the 81 women in the sample, 31% reported experiencing sleep disruption compared to 22% of the 64 men in the study who reported such issues. However, while this is an interesting finding, there is no significant difference with this data.

Level of study

The sleep data was also explored with regard to level of study as can be seen in Table 15 below.

Table 15 - Sleep disruption/insomnia by Level of Study

Reports of sleep disruption or insomnia	Level of study			Total
	4	5	6	
Yes	40%	33%	27%	100%
No	38%	28%	33%	100%
Total	39%	32%	29%	100%

Again, while there is not a statistical difference between those who experience sleep disruption and level of study, it does show higher prevalence at level 4.

Accommodation type

Analysis of the accommodation type was surprising in that those living in Halls experienced minimal sleep disruption as illustrated in Table 16 below.

Table 16 - Sleep disruption/insomnia by accommodation type

Reports of sleep disruption or insomnia	Halls	House/Flat Share	Living with Parents	Own Home (Owned or Rented)	Total
Yes	6%	33%	25%	30%	27%
No	94%	67%	75%	70%	73%
Total	100%	100%	100%	100%	100%

This was an unexpected finding as was the higher incidences of sleep disruption for those still living at home with their parents. The assumption that peer pressure to conform while living in student halls does not appear to be reflected amongst this cohort.

Discussion

The aims of the research was to explore possible barriers to submitting coursework on time. One of the key findings from this research was that sleep disruption was reported at an alarming rate throughout the EF forms. The importance of sleep cannot be overestimated yet we live in a culture that appears not to understand or value sleep. This seems especially so for those embarking on university where an active social life can go into the early hours of the morning. In some respects we might also be inadvertently promoting poor sleep practices by, for example, having the library open 24 hours a day. Yet sleep is vital to normal day-to-day functioning and cognitive processing. There is strong evidence that poor sleep and insomnia is implicated in a range of mental health conditions such as anxiety and depression (Choueiry, Salamoun, Jabbour, El Osta, Hajj, and Rabbaa Khabbaz, 2016). Might this be the start of a harmful journey to other seemingly unrelated issues including anxiety and depression? Staying up at night on social networks or studying throughout the night will lead to tiredness and impact on the following day's performance. This is likely to lead to stress and anxiety when a student feels underprepared to function while in class or when carrying out work needed to complete coursework. We therefore recommend a further exploration of students' sleep behaviour and the basis of sleep disruption.

As a matter of urgency, we also need to raise awareness of the importance of good quality sleep and the conditions that can have a negative impact on sleep (such as blue light, alcohol, and stress). As part of a long-term strategy, we could develop a support structure that uses other students in a Peer Wellbeing Mentoring role. For instance, with suitable training, they could advise those, experiencing sleep disruption on good sleep practices. Peer Wellbeing Mentors could raise awareness of the available apps that can reduce the harmful light on LCD screens. In addition, by making students aware of these free downloadable apps, the university would take a proactive approach that raises awareness of the dangers of blue light at night, the importance of sleep and empower students to take control of their own sleep regime. It is also necessary to be proactive with the information that students provide on the EF forms. For instance, a report of sleep disruption should automatically trigger an appointment with an appropriately trained advocate, such as a Peer Wellbeing Mentor who can offer helpful tips and advice on sleep. Finally, we also suggest that we review university policies around 24-hour access to the library.

Another key barrier that might exist to students seeking help is the complexity of support that Manchester Metropolitan University has in place. At a university and even faculty, level there appears a lack consistency in the supportive roles that academics offer. Student facing academic and pastoral support structures include Programme Leader, Subject Tutor, Year Tutor, Personal Tutor, Unit Leader, Student Experience Support Tutor, Personal Support Officer... the list seems endless. The knowledge and understanding of such systems is difficult to grasp at the best of times. A student struggling with a range of complex issues might find this complexity confusing and difficult to navigate. The evidence from this research shows that the more familiar the student is with the institutional *habitus*, the better equipped they are to seek support in a more timely fashion. For example, level six students more frequently submitted EFs early than did level four and five students. Was this because of their familiarity with the systems in place? Of course, the reason for this trend might also be related to the additional importance placed on doing well in their final year. In short, more is riding on their

performance as level six students. Either way, the evidence points to increased awareness being beneficial when submitting EFs. There are several points we can take from this. First, how do we promote the development of social and cultural capital needed to function at university; the development of Peer Wellbeing Mentors who can direct those who need support to the appropriate place might be a useful start.

Secondly, we need to support students in the transition to university life and better prepare them for the rollercoaster ride they are embarking on. The example from the University of York's 'W-Curve' is useful and could be, further developed by Manchester Metropolitan University. The induction programmes are central to this endeavour. We should however, resist the temptation to fulfil 'our' institutional needs at induction and ensure we focus on the students' needs. The focus could be the development of social capital. Making friends could be the one single factor that helps a new student settle in and settle down. It is also necessary to provide the necessary information needed to function. However, we need to explore how this can be done over a longer period of time that extends beyond the induction week and well into the first term. It could be argued that this is even more important at Manchester Metropolitan University because of the greater diversity of the student cohort and the differences this engenders in terms of the cultural capital they bring at the start of university (Bourdieu, 1990).

Lastly, a student's understanding of the processes involved in functioning within an institution is somewhat different to those of the academics charged with supporting students. Might a better solution be to develop a peer mentoring system that takes many of the support structures away from the academic and put them in the hands of students? That is not to say that academics have no role in supporting students as clearly, they do. The point here however, is who is best placed, to support other students in the first instance before they reach a crisis point and need to submit an EF application. An existing student who acts as Peer Wellbeing Mentor and who knows the current procedures needed to function at university might be the key here; they would certainly have a better understanding of what it is to be a student and as such, might be more approachable to a student who is in need of support. A peer mentoring system could be developed where those involved are highly visible and trusted. They would not act as a counselling service but rather, a friendly ear from which a struggling student could ask the seemingly 'silly questions'. Importantly, this need not be face-to-face contact and we propose an exploratory study be carried out to test the utility of an online portal, staffed by current peer mentor students, who could offer advice and serve as a springboard to other support services. They would also be trained and knowledgeable in other areas of wellbeing such as sleep, time management, social capital building, stress busting, etc. and as such try to head off issues before they hit crisis point.

Of course, some applications for EFs are due to short-term illnesses such as flu, a broken bone or a traumatic experience such as a close family member or friend unexpectedly becoming ill. In such cases, the support needed is often short term and the student soon gets back into university life. The longer term and persistent issues such mental health conditions are more complex and require more considered support. Conditions including anxiety and depression, along with panic attacks, are mentioned with alarming regularity. Students with a PLP can easily contact their departmental disability officer and in many instances, this is enough to negate the need to submit EFs. However, there are a sizable number of students in the current sample

who have a MHC but who do not have a PLP. Again, is there a role for the Peer Wellbeing Mentor here who can show the route needed to be taken to obtain the long-term support needed? As this report reveals, some students might not have had the necessary capacity to obtain the level of support they required and subsequently withdrew from university. Having such a Peer Wellbeing Mentoring system might provide an additional layer of accessible support and prevent such withdrawals. This could be by offering strategies to get back into the classroom and full engagement with their studies. It could be by helping them identify the barriers to re-engagement or by simply offering the much needed 'nudge' to attend regularly and as such, help them develop good learning and attendance habits. In essence, the Peer Wellbeing Mentor could act as the conduit that links the social and cultural capital needed to fully engage with university life.

Conclusion

The research sought to explore the barriers to students seeking support. There were some surprising findings. Sleep disruption and insomnia seems to be an issue for many students and we question whether this could be the catalyst to the development of more serious issues such as anxiety/panic attacks, increased stress and longer term mental health conditions. It would be interesting to explore this issue further and look for approaches that might engage students in improved sleep practices. We also wanted to explore the structural barriers to help seeking (i.e. what part do our support structures play in acting as a barrier). It is of note that while the support structures we have set in place are thorough they might benefit from simplification. This also raises the question of who is best placed to support the majority of cases where students require support. Embarrassment and the need to demonstrate resilience might point to a peer mentoring process being developed that would remove academics from the front line of support. The academics contribution might rest with providing the necessary knowledge students' need to function while at university.

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Appendix 1 – full list of aggregated reported issues

Anaphylaxis reaction	Death of dog - then computer crashed	Migraine
Anxiety and panic attacks leading to hospitalisation	Depression	Miscarriage and struggling to sleep and concentrate.
Anxiety	Depression and caring responsibility	Missed deadline
Anxiety and depression	Depression and Insomnia	Missed flight home
Anxiety and depression with sleep issues	Depression and insomnia due to death of close family member	Moving house
Anxiety and depression with stress	Depression (long term). Death of family	Pregnant - tired - then baby born ill
Anxiety and depression. also mentioned dyslexia.	External factors (eviction) causing worry and lack of sleep.	Serious car crash
Anxiety and insomnia	Family holiday around resit of exam.	Server stress that brought on eczema. This led to difficulty sleeping
Anxiety attack led to longer term MHC (mental health condition)	Family illness	Short term illness
Anxiety, depression and panic attacks.	Family issues causing stress and anxiety	So many things - MRSA, two deaths in family, house fire.
Anxiety, insomnia, stress and panic attacks	Family problems	So many things. 2 Deaths of family members, child also ill
Anxiety, sleep and panic	Family problems causing sleeplessness	Something happened
Anxiety/panic attack	Financial pressures	Something happened - Crime against person

Assaulted	Financial worries causing worry and lack of sleep	Stress - family problems
Attending court case	Home sick leading self-imposed social isolation	Stress of taking exam
Broken laptop	Hurt shoulder - painful disrupting sleep	Termination
Caring responsibilities	Jury service	Told to leave family home by police day before exam
Computer confiscated by police	Long term illness	University had closed early so could not submit
Death	Marriage breakdown	Wrote exam date down incorrectly and missed exam
Death (suicide of mother)		