Exploring the Roles of Help-Seeking Behaviours, Therapeutic Alliance, and Single Session Therapy on UK University Students' Mental Health

Chapter 1: Perceived Barriers and Facilitators to Help-Seeking for Mental Health Support in UK Students in Higher Education: A Systematic Review

Chapter 2: Single Session Therapy for UK University Students: The Perceived Change in Mental Health Concerns and Impact of the Therapeutic Alliance

Siobhan Williams

Supervised by:
Dr Warren Donnellan
Dr Victoria Vass
Dr Ben Gibson

Submitted in partial fulfilment of the
Doctorate in Clinical Psychology
12th June 2023

Word count including appendices: 29,615
SR: 8,528 Empirical:12,258

Acknowledgements

I would like to thank my research supervisors Warren Donnellan, Victoria Vass and Ben Gibson for their support and feedback throughout every stage of the project. Thank you to my participants, in particular to the university counselling staff who took time out of their busy schedules to take part and allowed me an insight into their experiences. Thank you to my family for your support throughout my psychology career this far, I could not have got to this stage without you all. To my partner Ben for supporting and sustaining me throughout the ups and downs I have experienced throughout the Doctorate, including the extension of this research project delaying our next adventures. A special thanks to Beth for proof reading the thesis whilst having her own to contend with. I would like to thank my fellow Trainee Clinical Psychologists for the support and encouragement they have given me especially at this final hurdle.

Sponsor

The University of Liverpool is the research Sponsor for this Study. For further information regarding the sponsorship conditions, please contact:

Research Support – Health and Life Sciences
University of Liverpool
Research Support Office
2nd Floor Block D Waterhouse Building
3 Brownlow Street
Liverpool L69 3GL
sponsor@liv.ac.uk

Table of Contents

Chapter 2:

Single Session Therapy for UK University Students; the Perceived Change in Mental Health Concerns and Impact of the Therapeutic Alliance

Exploring the Roles of Help-Seeking Behaviours, Therapeutic Alliance, and Single Session Therapy on UK University Students' Mental Health

Introduction to this Thesis

Recent UK Parliament data highlights a concerning increase in the number of students in higher education reporting mental health diagnoses and seeking counselling (Hubble & Bolton, 2020). According to the report, 16.2% of students surveyed reported a disability with 26.6% of these being mental health-related, amounting to approximately 82,000 students. This figure is 250% higher than that recorded in 2014/15 (The Higher Education Statistics Agency, as cited in Hubble & Bolton, 2020). Similar prevalence rates have been observed in a UK study by Hunt et al. (2012), where 33.9% of university students reported symptoms of common mental disorders. Moreover, the number of student suicides reached a record high in 2015, with a 79% increase between 2007 and 2015 (from 75 to 134 deaths) (Hubble & Bolton, 2020; NSSE 2007). Numerous studies have explored the mental health challenges faced by UK university students, shedding light on prevalence rates, access to interventions, and leading to recommendations for development of student mental health services. This has led to the introduction of innovative approaches like Single Session Therapy (SST) where patients have a one-off therapy session.

A survey conducted by the National Union of Students (NUS) in 2015 highlighted that only 15% of UK students experiencing mental health difficulties sought formal help from their institution's counselling or mental health services (National Union of Students, 2015). This suggests a significant underutilisation of available support services. Furthermore, the survey revealed that only 33% of UK students who sought help for mental health issues felt that the support they received was adequate (National Union of Students, 2015). Another study conducted by the Institute for Public Policy Research (IPPR) in 2017 found that 43% of students with mental health difficulties had not disclosed their issues to their university or sought support (IPPR, 2017). This indicates that a substantial number of students are facing mental health challenges without seeking appropriate help. Mental health concerns can lead to lower academic achievement, educational drop-out, increased dependence on parents, diminished career prospects and, in the most severe cases, suicide. This highlights the need

for more accessible and effective mental health interventions on campuses. Given the gravity of the situation, this thesis aims to provide a comprehensive overview of students' and therapists' experiences of mental health support within UK universities, and especially of SST as an intervention due to its recent inclusion across a selection of UK university counselling services in hopes to address student mental health needs within a timely manner. The research comprises two main chapters: a systematic review and a mixed-method empirical paper, both of which will be prepared for publication.

Chapter one includes the systematic review exploring university students' perceived barriers and facilitators to help-seeking for mental health support. By synthesising existing literature, this review aimed to shed light on the factors that influence students' decision-making processes when it comes to seeking professional assistance for their mental health concerns. The increasing prevalence of mental health concerns and reports of limited help-seeking by students underscore the importance of understanding the barriers and facilitators among UK university students. By identifying the factors that hinder or encourage students to seek mental health support, institutions can develop targeted strategies to improve access, reduce stigma, and provide more effective assistance to those in need.

Chapter two incorporates a mixed methods empirical study consisting of two key areas of consideration: 1. A quantitative study on university students' perceived changes in mental health concerns following SST; and 2. A qualitative study using interpretative phenomenological analysis (IPA) to explore therapists' experiences of delivering SST within a university setting. By considering the first-hand experiences and perspectives of therapists, this qualitative investigation seeks to provide insights into the challenges, successes, and unique considerations associated with delivering this intervention in a university context.

Together, this thesis seeks to contribute to a deeper understanding of mental health support within UK universities, highlighting both the student perspective and the experiences of therapists. The findings from this thesis have the potential to inform and enhance mental health services in higher education, with the ultimate goal of improving student well-being and reducing the negative consequences associated with untreated mental health issues.

References

Hubble, S., & Bolton, P., (2020). Support for students with mental health issues in higher education in England. *House of Commons Library Briefing Paper*, 8593.

Hunt, J., Eisenberg, D., & Kilbourne, A. M. (2012). Consequences of receipt of a psychiatric diagnosis for completion of college. *Psychiatric Services, 63*(12), 1222-1226. doi:10.1176/appi.ps.201100523

Institute for Public Policy Research (IPPR). (2017). *Not by degrees: Improving student mental health in the UK's universities*. Retrieved from https://www.ippr.org/research/publications/not-by-degrees

National Union of Students. (2015). Mental distress survey. Retrieved from https://www.nusconnect.org.uk/resources/nus-mental-distress-survey

O'Hanlon, M., McElvaney, J., & Timulak, L. (2019). The therapeutic impact of single-session therapy (SST): A systematic review. *Frontiers in Psychology, 10*, 2467. doi:10.3389/fpsyg.2019.02467

Stallman, H. M., & Shochet, I. M. (2009). Prevalence of mental health problems in Australian university health services. *Australian Psychologist, 44*(2), 122-127. doi:10.1080/00050060802548031

CHAPTER 1: Systematic Review

Perceived barriers and facilitators to help-seeking for mental health support in UK students in higher education: a systematic review

Abstract

This paper aims to systematically review current studies that report on barriers and facilitators to help-seeking for mental health difficulties in UK students within higher education settings. The research indicates that students frequently experience mental distress, but they often hesitate to seek help. To identify relevant papers, databases and grey literature have been searched, resulting in the identification of sixteen papers. Quality of the studies is assessed using the Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018). From these papers, eight qualitative, six quantitative, and two mixed-methods studies have been identified.

From the included studies, twenty-two barriers and twenty-two facilitators to help-seeking for students in higher education settings have been noted. The most commonly mentioned barriers are the lack of knowledge about where to seek support, stigma, lack of time, reliance on self, gender-related concerns, and worries about the impact on studies and future careers. On the other hand, key facilitators include support from friends and family, higher levels of psychological distress, and peer support.

It is crucial to improve help-seeking within this student population. Several implications are suggested, such as increasing awareness and disseminating information about mental health services and peer support networks, such as befrienders.

Key words: Systematic review, students, barriers, facilitators, help-seeking

Introduction

Young adults (aged 18-25) have been identified as one of the most vulnerable age groups for developing mental health difficulties (Kessler et al., 2005). Nearly 75% of adults with a mental illness experience initial symptoms before the age of 25 (Thorley, 2017). Despite these alarming statistics, young adults are the least likely to seek and receive mental health support, with only 42% experiencing mental distress accessing services (Substance Abuse and Mental Health Services Administration, 2021). The rising number of UK students in higher education reporting mental illness aligns with this trend (Broglia et al., 2017). Disclosure of mental health conditions by students to higher education facilities was five times higher in 2017 than 2007 (Thorley, 2017). Yet despite this significant increase, around 50% of students who report having a mental health condition still elect not to disclose it to their institution (Thorley, 2017).

Mental illness affects individuals in numerous negative ways, impacting relationships, self-esteem, academic attainment, employment, and housing, leading to significant effects on students' abilities to thrive and increasing the likelihood of withdrawal from university (Insight Network, 2020; Office for Students, 2019). While policies recognise the importance of preventative strategies and early intervention for poor mental health (Department of Health, 2011; Insight Network, 2020), it is important to consider barriers and facilitators to students seeking mental health support in order to design these strategies and interventions in a suitably accessible way.

UK based higher education establishments have a responsibility to support their students by providing a range of student services. While the structures of support may vary across each institution, they often include financial, disability, mental health and wellbeing support (University Mental Health Advisers Network [UMHAN], 2023). With access to free health care, and universities and other NHS services providing free short-term psychological therapies and counselling, one might expect students to seek help when experiencing a deterioration in their mental health. However, despite the impact of poor mental health on an individual, research suggests significantly low rates of mental health help-seeking amongst students (McLafferty et al., 2017).

A wellbeing survey found only 13.4% of students with mental disorders, and 15% with suicidal thoughts and behaviours (STB) would seek support from university services (Ennis et al., 2019). Help-seeking is seemingly a concern across all ages within the general population due to factors such as stigma, cost, or not expecting anything to help (Mojtabai, 2001). However, student-specific barriers mentioned in research highlight concerns regarding confidentiality and impact on future careers (Broglia et al., 2021; Chew-Graham et al., 2003). Cost is also identified in international studies, as students consider the cost-benefit of help-seeking, questioning if their problem is serious enough to seek help, especially when many students already face financial concerns. In the UK however, with access to free mental health support, it is important to review UK students' noted barriers (Czyz et al., 2013; Sheffield et al., 2004). While reviews have been conducted exploring various specific adult populations and adolescents' reasons for not accessing mental health services worldwide, to the author's knowledge, no review has systematically identified and synthesised literature specifically regarding UK higher education students' personal perceptions of barriers and facilitators to mental health help-seeking (Byrow et al., 2019; Clement et al., 2014; Gulliver et al., 2010).

Conducting a systematic review to explore these barriers and facilitators among UK university students is therefore crucial for understanding the factors that influence their help-seeking decision-making process. Synthesising existing literature on this topic, this review provides a comprehensive overview of the challenges students face in accessing and utilising mental health services. It sheds light on the various factors that hinder or facilitate help-seeking behaviours, including stigma, lack of awareness, concerns about confidentiality, perceived effectiveness of interventions, cultural factors, and structural barriers within university settings.

Understanding the barriers and facilitators is essential for developing targeted interventions and strategies that address the mental health needs of students. In identifying the specific challenges that students encounter when seeking support, universities can implement proactive measures to reduce stigma, increase awareness, improve accessibility, and enhance the overall support system for mental health. This systematic review will contribute to the existing body of knowledge by identifying

gaps and limitations in the literature. It will highlight the complexities of help-seeking behaviours among UK university students and provide recommendations for improving mental health services on campuses.

Aims of this study

This review will be a mixed-method synthesis which will integrate quantitative, qualitative and mixed-method evidence or data from studies. The aim of this report is to systematically review and critically appraise the available quantitative and qualitative literature on the perceived barriers and facilitators to help-seeking for mental health support in UK students within higher education. By synthesising and critically analysing the available evidence, this systematic review also seeks to inform policy-making, guide the development of interventions, and ultimately improve the well-being and academic success of UK university students.

Methods

Databases and Search methodology

A scoping search was conducted to assess what literature was available in the area. The Cochrane Database of Systematic Reviews (CDSR), the Database of Abstract of Reviews of Effects (DARE) and PROSPERO were checked for existing and in-progress reviews on barriers and facilitators to help-seeking for mental health difficulties within UK students in higher-education. No results were identified and as such, to the knowledge of the author, there has been no previous relevant review conducted. This systematic review was preregistered on PROSPERO (ID# CRD42022367442) prior to commencement (14 October 2022).

Consultation was provided by an NHS trusts specialist librarian, offering training and guidance for the systematic review searches. A search was conducted in four databases (PsycINFO, Medline, Psyc Articles and Web of Science) in October and November 2022 using identified search terms for research papers, dissertations, and grey literature from 2002 until 31st October 2022. Publications within the previous 20 years aligns with established guidelines in systematic review methodology, emphasising the importance of recent research to reflect the dynamic nature of societal developments and changes (Higgins et al., 2021). This ensures that the findings and implications referred to in the systematic review are up-to-date and directly applicable to the current landscape of UK universities. Secondly, considering the timing of included studies is crucial in assessing the heterogeneity of research, especially in an evolving field such as mental health support for university students. A 20-year window accommodates variations in research methodologies, interventions, and cultural contexts while preserving the clinical relevance of the systematic review (Harris et al., 2018). Furthermore, acknowledging the past two decades accounts for a period of significant technological advancement, with increased reliance on information technology and substantial progress in technologically blended learning, both of which have become increasingly pertinent, notably during the COVID-19 pandemic (Duncan, 2021). Incorporating research within this timeframe ensures that the systematic review remains sensitive to the contemporary challenges and opportunities in the field of mental health support for UK university students.

Google Scholar was also searched. The research team agreed it was important to include unpublished studies as they may include emerging research or research that includes null results which may not reach publication requirements. Additionally, with the research topic being focussed on university students, it was acknowledged that students may have a key interest in the area for research purposes but not have had the time or funding available to continue to publication standard. Search terms were generated for each concept through exploring appropriately related review papers, a dictionary for definitions and thesaurus to identify additional synonyms (see Appendix 1).

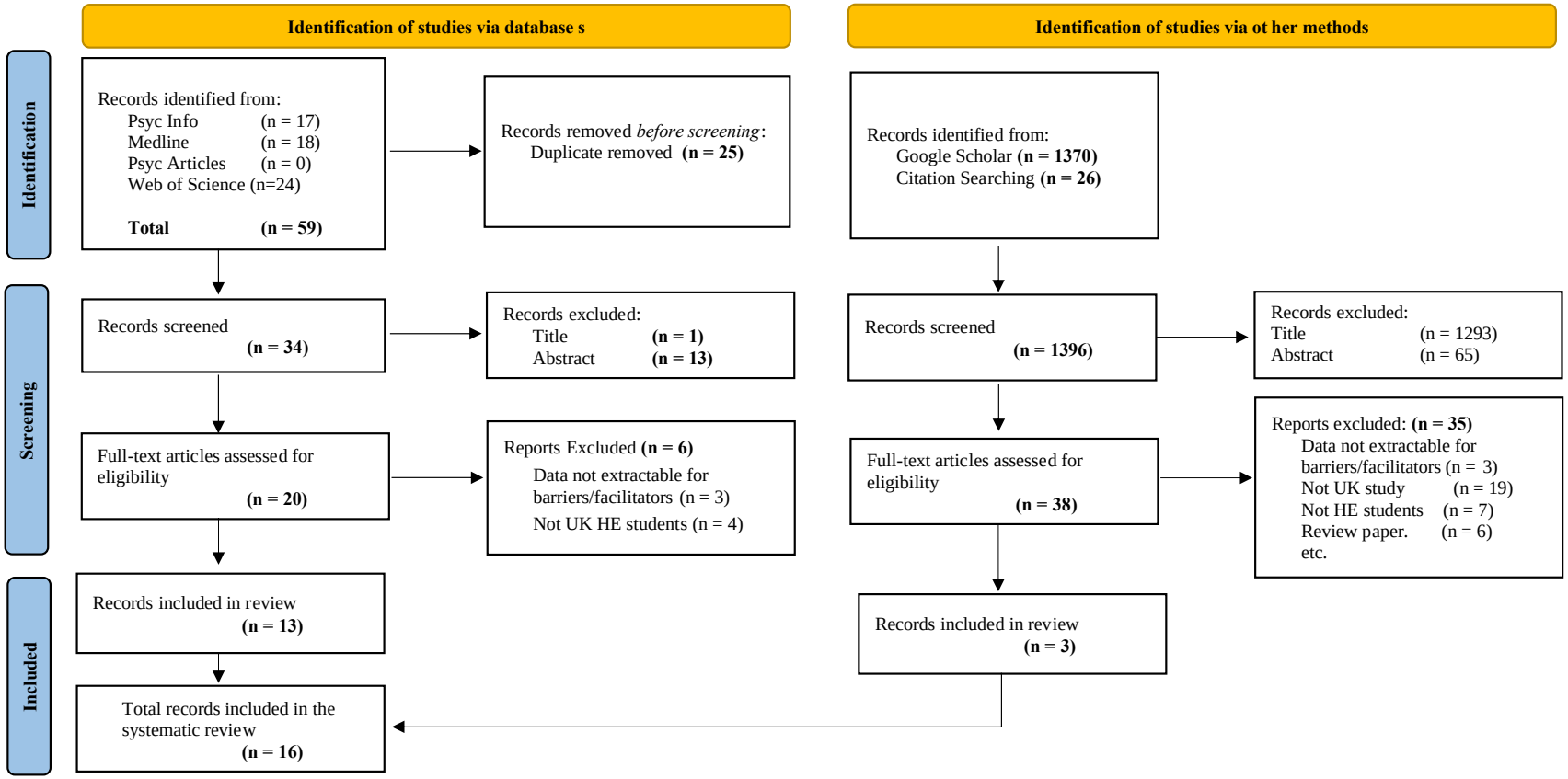
Study Selection

Inclusion and Exclusion Criteria

This report includes papers that meet the following inclusion criteria: (1) They are quantitative or qualitative studies, including dissertations and grey literature; (2) They address barriers or facilitators to help-seeking for mental health concerns; (3) The participants are students within UK higher education facilities; (4) They were published between October 2002 and November 6, 2022.

Papers were excluded from this report if they met any of the following criteria: (1) They were reviews or case studies; (2) They contained no extractable data on barriers or facilitators to help-seeking for mental health problems; (3) The study focused on help-seeking on behalf of another person, such as a parent seeking help for a child. No papers were excluded due to research quality. Due to the limited numbers, all papers in this field were included. Papers of low quality were interpreted more sensitively when using them to highlight knowledge or provide guidance to future research.

Figure 1: PRISMA diagram of the included studies selection.



From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71.

Data Extraction

Data were extracted from the included papers by the lead researcher (SW). The following data were extracted: (a) author(s) and year; (b) sample size; (c) participant demographics; (d) methodology; (e) measures used (if appropriate); (f) barrier themes reported; and (g) facilitator themes reported. Regular meetings were held with the research team to discuss any uncertainties or clarification of papers meeting eligibility criteria based upon data extraction.

Quality Assessment

All selected articles were evaluated to assess bias and quality. The Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018) was used to assess the quality of the selected papers. The MMAT assesses quality across two screening questions for all study designs: (1) "Are there clear research questions?" and (2) "Do the collected data allow to address the research questions?" and five additional domains that differ across study types. Each screening question is scored categorically ('yes', 'no', 'can't tell').

Within the current review, it was agreed within the research team that no studies were to be excluded based upon quality assessment outcome. Each paper was provided an overall quality appraisal as high, medium, or low quality based upon the total number of 'yes' responses across the seven assessment categories (High quality= 6-7 'yes'; medium quality= 3-5 'yes'; low quality= ,3 'yes' responses). The lead author appraised the papers with a colleague external to the research team independently assessing nine randomly selected papers. Overall, only two domain discrepancies arose within the papers reviewed and these were due to differences in interpretation of the criteria and resolved through discussion until 100% agreement was reached. Discrepancies were also reflected back to the research team. Inter-rater reliability was assessed with Cohen's kappa resulting in an 'excellent' agreement (k = .87) (see appendix 10).

Results

Paper selection

As of 30th November 2022, the search protocol yielded 1,429 papers and a further 26 from secondary searches, manually searching citations sections of included articles (see Figure 1). Twenty-five duplicates were removed and papers were reviewed based on titles. A further 136 abstracts were examined, and a subsequent 58 full texts reviewed. This resulted in 16 papers for detailed review.

Study quality and characteristics

Out of the 16 studies identified for this review, eight utilise qualitative methods, six quantitative, one predominantly quantitative but includes an option for participants to provide 'free text' responses, and one adopts a mixed methods approach. When quality assessed using the MMAT, 11 studies were rated as high, five studies as medium, and none were rated as low quality. The quality assessment outcomes are summarised in Table 1.1. In terms of gender representation, fifteen of the selected studies included both males and females, while one study included males only. Among the included studies, four specifically explore the experiences of medical students, one focuses on students from racial and ethnic minority (REM) backgrounds, one examines the experiences of Chinese international students, and one centers on individuals from the White-Polish immigrant community at university. Further details regarding the characteristics of the studies and key measures can be found in Table 1.2.

Analysis

A convergent integrated synthesis design was used to merge findings from the studies, reducing methodological disparities between qualitative and quantitative research (Noyes et al., 2019). This approach minimises the methodological disparities inherent in qualitative and quantitative research, as both types of research generate findings that can be seamlessly integrated due to the focus on addressing the same research questions. The collection and analysis of both qualitative and quantitative data take place concurrently. The results are presented cohesively, using a single

synthesis method to integrate both types of findings, offering a comprehensive view of our research questions. Notably, data transformation occurred, presenting the information thematically. This approach, adopting the convergent integrated synthesis design and following systematic steps, enables us to combine quantitative and qualitative data, yielding robust results that addressed our research objectives. Minimising methodological differences, this approach ensures a rigorous and informative synthesis, providing a deeper understanding of our topic. By integrating both data types, we gain a more comprehensive perspective, enhancing our ability to answer research questions thoroughly.

Table 1.2 presents a comprehensive summary of the key data from all sixteen studies, including sample size, participant demographics, methodology, measures, and reported barriers or facilitators to help-seeking. This table provides a concise overview of the essential information extracted from each study to meet the aims of the systematic review. The analysis of the selected studies identifies several key barriers to help-seeking, which are summarised in Table 1.3, highlighting their frequency across the studies. While three studies do not explicitly explore barriers, students in all sixteen studies share their reasons for not accessing mental health services. In-depth discussions will focus on barriers mentioned in four or more studies. Although facilitators of mental health help-seeking are not explicitly explored in several studies, ten do identify facilitator themes. Table 1.4 presents these facilitator themes, with further detailed discussions focusing on those found in three or more studies.

Table 1.1: Quality Assessment of Studies using the Mixed Methods Appraisal Tool (MMAT)

Author(s) (Year)	Screening Questions		Qualitative Domains					Total Score	Overall Quality Appraisal
	Clear Research Objectives	Data Addressing Research Objectives	Appropriate approach	Adequate methodology	Adequate findings	Sufficient substantiation	Coherence		
Chew-Graham, Rogers & Yassin (2003)	+	+	+	+	?	+	–	5	Medium
Law (2021)	+	+	+	+	+	+	+	7	High
Maciagowska (2018)	+	+	+	+	+	+	–	6	High
Olaniyan (2021)	+	+	+	+	+	+	+	7	High
Sagar-Ouriaghli, Brown, Tailor & Godfrey (2020)	+	+	+	+	+	+	+	7	High
Shahaf, Oren, Madan & Henderson (2021)	+	+	+	+	+	+	?	6	High
Simpson, Halpin, Chalmers & Joynes (2019)	+	+	+	?	?	+	+	5	Medium
Winter, Patel & Norman (2017)	+	+	+	+	+	+	?	6	High

Author(s) (Year)	Screening Questions		Quantitative Descriptive Domains					Total Score	Overall Quality Appraisal
	Clear Research Objectives	Data Addressing Research Objectives	Sampling Strategy	Represents Population	Appropriate Measurement	Nonresponse Bias	Statistical analysis		
Bryant, Cook, Egan, Wood & Mantzios (2022)	+	+	+	+	+	?	+	6	High
Cage, Stock, Sharpington, Ptiman & Batchelor (2020)	+	+	+	+	+	?	+	6	High
Ennis, Lafferty, Murray, Lapsley & Bjourson (2019)	+	+	+	+	–	–	+	5	Medium
Gorczynski, Sims-Schouten & Wilson (2020)	+	+	+	+	+	?	+	6	High
Gorczynski, Sims-Schouten, Hill & Wilson (2017)	+	+	+	+	+	?	+	6	High
Wadman, Webster, Mawn & Stain (2019)	+	+	+	?	+	–	+	5	Medium

Author(s) (Year)	Screening Questions		Mixed Method Domains					Total Score	Overall Quality Appraisal
	Clear Research Objectives	Data Addressing Research Objectives	Adequate rationale	Effective integration	Adequate interpretation	Adequately addressed	Quality adherence		
Broglia, Millings, & Barkham (2021)	+	+	+	+	+	+	+	7	High
Knipe, Maughan, Gilbert, Dymock, Moran & Gunnell (2018)	+	+	+	+	–	+	–	5	Medium

Note: '+' = yes, '–' = no, '?' = cannot tell.
An overall quality appraisal score was calculated for the purposes of this review as follows: 6–7 + = high; 3–5 + = medium; <3 + = low.

Table 1.2: Study characteristics

Author(s) (Year)	Sample Size & *Population Locality*	Participants & Key demographics	Methodology	Measures	Barrier themes reported	Facilitator themes reported
Broglia et al., 2021	1,956 5 UK Universities	18-24 years (M=21.5) • 71% female • 79% undergraduate • 65% home/birth country • 3% international student • 32% previously MH support • 39% avoided help-seeking	Cross sectional: quantitative and qualitative	• CCAPS-34 online questionnaire.	• Too uncertain & lack of time (not needed 'yet') • Structural barriers- not knowing what's available or 'put off' by information/ knowledge of service. • Limitation of service- wanting 'immediate' help. • 'Drop out' of counselling as want to handle problems alone. • Stigma: self & external. • Lack of support with previous attempts.	Not explicitly explored but facilitators noted from exploring barriers within the research: • Help from support network (friends) • Ability to explore support options • High psychological distress
Bryant et al., 2022	304 UK University-midlands	18-60 years (M=21.5) • 82% female	Quantitative: between subjects	• Demographic questionnaire- age, gender, ethnicity, year of study, living arrangements, average grade. • General help-seeking questionnaire short form (GHSQ- SF) (Wilson et al., 2005) • Benefits & barriers to help-seeking questionnaire (Vidourek et al., 2014) • Self-stigma of seeking help (Vogel et al., 2006) • Sense of belonging scale (Leach et al., 2008)	Barriers not explicitly researched but: • LGBTQQ students more likely to seek help from off campus service.	• Help-seeking from personal tutor more likely if: minority ethnic student; commuting student than in accommodation; or greater sense of belonging. • Help-seeking from mental health service more likely it: black student, and greater sense of belonging. • Help-seeking from peer more likely if: white student, younger student, greater sense of belonging. • Online availability did not impact help-seeking.
Cage et al., 2020	376 South-East England University	Mean age 20.73 years • 85% female • 82% born in UK • 76.9% white British • 76.8% heterosexual	Quantitative: cross sectional survey	• Demographic questionnaire • GHSQ (Wilson et al., 2005). • Additional- 'actual' help-seeking behaviour questions. • Adapted stigma scale (Golberstein et al., 2008) • Self-stigma of seeking help (Vogel et al., 2006).	• Gender- males more likely to seek help than females. • Prior diagnosis of mental health condition more likely to intend to seek help. • Self-stigma • Depression decreased intent to seek help from informal sources	• Educational impact increased help-seeking intent • Increasing stress increased informal help-seeking intent • Previous diagnosis increased intent for help-seeking • Increasing disclosure increased informal help-seeking.

				• Educational impact questions • Brief cope scale (Carver, 1997) • Distress discloser index (Kahn & Hessling, 2001). • DASS-21 (Henry & Crawford, 2005) and additional mental health questions.	• Disclosing to informal support sources did not increase help-seeking from formal sources. • Normalisation of mental health issues within students	
Chew-Graham et al., 2003	22 University of Manchester	Medical students in Years 3-5 Equal number of males & females.	Qualitative	Audio-taped semi-structured interviews, 20-40minutes	• Talking to a stranger- prefer to speak with friends or family • Perceived external stigma with stress or mental illness • Self-stigma: shame & embarrassment of needing help, a weakness. • Conflict in tutor assessing performance so cannot share stressors. • Fear of lack of confidentiality/ trust • Worries of impacting future careers. • Lack of knowledge of available support services (within medical school, university & external)	• Friends who are also medical students- a connection & understanding to the stressors increased likelihood to talk to peers. • "Advertising of services" via flyers, stickers via email & in commonly used areas eg toilet.
Ennis et al., 2019	392 4 N.Ireland Universities	18-47 years (M=21) • 58.7% female • First year undergraduate (UG) students with history of mental health disorder (MD).	Quantitative	• Various measures to assess for MD. • World Mental Health Composite Diagnostic Interview (WMH-CIDI) (Kessler & Ustun, 2008)	• Gender- males significantly less likely to access treatment than females (28% v 45%) • Readiness to change- 83.3% MD rated do not have a problem to change. 52.7% of pts with MD & suicidal thoughts/behaviours (STB)-rated problem does not need to change. • Being embarrassed (females) (self-stigma) • Worry about being treated differently (females) (external stigma) • Unsure on where to seek support (MD only)	Not explicitly explored but facilitators noted from exploring barriers within the research: • Having STB, increased likelihood to receive treatment (50.7% v. 20.2% with mental disorder alone).

Gorczynski et al., 2020	300 UK University students	18-25 years (M= 20.2) • 81.7% heterosexual; 14.7% LGB; 3.3% other • 90.4% UG (42.7% 1st year); 9.7% PG. • 71.7% no previous MD diagnosis.	Quantitative: cross-sectional	• Demographics • Mental health literacy (MHL) scale (O'Connor & Casey, 2015) • GHSQ (Wilson et al., 2007) • Kessler Psychological Distress Scale 10 (K10) (Kessler et al., 2002) • The Warwick-Edinburgh mental well-being scale (WEMWBS) (Tennant et al., 2007) • Self-compassion form, short form	Barriers not explicitly researched but: • Sexuality- heterosexuals showed greater help-seeking intentions that LGB+ other, therefore, sexuality an inferred barrier.	• MHL- a)gender- females sig. higher. b) sexuality- bisexual sig. higher than heterosexual c) previous MD sig. higher than no history of MD. but MHL not correlated to help-seeking. • Higher mental well-being increased intention to help-seeking. • Help from support network- intimate partner & friends. Third most common was mental health professional. • Knowledge of self-help/online resources
Gorczynski et al., 2017	380 South of England University students	18-64 years (M=20.94) • 61.3 % males (n=233); 38.4% females (n=146); did not specify, n=1 • 93.9% heterosexual • 54.4% 1st year UG. • 11.6% previous MD diagnosis.	Quantitative: cross-sectional	• Demographics • MHL Scale (O'Connor & Casey, 2015) • K10 (Kessler et al., 2002) • GHSQ (Wilson et al., 2007) • WEMWBS (Tennant et al., 2007)	Barriers not explicitly researched but: • Students have difficulty identifying mental health problems. • 42.3% do not know where to find resources.	• Increased help-seeking correlated to higher MHL • Higher help-seeking if lower distress & higher well-being. • Gender differences in MHL • Increase in MHL over University years (i.e. 1st year lowest, PhD highest) • Help from support network- prefer support from intimate partner or family than professional. • Online resources
Knipe et al., 2018	1139 One UK University	Median age- 21 years • 2133 invited to participate- 1139 opted in • 51% medical; 20% dentistry; 29% veterinary students • 64% females; 44% males	Quantitative, Qualitative- 'free text', thematic analysis.	• Demographics • Various measures to assess for MD (e.g. PHQ-9) • WEMWBS (Tennant et al., 2007) • Help-seeking questions	• Reasons from those with 'severe depression' (25.2%): fear of documentation (50%); lack of time (46%); unwanted intervention (46%); not knowing where/lack of service availability (17%). • Reasons from those with suicidal thoughts (1%, n=11) lack of confidentiality (46%); stigma (55%) • Concerns with fitness to practice policies & procedures • Lack of time- support hours clash with placement/teaching hours	Not explicitly explored but facilitators noted from exploring barriers within the research: • Ease of access to support (better hours)

Law, 2021	8 Southeast England University	18- 30 years (M=20.6) • Chinese international students • 50% male, 50% female • 5 in final year (3rd year)	Qualitative: unpublished dissertation IPA	Semi-structured interviews	• A need to be independent, expectations on adapting to independence quickly • Obstacles to seek support from home; time difference, lack of experience overseas from family (to understand/relate) • Disengaging from emotions- cultural view that self-control of emotions was positive; avoidance of expressing emotions (sociocultural upbringing) • To prevent peer distress/ worry- prioritising peers feelings over their own, protect social harmony • Lack of personal networks/connections making help-seeking confusing • Lack of trust in services in UK • Confusing experiences in help-seeking in UK • Lack of knowledge of UK psychological therapies • Normalising distress	• Personal networks and connections when sought help at home • Knowledge of what to expect from professional support • Intense psychological distress- support from friends.
Maciagowska, 2018	8 2 Northwest England Universities	22 to 27 years • 100% White-Polish • 50% male, 50% female • Emigration varied from 2 months to 10 years	Qualitative: unpublished dissertation Thematic Analysis	Semi-structured interviews	• Lack of awareness; understanding of mental health problems, where to seek support and what therapy was. • Shame/ stigma, not wanting to show weakness (cultural stigma & general shame) • Finances & wait times; long NHS wait times but private being too expensive • Gender- males less likely to seek help (male stereotypical roles of being masculine) • Language, emotions hard to discus in a second language • Previous negative experiences of help-seeking • Self-directed care- learn coping skills rather than seek-help.	• Awareness campaigns, where to receive help and stigma reducing • Therapeutic availability in other languages (first language) • Previous positive experiences of help • Easy access; University service, campus based • Speaking to trusted others- family, friends • Connecting with Polish communities

Olaniyan, 2021	48 2 UK Universities	Racial & ethnic minority students (REM) from Russell group (majority white student body, REM= 25.4% of students) & non-Russell group university (REM= 64.4% of students). • 28 NRGU • 20 RGU • 62.5% female • MD diagnosis, N=13 • Medical/ science course (N=30)	Qualitative: paired comparison	Semi-structured interviews	• Sociocultural context raised in-mental health discussions not embraced • Academic background/ course-biological/medical explanations considered for MD (normalisation of MD) • Use of prayer (but fear of alienation, being judged from community so not seeking help) • Gender disparity- professional help-seeking is "for women". • Poor University reporting experiences previously (to academic staff re. discrimination) • Prior negative experiences of mental health services. • Current negative experiences of mental health services	• Knowledge can stop treatment at any time • Similar faith beliefs to practitioner • Culturally sensitive support • Reassurance will not impact career prospects (medical & law students). • Support from network- friends
Sagar-Ouriaghli et al., 2020	24 One UK University (London)	18-31 years (M=21.89) • 100% male • 76% UG • 50% previous MH support. • 17% white British	Qualitative: three focus groups, recruitment with purposive sampling	Topic guide developed with the Young Peron's Mental Health Advisory Group	• Difficult to speak about mental health; fears about opening up. • Speaking to professionals- "strangers" • Lack of mental-health knowledge, including knowing when to seek help • Stereotypical masculinity; help-seeking being unmasculine • Lack of clarity on intervention preference impacting services designing support. • Lack of service knowledge, not knowing where to seek support. • Logistical & structural barriers (e.g. wait times)	• Safe spaces: male only • Trusted relationships: close friends/ social support • Clearer confidentiality information. • Use of male role models to normalise help-seeking • Promotion of help-seeking via student networks, clubs, face to face advertising (rather than emails, posters) • Mental-health initiatives at start of academic year, exam period, Christmas break • Incentives (e.g. snacks) • Re-labelling services- not called mental health.

Shahaf-Oren et al., 2021	11 One UK University	19- 26 years (M=23.09) • 54.5% male (N=6) • 72.72% white British (N=8) • UG medical students • Self-determined/ diagnosed health condition, or disability	Qualitative: recruitment with purposive sampling		• Personality type; "being private" • Prior experiences of mental health services; confidentiality limitations in counselling for U18s. • Sociocultural factors • Lack of mental health knowledge/ insight into difficulties- when to seek help. • Fear of escalating the difficulty, negative treatment side effects • Worries about judgement, being perceived differently, fear of stigma • Acceptance of mental health problems over physical health; knowledge of treatment for mental health problem • Not wanting to be a burden to family • Lack of acquaintance impacts opening up • Awareness/ observations of peers experiences • Desire to meet the medic stereotype; health & excellence • Logistical & structural barriers (e.g. wait times, time needed to attend, how to refer/access services) • Fear of losing place in medical school	• Severity of condition- help once at "lowest point". • Support from network- friends • Shared difficulties, connection to others with similar conditions • Accessibility & friendliness/approachability of University staff • Increase of awareness of wellbeing
Simpson et al., 2019	17 University of Liverpool	• 2nd year medical students	Qualitative	Semi-structured interviews	• Concerns of negative consequences within the medical school • Lack of clarity on intervention preference impacting services designing support. • Lack of time within teaching schedule to incorporate wellbeing sessions • Sense that student services will not meet their need	• Designated time with course staff members • Continuity of supervisory support • Support from those that can relate- older students, mentor system

Wadman et al., 2019	273	• Students who experienced mild/moderate psychological distress • 188 excluded (no or low psychological distress) • Predominantly white British, female psychology students.	Quantitative: cross- sectional	• Demographics • Help-seeking questions • Kessler Psychological Distress Scale 6 (K6) (Kessler et al., 2002) • Revised Adult Attachment Scale (Collins, 1996) • Multidimensional Scale of Social Support (Zimet et al., 1988) • The List of Threatening Experiences-Q (Brugha & Cragg, 1990) • The Discrimination-Devaluation Scale (Link, 1987)	• Perceived public stigma found to not be a barrier or facilitator (i.e. did not impact help-seeking behaviours) • Level of social support found to not be a factor in help-seeking. (or barrier). • Attachment style & level of psychological distress: mild/moderate distress less likely to seek help.	• Age- being older • Higher psychological distress & higher anxious attachment style
Winter et al., 2017	20 2 UK Universities	• Medical students • 57 interviews conducted, 27 met criteria for study. • 12 male, 8 female • 7 international students	Qualitative: thematic analysis	Semi-structured interview	• Failure to recognise a problem developing/ lack of mental health knowledge to recognise it. • Denial of a problem to not impact studies • Normalisation of symptoms & situation • Lack of time. • Fear of stigma • Dismissal by self & others of problem • Lack of support/ understanding from medical school. • Fear of impact on medical career.	• Recognition that mental health is important (for academics & quality of life) • Support/ recognition from friends/family or teaching staff • A trusted professional • Significant mental health symptoms (severe psychological distress e.g. suicidal thoughts)

Table 1.3 Barriers to accessing mental health services, listed by frequency

Barriers	Number of studies
Structural barriers- not knowing what is available/ where to seek support	10
Stigma: external & self-stigma	7
Lack of time	5
Reliance on self	5
Gender discrepancies	5
Impact on studies/ future careers	5
Prior negative experiences of help-seeking	4
Lack of mental health knowledge (identifying problems)	4
Normalisation of mental health issues	3
Sociocultural upbringing	3
Prefer other sources of support (e.g. friend/family)	3
Service limitations, waiting times & wanting immediate help	2
Confidentiality & trust	2
Readiness to change/ denial of problem	2
Fear of opening up/ negative treatment effects	2
Concern about being burdensome to friends & family	2
Lack of personal connections/ peer reflections of services	2
Sexuality	2
"Put off" by information/ knowledge of service	1
Financial implication of private support	1
Language barrier (English as second language)	1
Lack of support/ guidance from academic school	1

Table 1.4 Facilitators to accessing mental health services, listed by frequency

Facilitators	Number of studies
Support from friends & family	8
Higher psychological distress	7
Peer/ connected community support	5
Advertising of services/ awareness campaigns	3
Higher mental health literacy	3
Friendliness/ approachability of staff/ accessibility of support	3
Knowledge & use of self-help/ online support	2
Ease of access (better service hours)	2
Knowledge of what to expect from services	2
Clearer confidentiality policies	2
Demographic factors- racial differences, age differences, gender differences	3
Culturally sensitive services	2
Lower distress & higher mental wellbeing	2
Impact on education	1
Previous mental disorder diagnosis	1
Positive previous experiences in services	1
Ability to explore support options	1
Increasing disclosure to network	1
Incentives (e.g. snacks)	1
Re-labelling of services	1
Continuity of supervisory support	1
Safe spaces (male only)	1

Barriers

The systematic review highlights UK students lack of knowledge about available support services and where to seek help as the most salient barrier. Several studies report that students express uncertainty about the support options and are therefore being deterred by their limited understanding of the services (Broglia et al., 2021; Chew-Graham et al., 2003). Furthermore not knowing about university counselling services is also frequently mentioned (Maciagowska, 2018). This lack of awareness links with a lack of knowledge about therapy and psychological treatment processes

(Maciagowska, 2018; Sagar-Ouriaghli et al., 2020). Students also report difficulties navigating the referral system, long waiting lists, and the limited number of counselling sessions as barriers to accessing help (Shahaf-Oren et al., 2021).

A lack of mental health knowledge or the ability to identify mental health problems poses a significant barrier to help-seeking among university students in the UK. Insight plays a crucial role in recognising the need for help, but students often have limited understanding of common mental health conditions and how they manifest noting difficulties with recognising symptoms of mental health problems and therefore a need for support (Gorczynski et al.,2017; Sagar-Ouriaghli et al., 2020; Shahaf-Oren et al., 2020). This lack of awareness of one's own problems or noticing a deterioration in mental well-being has been identified as a major factor in reduced help-seeking (Maciagowska, 2018; Winter et al., 2017).

Students describe experiencing stigmatising experiences and self-stigma, believing that mental health problems are necessary for coping with university life (Broglia et al., 2021). Self-stigma negatively influences help-seeking intentions and behaviour, while perceived public stigma affects intentions to seek help from formal sources (Cage et al., 2020). Help-seeking at times of stress is viewed as admitting weakness, creating shame and embarrassment (Chew-Graham, 2003). Male participants are particularly concerned with how help-seeking will compromise their masculine identity (Sagar-Ouriaghli et al., 2020). Furthermore, the fear of being judged, exposed, and facing treatment side effects are highlighted as barriers to seeking help (Shahaf-Oren et al., 2021).

Gender differences also act as a barrier to mental health help-seeking. Studies highlight that males are less likely to receive treatment compared to females (Ennis et al., 2019; Gorczynski et al., 2017). Despite similar levels of perceived need and readiness to change, males show less inclination to seek help from external sources such as doctors, mental health professionals, or religious advisors (Ennis et al., 2019). This reluctance can be attributed to societal expectations of masculinity, the desire to appear strong and independent, and cultural beliefs (Maciagowska, 2018; Olaniyan, 2018). Male participants have reported being taught that help-seeking is more appropriate for women (Olaniyan, 2018). On the other hand, females may face barriers related to embarrassment and fear of

being treated differently (Ennis et al., 2019).

Students express concerns about how disclosing mental health issues may affect their future job opportunities and fitness to practice, particularly in fields such as medicine and law (Chew-Graham et al., 2003; Knipe et al., 2018; Olaniyan, 2021; Shahaf-Oren et al., 2021). The worry of potential reprisal, including the use of mental health problems as evidence against them and the fear of repercussions from a label of psychological distress or mental health disorder, prevents students from seeking advice or disclosing their difficulties (Simpson et al., 2019; Winter et al., 2017).

Concerns about limited availability to engage in counselling or seek support also reduces help-seeking (Broglia et al., 2021). Students with severe depression symptoms cite lack of time as a reason for not seeking help (Knipe et al., 2018). Issues such as conflicts with teaching and clinical placement hours, as well as demanding academic schedules, restrict access to support services (Knipe et al., 2018; Shahaf-Oren et al., 2021). The integration of well-being sessions into busy curriculums remains challenging (Simpson et al., 2019). Students' workload and limited opportunities during clinical placements further hinder their ability to seek help (Winter et al., 2017).

Some students choose to handle their problems alone or seek alternative support, such as online self-help, leading to a dropout from counselling (Broglia et al., 2021). A number of students with severe depression symptoms rely on the internet for assistance (Knipe et al., 2018). Psychological distress may lead students to withdraw from others and attempt to regulate their emotions independently (Law, 2021). Previous negative experiences drive students to develop personalised coping mechanisms and help-seeking strategies (Olaniyan, 2021). Those who had unsuccessful experiences with psychological support or mentoring in the past are less likely to believe they need such support in the present (Maciagowska, 2018). Additionally, hearing others' negative experiences can deter students from accessing or trusting mental health support (Maciagowska, 2018). Participants' negative experiences relating to perceived discrimination, practitioners' unwillingness to address race-related stressors, and impersonal approaches lead to a lack of confidence in universities' ability to offer suitable mental health support contributing to participants viewing mental health

services as potentially harmful environments (Olaniyan, 2021). Moreover, participants mention that past experiences during childhood or adolescence make it challenging for them to disclose mental health concerns (Shahaf-Oren et al., 2021).

Facilitators

The most predominant facilitator identified across the systematic review is the support from friends and family. Young people are more willing to seek informal help from their social networks, such as friends and family than university services (Bryant et al.,2022; Chew-Graham et al., 2003). Support from friends and family or online resources are preferencial to medical professionals (Gorczynski et al., 2017). Students express preferences for speaking to someone they know, emphasising the importance of social support in creating a trusting environment and encouraging help-seeking (Sagar-Ouriaghli et al. 2020).

The literature consistently highlights that an increase in psychological distress can act as a facilitator for help-seeking among university students. Several studies indicate that students who experience severe or complex mental health issues are more inclined to consider seeking help (Broglia et al., 2021; Shahaf-Oren et al., 2021). Overt symptoms of psychological distress or a mental health disorder motivates students to seek help, suggesting that the severity of the condition plays a significant role in the decision to seek assistance (Winter et al., 2017). Increasing depressive symptoms has been found to predict a decrease in help-seeking, while an increase in stress levels is associated with increased help-seeking (Cage et al., 2020). Suggesting that the nature of the mental health condition may influence help-seeking behaviour differently. There is a contradiction in findings regarding the relationship between help-seeking and mental well-being, with one study indicating that higher intentions to seek help are associated with higher levels of mental well-being (Gorczynski et al., 2020).

Students express a preference for seeking support from peers rather than utilising the available services provided by the university (Chew-Graham et al., 2003). They tend to form

connections with peers who share similar backgrounds or beliefs, creating a network of peer counsellors that helps alleviate feelings of isolation (Olaniyan, 2021). Additionally, students with mental health problems often feel more comfortable sharing and seeking help from individuals who have similar conditions, as there is a mutual understanding (Shahaf-Oren et al., 2021). However, it is important to note that seeking support from peers can lead to increased anxiety, as some students tend to compare themselves with their peers (Simpson et al., 2019).

Students emphasise the need for universities to advertise existing mental health services to increase awareness (Chew-Graham et al., 2003). Awareness campaigns address the lack of understanding surrounding mental health issues and aim to reduce associated stigma, conveying the message that mental health issues are common and not a sign of weakness (Maciagowska, 2018). Additionally, recommendations include promoting interventions through student networks, clubs, and existing university bodies. Face-to-face advertising proves more engaging than university-wide emails and posters, potentially leading to higher attendance (Sagar-Ouriaghli et al., 2020). Delivering mental health initiatives at the beginning of the academic year during orientation or 'freshers' week, when students have more time and motivation to engage with extra-curricular activities is suggetsed (Sagar-Ouriaghli et al., 2020). Participants also propose focusing interventions around critical periods, such as exams or the Christmas/winter break, to make them more appealing and relevant to male students (Sagar-Ouriaghli et al., 2020).

Individuals with higher mental health literacy exhibit a greater likelihood of seeking help for mental health concerns (Gorczynski et al., 2017). Understanding professional services and having knowledge about mental health interventions facilitate help-seeking (Law, 2021). Awareness of available support services and ability to discontinue treatment influences students' help-seeking behaviours (Olaniyan, 2021). Efforts to promote well-being and reduce stigma contribute to an increased intent to seek help among students (Shahaf-Oren et al., 2021). However, Gorczynski et al.'s (2020) research contradicts previous findings, indicating that mental health literacy is not significantly correlated with help-seeking behaviours or other mental health outcomes. This suggests the need for advocating alternative strategies to enhance mental well-being and alleviate distress among students,

taking into account potential sampling differences across studies (Gorczynski et al., 2020).

Students prefer seeking help from understanding and warm individuals, considering these qualities crucial for triggering help-seeking (Shahaf-Oren et al., 2021). Establishing trust with healthcare professionals or staff members, such as personal tutors, lecturers, or administrative staff, empowers students to seek help when needed (Winter et al., 2019). Dedicated time with staff members is valued by students, emphasising the importance of personal interactions (Simpson et al., 2019). Accessibility and convenient therapy services are facilitators to help-seeking. Students prefer on-campus therapy options provided by the university which are easy to book and seen as credibile and trustworthy compared to unfamiliar individuals or locations (Maciagowska, 2018). Accessible and easily available therapy services are considered more feasible and preferred by students.

Discussion

The present systematic review examined sixteen studies to identify perceived barriers and facilitators to help-seeking for mental health support among UK university students. Twenty-two barriers and twenty-two facilitators were identified, showcasing their impact on UK university students' help-seeking behaviour. While this review primarily focused on the most prevalent barriers and facilitators, it is important to consider all of them when exploring implications for practice in reducing barriers and enhancing facilitators across universities.

Mental illness has detrimental impacts on relationships, self-esteem, academic achievement, employment, and housing, hindering students' ability to thrive and increasing the likelihood of university withdrawal (Insight Network, 2020; Office for Students, 2019). Understanding barriers and facilitators to help-seeking is vital in developing targeted interventions to meet students' mental health needs. By identifying challenges students encounter for help-seeking, universities can implement proactive measures to reduce stigma, increase awareness, improve accessibility, and enhance the overall support system.

The transition from child and adolescent mental health services (CAMHS) to adult mental health services (AMH) is often reported as uncoordinated, resulting in a gap in care (Appleton et al., 2022; Bryant et al., 2021). Surprisingly, the reviewed studies do not mention this poor transition as a specific barrier, despite acknowledging previous negative experiences of mental health services. Readiness to change and denial of a problem are mentioned as barriers in one study each. The focus on students' self-reported views in the selected literature may hinder the identification of these barriers. Of students reporting mental illness and STB, 52.7% do not consider themselves to have a problem that requires change (Eniss et al., 2019). This suggests that students may not be aware of their own difficulties, rather than an unwillingness to accept help. It has been noted in this systematic review that lack of awareness of one's own problems and normalising symptoms are barriers to help-seeking (Maciagowska, 2018; Winter et al., 2017). Perhaps it is not that students are not ready to seek support but they are not recognising the significance of their mental health challenges and the importance of early intervention for outcomes on treatment. Future research should incorporate the

perspectives of therapists and staff members, allowing for a comprehensive understanding of the topic.

Despite cross-government policies emphasising the importance of early engagement, prevention, and interventions to address the causes of mental ill-health and stigma (Department of Health, 2011; Universities UK, 2015, 2020), the effectiveness of these are questioned by the number of barriers and facilitators to help-seeking noted within this systematic review. Universities have a duty of care to promote mental health and address mental health difficulties by encouraging more students to seek support. However, defining and implementing appropriate measures and policies pose challenges (Brown, 2016). It is crucial for universities to establish support systems that facilitate students in seeking help for mental health difficulties.

Limitations

Many of the selected papers were carried out within one site in the UK, with the systematic review also indicating a researcher and participant bias towards medical and health science students. These papers may therefore not be representative of the general student population within higher education limiting the generalisability of their findings across UK universities, as whilst all studies were carried out in the UK there are still demographic variables across each university. Whilst some did report university status (e.g. Russell Group), the majority did not, and as such the university setting is not known, and it is reported within research that those with Russell Group status are considered to have higher academic expectations and also, often have a lower REM student population (Olaniyan, 2021). This is important to consider as cultural differences in help-seeking are evident in the studies (Law, 2021; Maciagowska, 2018; Olaniyan, 2018). Findings underscore the importance of reflecting upon cultural contexts when considering the impact of stigma and importance of community on help-seeking behaviours.

There are further limitations within gender demographics within this systematic review. Whilst the review highlights that there are gender differences in help-seeking behaviours these are not

consistent across all studies. Contrary to the other papers, Gorczynski et al., (2020) found no significant differences between genders in terms of help-seeking behaviours and Cage and colleagues findings highlighted that male participants were more likely to help-seek that females (Cage et al., 2020). Findings in relation to gender disparities need to be interpreted with caution due to unequal weighting of gender in multiple studies (Broglia et al., 2021; Bryant et al., 2022; Cage et al., 2020; Wadman et al., 2019). Research indicates women are more likely to take part in survey research (Sax et al., 2003).

It is important to consider that many of these studies explore intent to receive support if students were to be in distress, however intentions do not necessarily translate into actual behaviour, particularly in the domain of mental health (Cage et al., 2020). Rickwood et al. (2005) conducted a systematic review of adolescents' help-seeking intentions for mental health problems and found mixed evidence on the relationship between intentions and behaviour. The relationship between intention and actual help-seeking has been suggested to be dependent upon specific mental health problems and the barriers people face (Rickwood et al.2005).

Stigma was consistently identified as a significant barrier to help-seeking across the studies, reflecting a common theme. However, it is important to note that some variations and contradictions in the findings exist within the literature. While some studies highlighted self-stigma as a significant predictor of help-seeking intentions and behaviour (Cage et al., 2020), others suggested that perceived public stigma had a stronger impact on help-seeking intentions from formal sources (Cage et al., 2020; Wadman et al., 2019). Overall, while there is general consensus regarding the presence of stigma as a barrier to help-seeking among UK students, variations and contradictions in the findings suggest that the relationship between stigma and help-seeking is nuanced and influenced by multiple factors.

The high quality of studies included in this review is an important aspect to consider. Eleven studies were rated as high quality, and five studies as medium quality. This indicates that the research methodology used in these studies is reliable and rigorous. By including high quality papers in a

systematic review, we can obtain a more accurate and reliable picture of the literature within this topic area. It helps to ensure that the findings and conclusions drawn from the review are based on sound evidence and are less likely to be influenced by biases or methodological limitations.

Implications for future research

Despite the limitations mentioned earlier, the results of this review provide valuable insights that contribute to our understanding of the topic area. Considering both the review's findings and its limitations, we can now pinpoint areas for future research exploration.

Considering the most prevalent barrier to seeking support, which is a lack of knowledge about available resources and where to find help, future research should investigate the potential impact of enhancing accessibility, ease of booking, and credibility of on-campus mental health services on students' help-seeking behaviour (Shahaf-Oren et al., 2021). It is imperative to assess the effectiveness of making support services more visible and user-friendly, as current research indicates that students are often unaware of available resources (Maciagowska, 2018). To ensure effective service development, it is crucial to conduct evaluations involving both staff and students. Additionally, further research is required to examine students' awareness and self-recognition of mental health issues and strategies to enhance these aspects. Researchers could consider developing educational programs or campaigns aimed at helping students identify early signs of mental health problems and understanding the significance of early intervention. Such programs should be evaluated for effectiveness, as the current review has emphasised the recognition of mental health difficulties as a common barrier (Gorczynski et al., 2017; Sagar-Ouriaghli et al., 2020; Shahaf-Oren et al., 2020).

Furthermore, it is essential to investigate the role of mental health literacy in help-seeking behaviour, considering potential variations across different mental health conditions. Research should aim to determine how improving mental health literacy can positively influence students' willingness to seek support. Additionally, there is a need to delve into the factors that contribute to students' trust in healthcare professionals and support staff within the university. The current review has highlighted that the lack of trust in professionals, as well as concerns about confidentiality and potential impacts

on future careers, often deter students from seeking help from professionals (Chew-Graham et al., 2003; Law, 2021). Understanding the elements that establish trust can aid universities in creating environments that encourage help-seeking from appropriate professionals, instead of relying solely on friends and family. While the support of friends and family can be beneficial, it is essential for some mental health issues to seek professional assistance.

Alongside developing students' mental health literacy and self-recognition of difficulties to access help at an appropriate time point, to also bolster help-seeking, further research is needed to better understand the complexities of stigma and its impact on help-seeking, taking into account cultural, contextual, and individual difference. As highlighted from literature selected for this review, efforts to reduce stigma and self-stigma related to mental health issues warrant further research (Knipe et al., 2018; Maciagowska, 2018; Shahaf-Oren et al., 2020). This entails exploring how targeted campaigns and educational initiatives can influence students' perceptions and attitudes toward seeking help. Running such campaigns alongside increasing mental health literacy could provide important research and knowledge for appropriate interventions in practice to improve help-seeking.

As highlighted within the research limitations, future research needs to consider how to reduce the gender disparity within research to provide a more representative participant sample (Sax et al., 2003). With this being considered, further research to explore gender-specific strategies to encourage help-seeking among male and female students should be developed and evaluated. Understanding the unique barriers faced by each gender and tailoring interventions accordingly can be beneficial but research needs to be generalisable to the considered populations and therefore have appropriate sampling.

Implications for clinical practice

This systematic review has important implications for clinical practice in addressing the mental health needs of university students. It provides help-seeking barriers and facilitators, guiding the development of effective interventions and strategies for student mental health support and well-

being. However, designing services that meet diverse differences poses a significant challenge. Students within research highlight divisive and unique preferences for help-seeking (Sagar-Ouriaghli et al., 2020; Simpson et al., 2019), requiring universities to explore a spectrum of approaches, ranging from informal and fun settings to more formal ones. Additionally, understanding the varying needs for shorter, less demanding interventions versus prolonged and frequent support is essential.

Creating awareness about mental health services and clear pathways within universities is crucial. Strategies like well-timed advertising campaigns, particularly at the start of academic years and during high-stress periods, can help students better access these resources. Improving mental health literacy empowers students to recognise symptoms and understand the impact of deteriorating mental health. Integrating psychoeducation into academic programs can enhance students' mental health literacy, enabling them to recognise symptoms and understand the importance of seeking help early (Chew-Graham, 2003). Efforts should also be directed at destigmatising help-seeking. Implementing policies and interventions that normalise seeking support can foster a more supportive university environment. Building peer support networks through befriender programs, mentorship initiatives, and peer support groups can create a sense of community where help-seeking is encouraged and seen as normal (Sagar-Ouriaghli et al., 2020).

Students need reassurance that seeking help for mental health concerns will not have negative consequences on their records or future career paths (Broglia et al., 2021). Flexibility in support options is important for student well-being. Academic institutions should accommodate students who need time off for physical and mental health appointments, reinforcing a culture that prioritises wellbeing. Education campaigns can help students manage their time effectively and reinforce standards of care that fully explain patient confidentiality, financial costs of treatment, alternative therapeutic support, and treatment effectiveness.

Building resilience to academic-related stress should be a focus, with personal tutors trained to identify academic declines and monitor students' well-being. This can create an environment where mental health difficulties are openly acknowledged and support is readily available. Additionally, allowing students to register with a GP both at home and their university can expand the support

network available to them, reducing the risk of gaps in support when transitioning between home and university.

Implications for clinical practice also need to consider diversity, equity and inclusion. Acknowledging and addressing gender and cultural differences in help-seeking behaviours is essential. Tailored interventions that account for these disparities can promote inclusivity and effectiveness in mental health support. Safe spaces, whether gender-specific or culturally inclusive, can facilitate open discussions about mental health concerns (Sagar-Ouriaghli et al., 2020). These spaces should be created and maintained within university environments. Faculty diversity plays a pivotal role in students' perceptions of the university environment. Diversifying faculty and support services can provide role models and support that align with the diverse backgrounds of students. Ensuring language accessibility and cultural competence in mental health services is imperative. Services should be available in students' first languages, and staff should be trained to address cultural nuances in mental health (Maciagowska, 2018; Sagar-Ouriaghli et al., 2020).

The suggested strategies need to be implemented to remove barriers and enhance facilitators to help-seeking among UK University students. This will enable the accessibility and effectiveness of mental health services in universities to be enhanced, leading to improved student well-being. However, a major challenge lies in designing services that meet the diverse preferences of individuals. As highlighted within implications for practice from research and practice-based evidence, there is not a universally suitable approach to providing mental health support. Therefore, adopting a 'one-size-fits-all' approach is unlikely to be effective. Instead, exploring different intervention formats and assessing their appropriateness is crucial. Universities should consider integrating ongoing research into their support strategies to stay updated on the evolving challenges and facilitators of help-seeking among students. This integration can ensure that support services remain effective and responsive to students' needs.

Conclusion

The systematic review identified a range of barriers and facilitators to help-seeking among UK university students. These findings have important implications for the development of interventions and support services to promote mental health and well-being on university campuses. Addressing barriers and enhancing facilitators to help-seeking for mental health support among UK university students is a complex and multifaceted challenge. Future research should delve into the specific strategies and interventions that can effectively reduce barriers and strengthen facilitators. At the same time, universities should take proactive steps to improve awareness, mental health literacy, and accessibility of support services to create a more supportive environment for their students. Implications from the review provide valuable insights for healthcare professionals, educators, and policymakers in creating a conducive environment for students to seek and receive the mental health support they need. Future research should consider students, university staff and mental health proffessionals views on barriers and facilitators to help-seeking to provide a valuable insight of all stakeholders experiences within this area. By combining research insights with practical interventions, universities can better meet the mental health needs of their diverse student populations.

References

Appleton, R., Loew, J., & Mughal, F. (2022). Young people who have fallen through the mental health transition gap: a qualitative study on primary care support. *The British journal of general practice : the journal of the Royal College of General Practitioners*, *72*(719), e413–e420. https://doi.org/10.3399/BJGP.2021.0678

Barbayannis, G., Bandari, M., Zheng, X., Baquerizo, H., Pecor, K. W., & Ming, X. (2022). Academic Stress and Mental Well-Being in College Students: Correlations, Affected Groups, and COVID-19. *Frontiers in Psychology*, *13*. https://doi.org/10.3389/fpsyg.2022.886344

Broglia, E., Millings, A., & Barkham, M. (2017). Challenges to addressing student mental health in embedded counselling services: a survey of UK higher and further education institutions. *Https://Doi.Org/10.1080/03069885.2017.1370695*, *46*(4), 441–455. https://doi.org/10.1080/03069885.2017.1370695

Broglia, E., Millings, A., & Barkham, M. (2021). Student mental health profiles and barriers to help-seeking: When and why students seek help for a mental health concern. *Counselling and Psychotherapy Research*, *21*(4), 816–826. https://doi.org/10.1002/CAPR.12462

Bryant, A., Cook, A., Egan, H., Wood, J., & Mantzios, M. (2022). Help-seeking behaviours for mental health in higher education. *Journal for Further and Higher Education*, *46*(4), 522–534. https://doi.org/10.1080/0309877X.2021.1985983

Byrow, Y., Pajak, R., Specker, P., & Nickerson, A. (2019). *Perceptions of mental health and perceived barriers to mental health help-seeking amongst refugees: A systematic review*. https://doi.org/10.1016/j.cpr.2019.101812

Cage, E., Stock, M., Sharpington, A., Pitman, E., & Batchelor, R. (2020). Barriers to accessing support for mental health issues at university. *Studies in Higher Education*, *45*(8), 1637–1649. https://doi.org/10.1080/03075079.2018.1544237

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 mental health problems. *Medical Education*, *37*(10), 873–880. https://doi.org/10.1046/j.1365-2923.2003.01627.x

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., L Brown, J. S., & Thornicroft, G. (2014). *What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies*. https://doi.org/10.1017/S0033291714000129

Czyz, E. K., Horwitz, A. G., Eisenberg, D., Kramer, A., & King, C. A. (2013). Self-reported Barriers to Professional Help-seeking Among College Students at Elevated Risk for Suicide. *http://Dx.Doi.Org.Liverpool.Idm.Oclc.Org/10.1080/07448481.2013.820731*, *61*(7), 398–406. https://doi.org/10.1080/07448481.2013.820731

Duncan, D. (2021). Twenty not out: how higher education has changed in 20 years. *https://www.ahua.ac.uk/twenty-not-out-how-higher-education-has-changed-in-20-years/*

Ennis, E., Lafferty, M., Murray, M., Lapsley, C., & Bjourson, A. J. (2019). Readiness to change and barriers to treatment seeking in college students with a mental disorder. *Journal of Affective Disorders*, *252*, 428–434. https://doi.org/10.1016/j.jad.2019.04.062

Farber, B. A., Lippert, R. A., & Nevas, D. B. (1995). The Therapist as Attachment Figure. *Psychotherapy*, *32*(2), 204–212.

Gorczynski, P., Sims-Schouten, W., Hill, D., & Wilson, J. C. (2017). Examining mental health literacy, help-seeking behaviours, and mental health outcomes in UK university students. *Journal of Mental Health Training, Education and Practice*, *12*(2), 111–120. https://doi.org/10.1108/JMHTEP-05-2016-0027

Gorczynski, P., Sims-Schouten, W., & Wilson, C. (2020). Evaluating mental health literacy and help-seeking behaviours in UK university students: A country wide study. *Journal of Public Mental Health*, *19*(4), 311–319.

Harris, J. D., Quatman, C. E., Manring, M. M., Siston, R. A., & Flanigan, D. C. (2014). How to write a systematic review. *The American journal of sports medicine*, *42*(11), 2761–2768. https://doi.org/10.1177/0363546513497567

Higgins, J. P. T., Thomas, J., Chandler, J., Cumpston, M., Li, T., Page, M. J., & Welch, V. A. (Eds.). (2021). *Cochrane Handbook for Systematic Reviews of Interventions*. Version 6.2. Cochrane.

Insight Network. (2020). *University Student Mental Health Survey 2020 A large scale study into the*

prevalence of student mental illness within UK universities. https://assets.website-files.com/602d05d13b303dec233e5ce3/60305923a557c3641f1a7808_Mental%20Health%20Report%202019%20(2020).pdf

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *62*(6), 593–602. https://doi.org/10.1001/ARCHPSYC.62.6.593

Knipe, D., Maughan, C., Gilbert, J., Dymock, D., Moran, P., & Gunnell, D. (2018). Mental health in medical, dentistry and veterinary students: cross-sectional online survey. *BJPsych Open*, *4*(6), 441–446. https://doi.org/10.1192/bjo.2018.61

Law, S. (2021). Chinese international students' cross-cultural adaptation, mental health and related coping strategies and help-seeking behaviours in the UK. *Dissertation*.

Maciagowska, K. (2018). Mental health, coping strategies and help-seeking behaviours among Polish university students in the UK. *The University of Manchester; Dissertation for Doctorate in Counselling Psychology*. https://www.research.manchester.ac.uk/portal/files/188962855/FULL_TEXT.PDF

McLafferty, M., Lapsley, C. R., Ennis, E., Armour, C., Murphy, S., Bunting, B. P., Bjourson, A. J., Murray, E. K., & O'Neill, S. M. (2017). Mental health, behavioural problems and treatment seeking among students commencing university in Northern Ireland. *PloS one*, *12*(12). https://doi.org/10.1371/journal.pone.0188785

Mojtabai, R. (2001). Unmet need for treatment of major depression in the United States. *Psychiatric Services*, *60*(3), 297-305.

Nha Hong, Q., Pluye, P., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., Gagnon, M.-P., Griffiths, F., Nicolau, B., Rousseau, M.-C., & Vedel, I. (2018). *Mixed Methods Appraisal Tool (MMAT) Version 2018, User guide*. http://mixedmethodsappraisaltoolpublic.pbworks.com/

Noyes, J., Booth, A., Moore, G., Flemming, K., Tunçalp, Ö., & Shakibazadeh, E. (2019). Synthesising quantitative and qualitative evidence to inform guidelines on complex

interventions: clarifying the purposes, designs and outlining some methods. *BMJ Global Health*, *4*(Suppl 1), e000893. https://doi.org/10.1136/bmjgh-2018-000893

Office for Students (2019). Mental health: Are all students being properly supported? *Insight 5*, November 2019. https://www.officeforstudents.org.uk/publications/

Olaniyan, F.-V. (2021). Paying the widening participation penalty: Racial and ethnic minority students and mental health in British universities. *Analyses of Social Issues and Public Policy (ASAP)*. https://doi.org/10.1111/asap.12242

Rickwood, D., Deane, F. P., Wilson, C. J., & Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Australian e-journal for the Advancement of Mental health*, *4*(3), 218-251.

Sagar-Ouriaghli, I., Godfrey, E., Graham, S., & Brown, J. S. L. (2020). Improving mental health help-seeking behaviours for male students: A framework for developing a complex intervention. *International Journal of Environmental Research and Public Health*, *17*(14), 1–34. https://doi.org/10.3390/IJERPH17144965

Sax, L. J., Gilmartin, S. K., & Bryant, A. N. (2003). Assessing response rates and nonresponse bias in web and paper surveys. *Research in higher education*, 409-432.

Shahaf-Oren, B., Madan, I., & Henderson, C. (2021). "A lot of medical students, their biggest fear is failing at being seen to be a functional human": disclosure and help-seeking decisions by medical students with health problems. *BMC Medical Education*, *21*(1). https://doi.org/10.1186/S12909-021-03032-9

Sheffield, J. K., Fiorenza, E., & Sofronoff, K. (2004). Adolescents' Willingness to Seek Psychological Help: Promoting and Preventing Factors. *Journal of Youth and Adolescence*, *33*(6), 495–507.

Simpson, V., Halpin, L., Chalmers, K., & Joynes, V. (2019). Exploring well-being: medical students and staff. *The Clinical Teacher*, *16*(4), 356–361. https://doi.org/10.1111/tct.13080

Stallman, H. M. (2011). Psychological distress in university students: A comparison with general population data. *Australian Psychologist*, *45*(4), 249–257. https://doi.org/10.1080/00050067.2010.482109

Substance Abuse and Mental Health Services Administration. (2021). *Key substance use and mental*

health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). https://www.samhsa.gov/data/report/2020-nsduh-annual-national-report

Thorley, C. (2017). *Not by degrees: Improving student mental health in the UK's universities*. Institute for Public Policy Research. https://doi.org/https://www.ippr.org/publications/not-by-degrees

University Mental Health Advisers Network (2023). *What support is available at uni?* https://www.umhan.com/pages/support-at-uni

Wadman, R., Webster, Mawn, L., & Stain, H. J. (2019). Adult attachment, psychological distress and help-seeking in university students: Findings from a cross-sectional online survey in England. *Mental Health and Prevention*, *13*, 7–13. https://doi.org/10.1016/j.mhp.2018.11.003

Watkins, D.C., Hunt, J.B., & Eisenburg, D. (2012). Increased demand for mental health services on college campuses: Perspectives from administrators. *Qualitative Social Work, 11*(3), 319–337. https://doi.org/10.1177/1473325011401468

Winter, R. I., Patel, R., & Norman, R. I. (2017). A Qualitative Exploration of the Help-Seeking Behaviors of Students Who Experience Psychological Distress Around Assessment at Medical School. *Academic Psychiatry*, *41*(4), 477–485. https://doi.org/10.1007/s40596-017-0701-9

CHAPTER 2: Mixed Methods Empirical Study

Single Session Therapy for UK University Students; the Perceived Change in Mental Health Concerns and Impact of the Therapeutic Alliance

Abstract

The prevalence of mental distress among UK university students continues to increase, necessitating the implementation of accessible, clinically effective, and cost-effective services. Single Session Therapy (SST) has been introduced within a few UK University and College Counselling services as part of their mental health support option, but the effectiveness of a single session in reducing symptoms is questioned. This mixed-methods study aims to comprehensively examine the effectiveness and experiences of SST for students and therapists within a UK university setting.

Quantitative anlysis using repeated measures indicates no significant change in self-reported anxiety, depression, or distress following SST. Additionally, no significant relationship has been found between self-reported mental health symptoms and the therapeutic alliance. Qualitative analysis using Interpretative Phenomenological Analysis (IPA) identifies two main themes: therapeutic expectations and the power of connection in SST. Overall, the study suggests that SST is a valuable intervention within student services. However, it may be more effective and better suited in a different student service setting, such as the Wellbeing service. Further research is needed to explore alternative placement options and enhance the overall effectiveness of SST in supporting students' mental health.

KEYWORDS: Single Session Therapy; students; emotional distress; therapeutic alliance

Foreward

The systematic review revealed that despite high prevlances of reported mental distress in UK university students, reported intentions of help-seeking is significantly lower. The impact of mental health conditions on students is significant and therefore universities have needed to consider barriers to accessing professional services and consider innovative ways to facilitate the necessary support. This empirical study will consider one such intervention which aims to reduce barriers affecting access to appropriate mental health support. As highlighted in the systematic review, implementation of novel approaches to supporting university students mental health needs researching to ensure student needs are being met.

Introduction

The developmental changes experienced during adolescence, which extends into the mid-20s, are characterized by normative transitions such as puberty, educational changes, autonomy, self-identity, social and romantic relationships, and career aspirations (National Academies of Sciences et al., 2019). The Focal Model, proposed by Coleman (1974), offers insights into the impact of overlapping transitional phases during adolescence and their influence on mental health. According to the model, the combination of normative changes and daily-life stressors can contribute to maladaptive development or mental health difficulties. This framework helps explain why young adults, specifically those aged 18-25, are considered one of the most vulnerable age groups in terms of mental health (Kessler et al., 2005). Transitioning to university is a significant period for adolescents, and while it can bring excitement, it can also be accompanied by stressors that impact mental well-being (Barbayannis et al., 2022). It is important to consider alongside the normative changes of entering adulthood, relative to their same-age peers, those that choose to continue into higher education can be at increased vulnerability due to the additional financial, academic, and social pressures (Thorley, 2017). Relocating for university adds to these challenges, disrupting established support networks (Chew-Graham, et al., 2003).

Understanding the unique challenges faced by university students in terms of mental health is crucial, as research demonstrates that university students are at higher risk of experiencing mental health difficulties compared to their non-student peers. There is a consistently increasing number of students in higher education reporting mental health difficulties, with the Office for National Statistics (2022) reporting an increase from 28% to 36% of students reporting a decline in their mental health and wellbeing over the academic year. The Office for Students (OfS, 2019) have reported that more students than ever are reporting mental health conditions, with less than one in five students reporting high levels of wellbeing: lower than the general adult population (Thorley, 2017). A study conducted by Hunt et al. (2012) in the UK found that 33.9% of university students reported symptoms of common mental disorders. Similarly, a systematic review by Ibrahim et al. (2013) indicated a higher prevalence of depression and anxiety among university students compared to the general population. It therefore seems unsurprising that UK media outlets are reporting that there is a student mental health crisis (Hall, 2022). This in turn is leading to a concern that university student support services are not meeting students' current mental health needs (Frye, 2023). Ninety-four percent of higher education institutes in the UK are reporting an increase in counselling service use, with some reporting a quarter of their students are using or waiting to use disability services (Thorley, 2017).

In addition to the insights provided by Coleman's (1974) Focal Model, it is important to consider the challenges faced by university students in accessing appropriate mental health services. The transition from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS) in England has been identified as a critical period, often resulting in poor transitions or a lack of continuity of care for young adults (Appleton et al., 2022). This issue becomes particularly significant for university students who may be relocating for their studies, leaving them at risk of falling through the gaps in the mental health support system or experiencing uncertainty about how and where to seek help. The author's prior systematic review highlighted lack of knowledge of services as the most prevalent barrier to help-seeking amongst UK university students. The challenges in accessing appropriate mental health support during the transition to university are further compounded by the potential stigma surrounding mental health issues. Students may hesitate to seek

help due to concerns about how it may affect their academic standing, social relationships, or future career prospects (see Chapter 1). This highlights the importance of destigmatising mental health and creating a supportive and inclusive environment within universities to encourage help-seeking behaviours.

With the continual rise in mental health conditions and reported decrease in wellbeing, the need for accessible, clinically effective but cost-effective services that are reactive to client need is increasingly being recognised by healthcare professionals as well as by funders and policymakers (World Health Organisation [WHO] et al., 2018). In a recent public policy research report of UK higher education mental health and wellbeing support, only 29% institutions have designed a definitive mental health and wellbeing strategy (Thorley, 2017). Universities are being encouraged to develop whole university approaches, reviewing their student wellbeing provisions, reconsidering service pathways and explore the evidence base for alternative interventions which can meet this growing need within a timely manner to prevent further escalation of distress in students (OfS, 2019; Thorley, 2017; Universities UK, 2018; 2020). Efforts have been made to address these challenges and improve mental health support for university students. The development of university-based counselling and mental health services aims to provide accessible and student-centred support. With this growing demand on services but limited funding to promote and support mental health and wellbeing of students, it is unsurprising that universities are looking towards briefer therapies as a possible intervention to meet requirements. Briefer therapies are highly prized as potential sources of cost-effective mental health interventions, such as brief Cognitive Behaviour Therapy (CBT) or Improving Access to Psychological Therapies (IAPT). The briefest of all in consideration by higher education institutions is Single Session Therapy (SST).

SST as an intervention

Talmon (1990 as cited in Hoyt et al., 2018, p4) defined SST as: "*one face-to-face meeting between a therapist and patient with no previous or subsequent sessions within one year*". This

definition was originally coined for research purposes and as such needed a clear arbitrary cut-off. This has since developed and clinical services can provide clients with further help if clinically needed, but the underlying principle of SST is that the session is to be approached with an aim to help create meaningful change in one session (Dryden, 2019). SST aims to help the client generate personally achievable goals in one session and take ownership of making these changes after the session. With SST being reported as cost effective and clinically effective it is unsurprising that it has been increasing in use across mental health services worldwide (Hymen et al., 2013). It seems plausible that it could be an effective intervention for university students who choose to engage (Dryden, 2020).

In contrast to many therapies used within student counselling services, SST has very limited empirical evidence and, of those published studies, there are several limitations (Hymen et al., 2013). Concern has been raised that perhaps budget constraints are the leading cause for the rise in SST rather than a concrete evidence base, with questions around if one session can be sufficient for meaningful change (Hurn, 2005). Initial research indicates SST can lead to perceived improvement in presenting problems including depression and anxiety. Participants have reported significant reductions in depressive symptoms following the single session (Talbot et al., 2011). Similarly, a study by Barker and Pistrang (2005) investigated the effects of SST for individuals with anxiety disorders and observed positive changes in anxiety symptoms after the session. Improvements in waiting times have also been found, helping achieve one of SST's aims of providing help at the point of need (Dryden, 2020).

However, there is a lack of consistency among studies in how effectiveness is measured with few studies using standardised measures to assess this (Hymen et al., 2013). Many studies seem to report effectiveness based upon client satisfaction rather than a reduction in presenting difficulties (Miller, 2008; Perkins & Scarlett, 2008). Additionally, student populations, even within one University, are vastly ranging with students from across the world, differing socio-economic status, age spans, gender and many other demographics (Ramsden, 2014), with counselling services offering support to a very large list of possible presenting concerns. Therefore, research conducted within

specific sample populations needs to be considered with caution when generalising findings to UK university students.

The therapeutic alliance

To promote the development of a therapeutic relationship and establish a secure base for patients to apply their newly acquired relational skills and navigate anxiety-provoking situations, it is commonly anticipated that multiple therapy sessions will be necessary (Farber et al., 1995), as opposed to the one offered in SST. Consequently, there is a prevalent concern within the field of psychotherapy regarding the efficacy of a single session in achieving substantial improvements in presenting difficulties. Numerous research findings have indicated the importance of the therapeutic alliance (TA) with Bowlby (1988) noting that the therapist's role is to provide a secure base for the client to explore the world. Therapeutic alliance, initially coined within psychodynamic therapy to provide a relational understanding of positive transference, is through the development of research and psychological interventions, more simply referred to as the quality of the relationship between therapist and patient (Murphy & Hutton, 2018). This interaction between client and clinician is noted as the "foundation of any therapeutic or healing activity" (Tresolini & Pew- Fetzer Task Force., 1994 p22). It is widely viewed to have three components: task, goal and bond (Goldsmith et al., 2015). These elements require collaboration and agreement. Research shows having a good TA predicts positive outcomes across multiple therapeutic modalities and in various conditions (McLeod, 2011).

Research has shown that in times of change, threat and stress, attachment behaviours are activated (Mikulincer et al., 2002). Starting university is a significant period of change for most students. During moments of childhood distress, infants seek their primary caregiver for safety, comfort, and guidance, as emphasised by Bowlby (1988). Crowell and Treboux (1995, p. 298) define secure attachment relationships as those that offer a sense of security and belonging. When adults experience heightened stressors or perceive a sense of threat, they naturally seek care and a secure foundation, just like children. Bowlby (1977) emphasised the crucial role of the therapist in fulfilling

this need for patients, acting as a trusted and dependable figure. Although the therapeutic relationship differs from that of a childhood caregiver in various aspects, such as maintaining objectivity and being less emotionally involved, therapists still offer a confidential space where concerns are heard and understood, ultimately enhancing the desired sense of safety typically associated with attachment relationships (Farber et al., 1995). By providing a compassionate and confidential ear, therapists contribute to fostering a secure and supportive environment for their patients.

The therapeutic relationship is a dynamic and evolving process that requires time and continuity to unfold. Research has consistently indicated that the quality of the therapeutic alliance, characterized by factors such as trust, empathy, and collaboration, significantly influences treatment outcomes (Horvath & Symonds, 1991). The establishment of a secure base within this relationship provides a foundation from which patients can explore their emotional challenges, develop insight, and cultivate more adaptive coping strategies (Bowlby, 1988). While the initial session can serve as an introduction and provide an opportunity for assessment, it is often regarded as a preliminary step in a more comprehensive therapeutic journey. According to Norcross and Lambert (2019), the average number of therapy sessions attended by clients is around 13, highlighting the recognition that meaningful change typically requires an extended period of therapeutic engagement. Over time, patients become increasingly comfortable and familiar with the therapeutic process, allowing for deeper exploration and resolution of presenting difficulties (Baldwin & Imel, 2013).

The complexity of psychological issues and the multifaceted nature of human experiences suggest that a single session may not provide sufficient time for adequate assessment, intervention planning, and the implementation of evidence-based therapeutic techniques (Wampold, 2001). While a single therapy session can contribute to rapport building and initial exploration, the cumulative effect of multiple sessions allows for the development of a secure therapeutic relationship and the application of newly learned relational skills. As emphasised by Farber et al., (1995, p.207) this progression occurs "within sessions, by the therapist's constancy, availability, sensitivity, and responsiveness" to the patient's distress. The prevailing concern within the field of psychological

therapies is that one session may not be sufficient for significant improvement in presenting difficulties, underscoring the importance of ongoing therapeutic engagement and continuity of care.

Study context

According to the Stepchange Framework, cited in Hubble and Bolton (2020), mental health needs to be regarded as a strategic priority within universities in the UK. The framework recommends the active involvement of both staff and students in the development of mental health policies at all stages, facilitating a comprehensive and inclusive approach to addressing mental health challenges.

In recent years, a minority of UK Universities and College Counselling (UCC) services have implemented SST as part of their mental health support offerings. University College London and the University of Liverpool (UoL) are among the institutions that have adopted SST, while the University of Cambridge and the University of Surrey have similarly embraced the approach, referring to it as 'one-at-a-time therapy' (OAATT). The adoption of SST or OAATT in these university settings represents a shift towards a more time-efficient and flexible approach to counselling, aligning with the goal of increasing accessibility to mental health services. By offering brief, targeted sessions, SST aims to address immediate concerns and provide support in a timely manner, which can be particularly beneficial for students facing time constraints or seeking help for specific issues. This approach also allows universities to allocate their resources more effectively and optimize their counselling services to accommodate a larger number of students (UoL, 2020).

These universities demonstrate a commitment to adapting their mental health support systems to better meet the needs of their student populations. The emphasis on early intervention and reducing wait-times aligns with the growing recognition of the importance of timely access to mental health services in supporting students' well-being and academic success (Gulliver et al., 2018). These innovative approaches contribute to the ongoing evolution of university mental health policies and practices, paving the way for more comprehensive and student-centred support systems.

The UoL Student Counselling Service introduced SST in September 2019, aiming to prioritize the well-being of their students and pioneer efforts to enhance the accessibility of mental health services. The primary objectives include meeting clients' needs effectively, reducing clinical wait-times, facilitating early intervention, and providing assistance promptly when it is most needed (Univerity of Liverpool, 2020). Therapists within the UoL Counselling service provide other psychotherapeutic interventions alongside SST. This stands them in a unique position to be able to reflect upon first-hand experiences of delivering SST, whilst having comparators of longer-term therapies to the same student population to provide valuable insight. Since therapeutic alliance is a collaborative construct based on the quality of the relationship between the therapist and the patient, it is essential to consider therapists' experiences of therapeutic alliance within the context of SST. Furthermore, therapists can reflect upon their experiences of delivering SST to high numbers of students, as the service often delivers around 150 SST interventions in a single month (as recorded in April 2022 prior 6-month review), whilst students will likely have only had one encounter with this type of intervention.

The current study

To advance the understanding and effectiveness of Single Session Therapy (SST) within UK university settings, further research is needed due to limited existing studies and the absence of published research evaluating SST in higher education contexts. While Dryden (2020) asserts that a strong therapeutic alliance contributes to positive outcomes in SST, there is currently no published evidence examining the impact of the therapeutic alliance on SST outcomes. Therefore, it is essential to investigate whether students report a positive therapeutic alliance after just one session and determine if this alliance plays a role in therapeutic outcomes in SST, or if other variables are more central to the provision of beneficial and effective treatment for reducing distress.

To bridge the gaps in research and expand the evidence base for SST, studies should be conducted to evaluate its efficacy within the unique context of UK higher education. These studies can focus on assessing the therapeutic alliance in SST and its impact on treatment outcomes, as well

as examining the perceived benefits of SST reported by students. Such investigations will provide valuable insights into the suitability and effectiveness of SST for addressing the mental health needs of university students. Given that SST is still a relatively new intervention in UK university mental health services, including students and therapists in research is crucial to assess the perceived therapeutic benefits and guide ongoing treatment approaches while exploring the specific value of SST for different individuals.

By employing quantitative methodology, this research aims to assess students' self-reported changes in anxiety, depression, and distress. Additionally, qualitative methodology will be employed to delve into therapists' experiences of delivering SST and gain a deeper understanding of the intervention's impact from their perspective. This mixed-methods approach will provide a comprehensive examination of the effectiveness and experiences associated with SST within the university setting. It aims to contribute to the development of evidence-based practices in student mental health support and inform the future implementation of SST and similar interventions in universities.

Objectives

The objectives for this empirical research will enable us to explore student and therapist experiences of Single Session Therapy (SST).

Primary objectives include:

1. To assess if there are associated changes in students self-reported ratings of anxiety and/or depression and distress following SST.
2. To assess if therapeutic outcomes are associated with the students' perceived therapeutic alliance.
3. To explore therapists' experiences of delivering SST to University students.
4. To explore therapists' views of the therapeutic alliance in SST.

To enable the research team to achieve the desired research outcomes, a mixed-methods design will be employed. A quantitative, repeated measures design with students will be employed in

the first instance, followed by an in-depth qualitative semi-structured interview study with therapists. A mixed methods design will provide a triangulation of the exploratory research.

Quantitative hypothesis

1. Students self-reported ratings of anxiety, depression and distress will reduce following SST.
2. Increased therapeutic alliance will be associated with a reduction in self-reported anxiety, depression and distress following SST.

Qualitative research questions

1) What are therapists' experiences of delivering SST to University students?
2) What role or impact do the therapists feel the therapeutic alliance has in SST?

A Quantitative Investigation of Students Perceived Changes in Mental Health Concerns and Impact of the Therapeutic Alliance in SST

Initial research plans included a large-scale, repeated-measures quantitative study with three time points (before SST, within 72 hours of SST and three months post-SST). Despite numerous additional attempts to increase participation including changes to recruitment methods; participant uptake was limited within the time constraints. Consequently, data collection and analysis at Time 3 (three months post-SST) had to be excluded from the research during its development due to these challenges and therefore was not investigated further within the scope of this quantitative analysis.

To avoid undue extrapolation from the quantitative data, given the limitations of sample size and data not meeting the necessary assumptions for the planned statistical analysis, our approach will involve a non-parametric exploration for hypothesis analysis, complemented by a descriptive introduction to the qualitative exploration.

Methodology

Participants and Recruitment

To be eligible for inclusion in this study, participants must be 18 years of age or older and enrolled as students at the University of Liverpool. They should have undergone assessment by the University's Student Counselling Service, following their existing criteria, and have been accepted and offered an appointment for Single Session Therapy (SST) for the first time. Additionally, participants need to have internet access in order to complete the outcome measures through Qualtrics Survey Software. Exclusion criteria include having an insufficient understanding of the English language to provide informed consent or comprehend the study procedures.

Recruitment and "Opting In"

Students were emailed by *"Student Services"* following triage and signposting, advising of a referral to SST within the Counselling Service and at a second time point by the University Counselling Service, when receiving information regarding their SST appointment. A study advert was attached (see Appendix 2) which had a QR code and weblink to access Qualtrics which held a detailed research information sheet including; i.) researcher contact details; ii.) consent form to opt-in to the proposed study; and iii.) student contact details request for follow-up. The poster was also put up within the waiting room at the counselling service.

Design

The study uses a repeated methods design. Dependent variables include the self-reported "level" of depression, anxiety or distress and therapeutic alliance. The independent variable is: Time, (i.e. pre or post SST session). Descriptive analysis was conducted on demographic data including: age; gender; method of SST delivery; and previous mental health support. Descriptive analysis was conducted on Time 1 (pre SST) outcome measure data. All analyses were run using *SPSS 27*.

Materials

Measures were selected due to being standardised outcome measures (as recommended for future research in reviewing the efficacy for SST in Hymen et al., 2013). During Time 1, the following measures were utilised:

Demographics, including age, self-reported gender, previous mental health input and method of delivery for SST.

Generalised Anxiety Disorder Screener (GAD-7) (Spitzer et al., 2006) measured the self-reported severity of anxiety. A seven-item questionnaire with total scores ranging from 0-21. Scores are totalled to represent a clinical range: GAD-7 scores between 0-4 indicate minimal anxiety; 5-9 mild anxiety; 10-14 moderate anxiety and a score greater than 15 indicative of severe anxiety.

Patient Health Questionnaire- 9 (PHQ-9) (Kroenk et al., 2001) measured the self-reported severity of depression. A nine-item questionnaire, with total scores ranging from 0-27. Scores between 5-9 indicates mild depression; 10-14 moderate depression; 15-19 moderately severe depression; and 20 or more points indicates severe depression.

The Distress Thermometer (DT) (Roth et al., 1998) is a visualised one-item Likert scale which uses a thermometer image ranging from 0 (no distress) to 100 (highest distress ever felt). Students indicated their level of distress over the course of the week prior to SST for their primary presenting problem.

At Time 2, demographic questionnaires were excluded, while the GAD-7, PHQ-9 and DT were repeated and there was the inclusion of the:

Working Alliance Inventory-Short Form (WAI-S) (Tracey & Kokotovic, 1989). The working alliance inventory (short form) assesses the three key aspects of the perceived therapeutic alliance: agreement on the tasks of therapy, development of an affective bond and agreement on the goals of therapy. The higher the score, the greater the reported therapeutic alliance. The highest possible score for each of these subscales is 28.

Procedure

Participants opted in via email advert or poster in the counselling service waiting room and accessed a Qualtrics website via the links provided. They were required to read an information sheet and complete an informed consent form (see Appendix 3). Participants were informed of their right to withdraw at any time and were made aware of contact details of the research team and gatekeeper. Participants completed the required measures at each time point; before their SST appointment and within 72 of receiving SST from the university counselling service. Upon completion, participants were debriefed and provided relevant details of helplines they could contact if they felt affected by anything within the study (see Appendix 4). Data was collected from 4th October 2021 until 1st November 2022.

Contextual information

Method of delivery

During Covid-19 lockdowns, services were required to change their method of delivery. The University Counselling Service adapted delivery of SST to be provided face-to-face or remotely via telephone or video software. Despite lockdowns having ended and services being able to return to face-to-face provision, this service chose to retain its hybrid model of delivery due to student preference for these additional options enabling extra flexibility. Most participants had their sessions remotely, with 17 delivered via video, and 8 via telephone.

Ethical considerations

Ethical approval was granted by the University's Ethics Committee before the collection of data. All amendments throughout the study period were approved via the Doctoral Research Team and the Ethics Committee before being implemented.

Results

Descriptive Findings

A priori power analysis indicates that 77 participants are needed in order to have 80% power for detecting a small sized effect with a .15 statistical significance (Cohen, 1992). A small effect size was selected within this research. Whilst a medium effect size is often indicated in research guidance for under or newly research field, this would have required only 27 participants and due to the number of students accessing the service this did not indicate a reflective sample of the population and recruitment was not anticipated to be as challenging as arose. A small sample size was selected as more scientific, logical and ethical (Kang, 2021).

There were 78 initial responses at Time 1 (Pre SST). Six incomplete responses were removed, resulting in a total of 72 participants at Time 1.

There was significant attrition to Time 2 (Post SST), with a total of 44 responses. Five incomplete responses were removed. A further five were removed due to completion time being more than 72hours post SST appointment. This resulted in 34 participants at Time 2 for data analysis.

Demographic data including; age, self-reported gender, previous mental health input and method of delivery for SST (i.e. virtual or in-person) was collected. Table 2.1 demonstrates the breakdown of this data between Time 1 and 2. Whilst participants ages ranged from 18 to 41 years at Time 1, and 18 to 38 years at Time 2, most participants were 20 years of age at both time points. Seven response variations were recorded at Time 1 for *"how do you currently describe your gender identity?"*. Most respondents identified themselves as female at both time points. Table 2.2 demonstrates descriptive analysis of participants self-reported levels of anxiety, depression and distress at Time 1.

Table 2.1: Complete Time 1 and Time 2 demographic data

Characteristic		**Time 1 (n=72)**	**Time 2 (n=34)**
Age	18-22	55	27
	23-27	10	5
	28-32	3	0
	33+	4	2
Gender	Female	56	28
	Male	10	4
	Cis. Male	1	0
	Cis. Female	1	1
	Genderfluid	1	0
	Do not prescribe to any label	1	0
	Prefer not to say	2	1
Previous Mental Health Input	Yes	36	13
	No	34	21
	Prefer not to say	2	0
Method of Delivery	Face to Face (i.e. Clinic)		9
	Telephone		8
	Video (MS Teams)		17

Table 2.2: Descriptive analysis for Time 1

	N	**Minimum**	**Maximum**	**Mean (+SD)**	**Modal Clinical Interpretation**
GAD-7	72	3	21	12.67 *(4.34)*	"Moderate Anxiety"
PHQ-9	70	1	27	15.03 *(6.24)*	"Moderately Severe Depression"
DT	70	10	100	64.71 *(18.32)*	70 (quite anxious/distressed, can't concentrate. Physiological signs present)

Further statistical analysis

Hypothesis 1: Students self-reported ratings of anxiety, depression and distress will reduce following SST.

Data did not meet the required assumptions for a MANOVA or *t*-tests, therefore non-parametric analyses were conducted. Wilcoxon signed rank tests revealed that there were no significant changes across the three dependent variables. The bar chart in figure 2 demonstrates the mean change over time for anxiety, depression and distress.

Anxiety

Participants self-rated anxiety did not significantly decrease after the intervention (*Md*= 13.00, *n*= 34) compared to before (*Md*= 13.50, *n*= 34), *z*= -.557, *p*= .578, with an effect size of *r*=.068.

Depression

Participants self-rated depression did not significantly decrease after the intervention (*Md*= 13.50, *n*= 34) compared to before (*Md*= 15.00, *n*= 34), *z*= -.736, *p*= .461, with an effect size of *r*=.089.

Distress

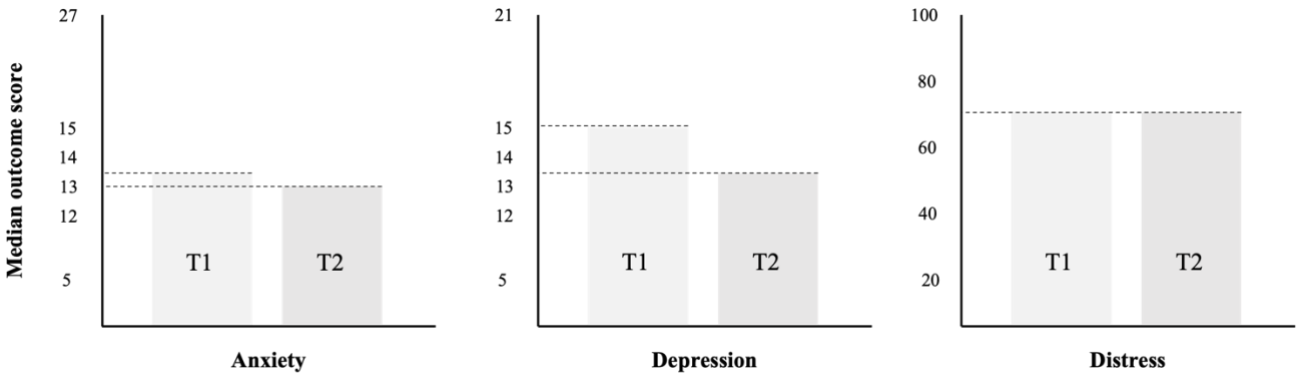
Participants self-rated distress did not significantly decrease after the intervention (*Md*= 70.00, *n*= 34) compared to before (*Md*= 70.00, *n*= 34), *z*= -.299, *p*= .765, with an effect size of *r*=.036.

Tests to see if data met the assumption of collinearity indicated that multicollinearity were not a concern (see Table 2.3).

Table 2.3: Correlation matrix to show coefficients between variables

Measure	Anxiety Tolerance, *(VIF)*	Depression Tolerance, *(VIF)*	Distress Tolerance, *(VIF)*
Anxiety (GAD-7)	-	.68 *(1.47)*	.68 *(1.47)*
Depression (PHQ-9)	.91 *(1.09)*	-	.01 (1.09)
Distress	.95 *(1.05)*	.95 *(1.05)*	-

Figure 2: Bar chart to show median change in the dependent variables over time



Hypothesis 2: Increased therapeutic alliance will be associated with a reduction in self-reported anxiety, depression and distress following SST.

Data did not meet the required assumptions to complete multiple linear regression analysis. Non-parametric correlational analysis was therefore conducted. As data were not normally distributed, Spearman's rank-order correlations were run to examine the relationship between level of self-reported mental health symptoms; anxiety, depression or distress and the three working alliance subscales; agreement on task, development of an affective bond and agreement on goals. No significant relationships were found between self-reported mental health symptoms and reported therapeutic alliance (see Table 2.4).

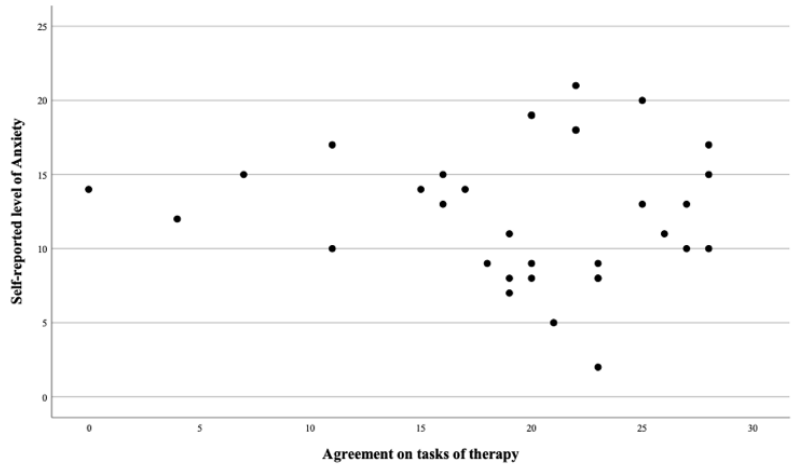
Table 2.4 : Spearman rank coefficients between self-reported mental health symptoms and working alliance

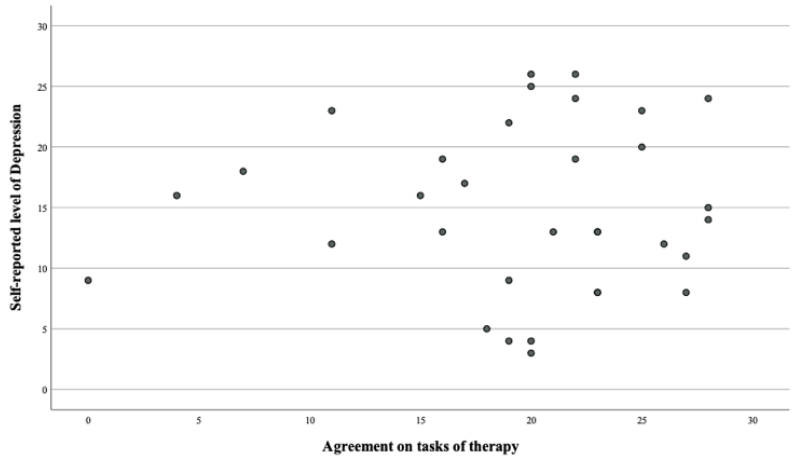
Measure	Agreement on task	Development of bond	Agreement on goals
Anxiety (GAD-7)	-.04	-.06	.04
Depression (PHQ-9)	.02	.14	.14
Distress	-.26	-.14	-.12

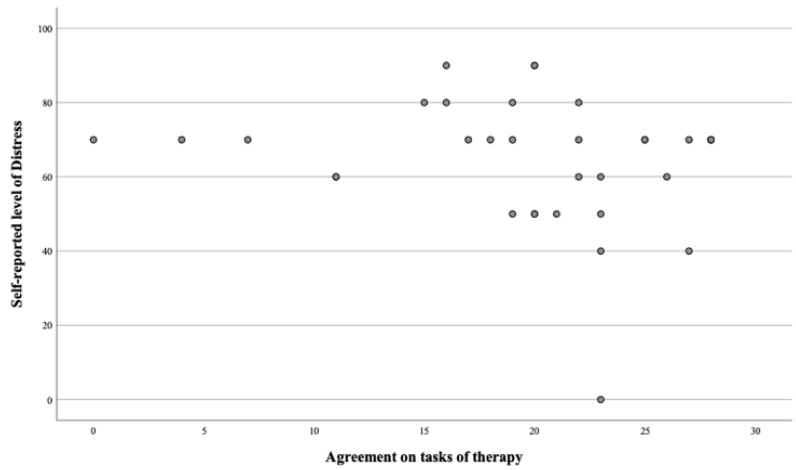
Figure 3

Scatter plots to show relationship between variables

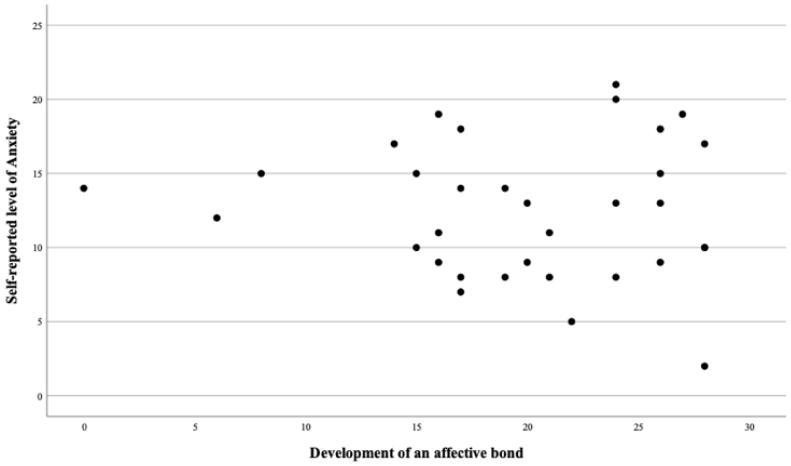
1. *Agreement on the tasks of therapy*

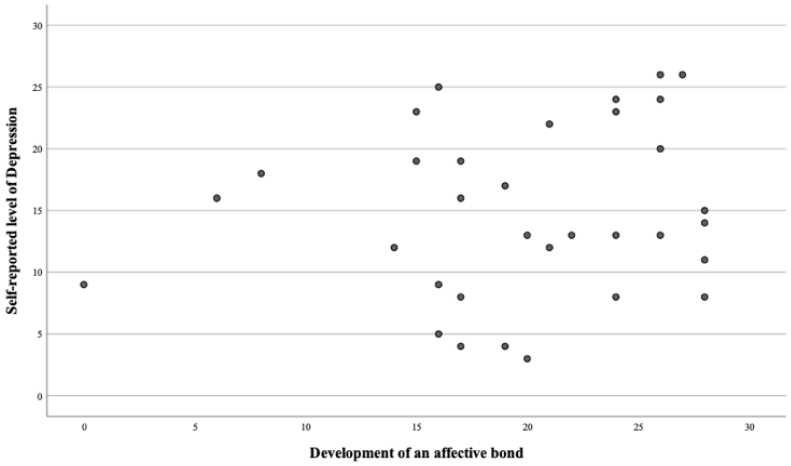


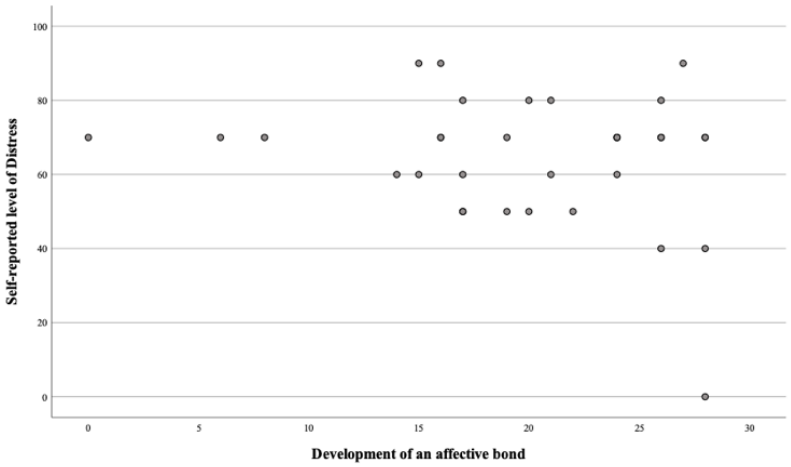




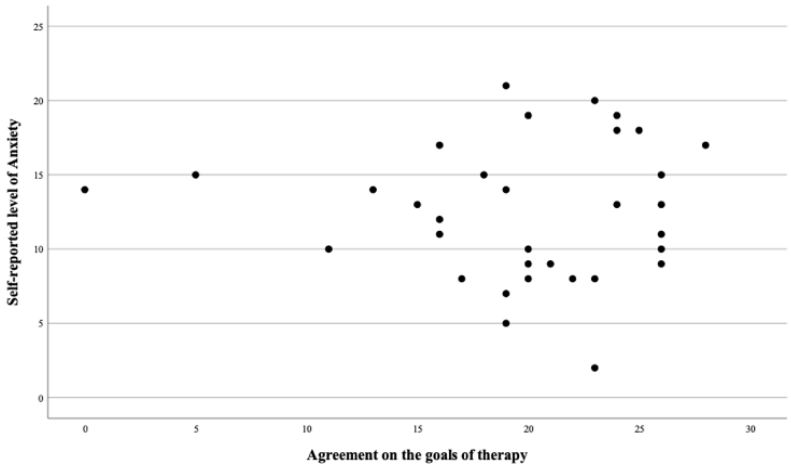
2. Development of an affective bond

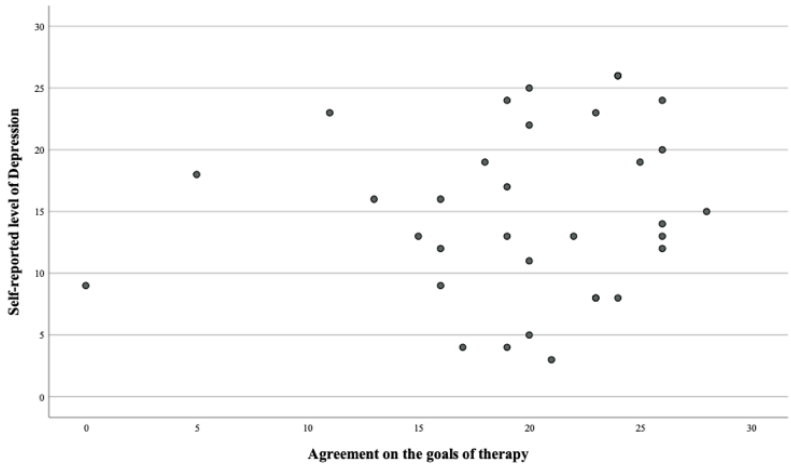


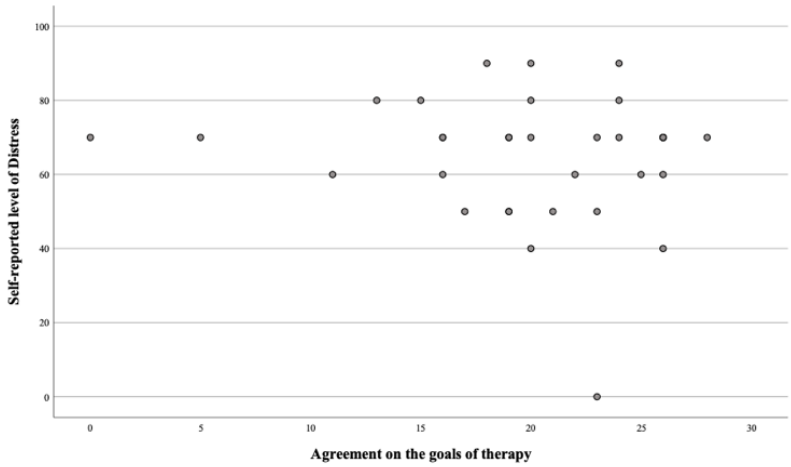




2. *<u>Agreement on the goals of therapy</u>*







Quantitative investigation summary

To summarise the quantitative research, the sample size was determined through a power analysis, with 72 participants at Time 1 and 34 participants at Time 2 for data analysis. Participants were mostly around 20 years of age, and most identified as female. The study aimed to investigate the impact of a therapeutic intervention (SST) on self-reported levels of anxiety, depression, and distress. However, the analysis did not show any significant changes in anxiety, depression, or distress levels following the intervention. Non-parametric analyses were conducted due to data not meeting the required assumptions for parametric tests. The study also explored the relationship between self-reported mental health symptoms and therapeutic alliance but found no significant correlations. These descriptive findings will be further discussed in the subsequent sections to explore the implications and possible reasons for the lack of significant changes and associations in the data.

A Qualitative Analysis of Therapists' Experiences of Mental Health Concerns and Therapeutic Alliance in SST

Methodology

Interpretative phenomenological analysis (IPA) will explore how participants make sense of their lived experiences. IPA enables a rich and detailed description of participants' sense-making process, considering their experiences of delivering SST to UK University students.

Participants and Recruitment

In keeping with IPA methodology, the study aimed to complete between six and ten interviews, allowing for detailed accounts of therapists' experiences and analysis of patterns and similarities (Smith, Flowers & Larkin, 2022). Therapists were purposively selected from the University student counselling service. Seven professionals met the inclusion criteria. Of those, six opted in and consented to participate within the research. All participants were accredited therapists registered with the required therapeutic associations to practice within UK mental health services (UK Council for Psychotherapy). There was homogeneity between participants and it was perceived by the research team and gatekeeper that the research question would be meaningful for all participants due to their choice to work as therapists delivering interventions to those seeking mental health support. Participants uniformity included i) delivering SST within the same University counselling service to students; ii) delivering other therapeutic interventions to students, such as Cognitive Behavioural Therapy (CBT) iii) experienced therapists, having between five and seventeen years of experience, iv) various experience in other therapeutic settings, including NHS, private and third sector charitable organisations. Four females, and two males participated. Therapists' primary modalities included person-centred, psychodynamic or CBT. Therapists had a wide range of varied experiences, including client group, such a CAMHS, asylum seekers and between NHS, private or charitable organisations and with their chosen further therapeutic training, such as EMDR. All identifiable information has been changed to maintain anonymity.

The inclusion criteria for this study involve therapists who are employed within the University of Liverpool Student Counselling Service. They must have experience in providing Single Session Therapy to University of Liverpool students. Additionally, they should be offering alternative therapies in addition to Single Session Therapy within the Counselling Service. It is necessary for the therapists to have a satisfactory comprehension of English to ensure their ability to give informed consent and comprehend the interview questions

The gatekeeper for the service distributed an email to all therapists who met inclusion criteria within her team, inviting them to contact the lead researcher to participate in semi-structured interviews either online or in person. A detailed research information sheet including; ii.) researcher contact details; iii.) consent form to opt-in to the proposed study; and iv.) student contact details request for follow-up was included alongside a consent form (see Appendix 5).

Design

A qualitative methodology using a semi-structured interview design enables a focus on subjective experience. The participants are provided a space to think, speak and be heard (Smith et al., 2022).

Data collection

An interview guide following IPA guidelines has been developed (Smith et al., 2022) including initial factual demographic questions to further explore participant homogeneity such as length of time as a therapist, and therapeutic modality and continued with open-ended and non-directive questions with an aim to facilitate in depth dialogue from all participants. This interview guide enables a format to frame the interviews to explore the research question. The interviewer ensured they followed IPA guidelines in not remaining rigid to the interview schedule but to set a loose agenda and listening to the participants, probing as appropriate to elicit a first-hand account of

their experiences as therapists'. The interviewer remained an active participant alongside the interviewee's (Smith et al., 2022).

The interview schedule was developed during discussions with three research supervisors, the gatekeeper and with reference to existing literature. It consisted of six main questions with two to three follow up questions (see Appendix 6). These had a focus on therapists' experiences of delivering SST and their experience of the therapeutic alliance within SST. Questions were designed to encourage therapists to provide personal accounts of their experience within the topic area. All participants opted to be interviewed remotely, via Zoom. Interviews lasted between 40minutes to 1hour, with all interviews audio recorded.

Data analysis

Interviews were transcribed verbatim and the 7-step IPA analytic process guidelines were followed for analysis (Smith et al., 2022). As noted by Smith and Osborn "*the aim is to try to understand the content and complexity of those meanings rather than measure their frequency"* (2007, p64). These meanings are achieved through a continual engagement with the transcripts and using a process of interpretation. Immediately following all interviews brief notes were made of initial thoughts and reflections. The first stage of the analysis included listening to the audiotapes and rereading the transcripts multiple times to provide familiarisation with the data. These were reviewed ascendingly (i.e. in the order they were completed). Whilst reviewing each interview, any initial thoughts, interpretations, connections, associations were noted in the margins (see Appendix 7 for an example). Upon completing initial reviews of all transcripts, they were again each revisited in order with *experiential statements* being recorded in the opposite margin. These experiential statements reflect a combination of the therapists' voice and the researcher interpretation. Various methods were used to develop upon these statements to identify initial connections, including matching colour-memos and mapping to develop meaningful groupings of the therapists' experiences (see Appendix 8 for an example) (Smith et al., 2022).

Statements were clustered numerous times until it was perceived the cluster of experiential statements best reflected the experiences of the therapists and mapped the interconnections of this, whilst also reflecting the research questions. These clustered statements become the therapists' *Personal Experiential Themes* (PETs). This process was repeated for each individual transcript. Patterns of similarity or differences were then explored across the PETs to finally create *Group Experiential Themes* (GETs). The aim within this step in IPA was to highlight the shared and if present, unique, features of the experiences across the therapists. Themes were then translated into a narrative account using key quotes to enable exploration of the results.

Reflexivity and Epistemology Statement

Within IPA it is important for the researcher to be reflective of one's own perspective to maintain quality and validity of the data. It felt important to note that the research team had a working relationship with the service interviewed due to the managers gatekeeping and consultant role throughout the research design process. Additionally, the lead researcher, being a Trainee Clinical Psychologist at the time of analysis was a student within the same University and working as a mental health practitioner in NHS services. This felt important to reflect upon by the lead researcher as experience and interest in working within therapeutic services and being a student within the University SST is delivered influenced the questions formulated. The experience of the researcher has inspired interest in researching this area and it is important to consider how this experience may influence interpretations of the transcripts. It was important to hold in mind that some therapists' experiences of working within a mental health service may be reflective of the researchers but important to remain open minded in analysis to explore other experiences which may emerge.

To try to ensure any researcher biases did not overtly influence data analysis and remain critically reflective, thoughts and feelings were noted via reflexive journaling and continuous supervisory discussions throughout the research process. Attempts to remain open and keep therapists' narratives in focus were made throughout, to formulate a balanced view of the research topic. A second coder was also consulted who listened to 50% of the interviews and discussed themes

and clustering to reduce bias. Numerous discussions were also held within research supervision and reflections shared by the researcher when concerned personal experience may have been skewing emergent themes. Supervisors feedback was incorporated into the analysis. These steps ensured themes were representative of the data.

Results

A total of five themes were developed and organised in two clusters of Group Experiential Themes. The experiential themes included: 'the impact of therapeutic expectations on SST' and 'the power of connection'. Due to participant numbers and word restrictions, quotes which were salient and representative to the experience of the larger group have been selected.

Table 2.5: Group Experiential Themes and their associated subthemes

1. The impact of therapeutic expectations on SST
A. The dichotomy between professional values & expectation/requirements of SST
B. Is one enough?
C. Frustration at the wider system
2. The power of connection.
A. An intrinsic connection
B. The balance of power

Experiential theme 1: The impact of therapeutic expectations on SST

The group experiential theme revealed three sub-themes: therapists' extensive work experience, knowledge, and therapeutic skills, along with their intrinsic desire to connect with clients and share knowledge. Their passion for improving mental health drives their commitment to helping those they work with. However, there was also an overarching feeling of discontent and frustration communicated by therapists.

Subtheme A: The dichotomy between professional values & expectation/requirements of SST

All therapists emphasised the significance of sharing their knowledge with students and

recognised the importance of equipping students with new knowledge and skills during the SST sessions for achieving therapeutic outcomes. A strong sense of desire to help improve students' wellbeing was interpreted. Accounts suggested therapists were provided with a feeling of success if students were leaving with a new thought or understanding and had the *"aha"* moment as described by Therapist 4. However, therapists also seemed to want something more concrete to provide themselves with a feeling of helpfulness. There was a sense of need from the therapists that if students were not given explicit resources, or tasks to implement change or continued development of psychological knowledge after the session, that they felt success would be limited. Therapist 4 embodied this therapeutic need to share knowledge with students: *"I need to deliver something to engender hope…give the student something practical to do, or some thoughts that they can take away with them".*

Therapists noted having received training in numerous therapeutic modalities since starting their careers. When reflecting on their therapeutic journey and experience in delivering SST to students there was a felt sense that skills and therapeutic ability in delivering SST had developed over time. All therapists inferred that there had been a process of adaptation to SST. For some, this "process" had been more challenging than for others:

> *"When I started …I was doing it literally as I understood it…I found it very tiring, and I felt that I was, I was just doing too much, and that has now changed throughout the three years I've been doing it. …. Really freed up a lot of energy for me. I feel much more relaxed now doing an SST…They get a less grumpy therapist. A less tired one."(Therapist 4)*

It was noted that length of time in delivering SST provided a challenge to adapt and an inferred initial anxiety in delivering it right. However, over time, through supervision and team discussions, their confidence in their therapeutic skills had enabled flexibility within their work to adapt their skill set in the moment to meet the needs of the individual presentation. This, alongside the service design enabling speed of access, provided a felt sense of consensus that SST has a place in

meeting student's mental health needs.

Nevertheless, there was an underlying uncertainty whether they were meeting students' needs or if they were guiding a change in the presenting problem. Despite four of the six therapists utilising person-centred approaches, there was an underlying current of discontent and doubt at being able to develop meaningful connections in SST, evoking a sense of frustration and disconnection from their therapeutic values. Therapist 2 described SST as "*feel[ing] like I'm pushed, I'm firefighting in single sessions*". It was felt that most of the therapists, whilst they could see a value in SST, were experiencing a lost sense of achievement in delivering it and felt it did not fit within their expectations and professional values in being therapists within the student counselling service: *"I don't feel like I'm a therapist really, in single sessions. I feel like I'm a coach, or a mentor"* (Therapist 2). This undercurrent of discontent inferred that therapists' work values were not being met within SST, requiring a period of adjustment, and a hope that SST is not incompatible with their "true" therapeutic values: *"taking me some time to feel comfortable with, the match up of my person-centred philosophy and SST…your natural instinct is to let people explore…really create a connection"* (Therapist 6). Interviews suggested that therapists were struggling to embrace SST within their professional identity, wanting to remain steadfast to their core modalities. This disparity between one's values is reflected clearly by Therapist 6 describing how SST can be *"really disheartening sessions…you want to be able to help them more than you can".*

Subtheme B: Is one enough?

SST is designed to be delivered within one session; therapists enter the room holding in mind that *"I might be speaking to this person just one time. So, it has to be a kind of…complete thing"* (Therapist 1). How therapists experienced providing therapeutic support within one session provided mixed interpretations. Value was noted for students receiving *"help at the point of need"* (Therapist 1) and the importance in speed of access as *"it helps that we've got a resource that students can access quite quickly to check in on them"* (Therapist 3). This view was repeated by different therapists and by some therapists' multiple times within the interviews, inferring how important they felt the

timeliness of receiving *"a little taster of therapy"* was, having *"one chance to address the issue"* (Therapist 4). Therapists' experiences of SST were perceived as beneficial as they inferred a key advantage being its use as a preventative strategy, to help support students early on, when feeling distressed, with the aim of stopping emergent mental health problems and promoting good mental health through psychoeducation about mental wellness, it could help *"nip things in the bud"* (Therapist 2).

Therapist 1 suggested that some students *"just kind of want some techniques, self-help type stuff…coping mechanisms".* A benefit of one session, whilst perhaps not a conscious benefit of SST, was the promotion of independence, for students to *"do the work themselves…very much a standalone thing"* (Therapist 5). Providing one session requires the student's motivation to change. There was also an implication of personal responsibility for positive change within one session, with therapists being *"more pressurised in terms of getting along"* (Therapist 4). This reference to pressure inferred that therapists' hold the responsibility for the therapeutic alliance and that this impacted the success of the session. It was interpreted that all therapists held a positive reflection of SST and could see value in offering one session to students, but they also had an internal conflict of uncertainty of if this was sufficient. Therapist 1's use of the word *"taster"* suggested they see SST as just a starter and feel more will be needed once students know they 'like' therapy.

All therapists shared similar views that SST has *"got its place…[and] got really good results with some people"* (Therapist 2), and that *"things can get resolved in the session…that first encounter can be very significant"* (Therapist 4). There was an interpreted undercurrent though that therapists' felt perhaps for students one session is sufficient for might not need to be seen within the counselling service, as a less intensive intervention might be more appropriate which would free up resources: *"I think there's a place for it as well, erm. I do wonder whether the wellbeing staff could do some of that."* (Therapist 3). In contrast, those that they perceived as in need of full counselling service support were perhaps not having their needs met with SST: *"You wanted to have enough sessions with people, and sometimes you just weren't able to…personally I struggle with that in single*

sessions."; "the deeper stuff, you can't really get to" (Therapist 2). This unconscious bias that one session will or will not be enough will likely impact therapeutic outcomes. It seemed that therapists either screened the presenting problems prior to the session and deemed it 'non-counselling' worthy or 'too complex' giving them time to only *"deal with the immediate issues", "crisis intervention…and there's only so much you can do with that"* (Therapist 2).

Subtheme C: Frustration at the wider system. (Systemic issues)

SST sits within a much larger university student support services network, alongside the availability of local and national services supporting mental health and wellbeing. Therapists spoke about the need to highlight this wider network to students, often asking *"what they've tried, around the university or within the city"* (Therapist 3). It became clear that all therapists appear to hold a frustration towards the wider university network, at the presenting difficulties that are being signposted to student counselling, and referred for SST. Therapists implied a gap in provision within the University and a fear of mental health by others within the University leading to, in their opinion *"a lot of the stuff that… aren't really appropriate for a single session"* describing mental health concerns as *"like a hot potato it's like, go to them"* (Therapist 2).

There was further frustration with wider systemic issues: particularly limitations to students' mental health knowledge and understanding – specifically in differentiating mental health crises from those that do not require intervention:

> *"…normalising symptoms, everything's pathologised now, everybody's got anxiety…it's my anxiety, my depression…it's actually about just normalising their symptoms often as well, as as part of just general living….*
>
> *It's like there's nothing wrong with you. You know, you're not broken you know. It's this like, there's something wrong, it's like no, it's not. It's uncomfortable but I think it's a hangover from school as well, I think there's push push push you know, they come burnt out by the time they hit this year, first year."* (Therapist 3)

The repeated use of push, their tone and speed when speaking show this exasperation at the wider system. There was a repetition of SST sessions being *"proactive"* and *"active"*. However, there was also an inference that there was a need for the students to be similarly proactive but feeling many are not and want to be "done to". Therapist 2 spoke about an *"expectation"* that students would take any learnt knowledge and skills from the session and implement them outside of the room:

"You need to be doing it, because if you don't, things aren't going to change" but a frustration that *"sometimes they, they're so (pause), they're (sigh) they're so young, and so, inexperienced, and that's not their, obviously not their fault but it feel like erm, you've got, er as a therapist you've got to, to do more."*

On the other hand, there was concern that some students are only attending when in crisis, suggesting the wider University system is not "doing enough" to support students to attend prior to crisis point. Therapist 2 spoke about this challenge: *"there's a lot more, poorly people…you're not gonna be able to do an awful lot, with that in one single session"*. This crisis presentation does not match the model of SST the University counselling service had shared in the initial development of including this pathway. The interviewer had been informed it was for students presenting with 'stress and distress' as a preventative intervention to *"figure out what's going on right now…instead of putting you on a waiting list for six months…let's figure out what we can do right now to get moving again"* (Therapist 2).

Therapists' often felt that students have been failed by the networks around them to prepare them for the transition to university, and on a wider level, to adulthood. This responsibility for 'teaching' about mental health and sharing psychoeducation and skills was interpreted as feeling like it had fallen to the hands of the therapists and whilst this was an area they are highly knowledgeable in, their tone and word choice inferred a frustration at this and a sense that they feel that their expertise could be better utilised, and this knowledge should have been given to students either by their parents, high schools or even by other university professionals.:

"…parents need to be teaching them before they come in, as well as school…didn't

get the access and support they needed and now it's just landed in us, so we're picking up stuff that should have been dealt with in school and at home" (Therapist 3).

Similarly, therapists' commented on how this lack of utilisation fed in through the organisational structure, feeling in conflict at working within a counselling service but not providing counselling as they are all registered therapists with core modalities and providing specific therapeutic interventions alongside SST

> *"I feel like they want advice….And I don't, like I don't think that it fits, in, in our organisation, with, (pause) the type of therapies that we do…I, I feel like it should be with well, wellbeing, I think it'd be perfectly set with them…There's that education the, the, organisation on what counselling is the, the students as to what, so I don't call myself a counsellor, because I'm not, I'm an 'x' therapist, I'm a 'y' therapist, so, not that I, I'm being disrespectful but that's what my qualification is."* (Therapist 2)

It leaves the question of how does this exasperation at the wider system around the student impact the therapy? If therapists are frustrated at the referral reason, at students' lack of understanding and 'preparedness' for adulthood, it can be assumed that this will impact the connection in the room. It was interpreted that there is an unconscious bias towards certain presenting problems, feeling certain difficulties should be "dealt with" elsewhere: "*a lot of staff push them for SSTs when it's like, why are they here? They shouldn't even be seeing us"* (Therapist 3). The use of the word push infers that they feel students are not requesting this support and perhaps the therapist has experienced students as unprepared for the session or not yet ready to be *"their own agents for change".* Therapist 6 suggested how the system could work better together: *"distress could be managed with befriending and a little bit more work on the sort of lower level stuff of helping someone to navigate getting to uni".*

Experiential theme 2: The power of connection

This Group Experiential Theme had two subthemes: an intrinsic connection and the balance of power. The therapeutic alliance is usually considered a central part of therapy, yet questions have been raised for how this can be possible within one session. Within the interviews, therapists explored how therapeutic relationships in a single session develop and fit within their wider role, values and experience as therapists.

Subtheme a) An intrinsic connection

Therapists' reflected on their experiences of the working relationship and if they felt one session impacted this or their process of developing the therapeutic alliance. It was interpreted that there was a joint sense amongst therapists that this relationship is natural, it just happens. It was perceived that therapists do not perceive one session as a limitation in establishing this connection: Therapist 2 spoke about this promptness: *"is it seven seconds you judge somebody and you get a sense of someone, that's gonna be reciprocal isn't it"*. This reflected the notion that SST is not a limitation to building a bond as they feel it happens almost instantaneously.

Interpretative analysis exposed a shared view of a personal value in the alliance and that it enables a feeling of therapeutic success, due to therapists' experiencing this relationship as creating *"a safe environment"*. It was clearly interpreted from the interviews that therapists hold a strong belief that the therapeutic relationship is key in empowering students to feel comfortable to talk, which is crucial to produce effective outcomes from the session. Therapist 1 succinctly communicated this: *"if you can't build a relationship kind of quite quickly then, they're not gonna open up for you to be able to bring in the other things really".* Therapist 1's repetition of this need for students to *"feel safe"* and *"creating a relationship and trust, a safe environment"* at various time points throughout the interview emphasises how important this connection with the student is to them and how much value they put on it for a successful SST, and that for the therapists' this feels like it is something that predominantly comes naturally to them within their therapeutic skill set. The value of the alliance

between therapist and student observed within all interviews was summarised succinctly by Therapist 2: *"the relationship is really important, no matter what"*.

Subtheme b) The balance of power

Students attending SST are coming to seek support and guidance, answers to their difficulties. They look to the therapist as the person who can help, *"they want an answer, some of them"* (Therapist 6). This results in a natural power difference between therapist and student. The way this power is "used" within the therapy room is what is important and affects the alliance. Students could be entering the therapeutic space vulnerable to harm if therapists' power was misused. It could be anticipated that due to therapists' pressure to create change within a single session they might 'tell' students what to do, especially with therapists experiencing some students as *"expecting to be fixed"* (Therapist 3).

All therapists were conscious of this important dynamic and the challenging balance of power in their role, emphasising the importance of collaboration within SST. Their acknowledgement that they could try to give answers to students but for them, a sense of success came from *"making them be proactive…that joint work"* (Therapist 3). Therapist 4 seemed to come back to the balance of power at various time points within the interview exhibiting the importance of this dynamic in the therapeutic relationship to them. They spoke of wanting a *"dialogue going on, rather than me, erm, presenting a menu of options"* and later that *"I'm not here to tell you what to do, erm, I'm listening and this is what comes up for me…feeling as if I am an equal, with a different set of knowledge than the student has"*. Their use of the word dialogue shows that they want the student to experience SST as a joint conversation, a two-way exchange.

Therapists were interpreted as utilising the power difference they have within the therapeutic relationship to *"make the client feel safe…reflect their situations, thoughts, feelings, back to them"* (Therapist 1). Rather than using this power to give authority over students, the skills and knowledge

therapists' have enables them to seemingly transfer this to students. This can be interpreted from Therapist 3's experiences of *"joint work, so they, they're kind of, they're empowering themselves, to be, part of their own wellbeing"*. Therapists were aware of the detrimental impact of not using their power differential in this way, that whilst students may be explicitly asking for answers within the room, this would not lead to longer term success and the importance of change taking place outside of the room when they are only attending for a single session. Whilst therapists experienced an expectation from students that they would be "done to", or given a fix, this does not align with therapists' values, *"the student needs to go away and so some work as it were, you know, that's the challenge. …they have to do some work themselves…it's very much a standalone thing"* (Therapist 5). Therapist 4 summarised the inferred sense of value this balance of power is to therapists within SST: *"if I feel that if I … tell them what to do, this is the cure...there are implications erm in terms of the students feeling even more alone because their issues is not, is not properly heard."*

These two subthemes both echoed a natural *"way of being"* for therapists, but also, the exploration of therapeutic relationships is something therapists evidently all reflect on, and all hold at their core when working with SST.

Discussion

Summary

This study, to the author's knowledge, is the first to explore the self-reported impact from students receiving SST and therapists' experiences of delivering SST. In contrast to previous research, no significant change in self-reported anxiety, depression, or distress has been found after SST (Barker & Pistrang, 2005; Talbot et al., 2011). There is also no significant relationship between self-reported mental health symptoms and the therapeutic alliance. Qualitative analysis identified two Group Experiential Themes: the impact of therapeutic expectations on SST and the power of connection. Due to quantitative data being underpowered the author does not want to overstate the findings and as such greater consideration will be given to the qualitative element of this study.

This study finds no evidence of a clinically significant reduction in anxiety, depression or distress following SST which contradicts a recent systematic review findings that SST leads to a reduction in symptoms (Bertuzzi et al., 2021). Although the empirical findings do not show significant reductions in self-reported mental health symptoms through SST, the study provides important descriptive information. Prior to SST, 44.3% of participants report having recent suicidal thoughts. Descriptive analysis also reveals that most students report moderate anxiety symptoms and moderately severe depression symptoms. Prior discussions with the head of student services and counselling service manager clarified that SST is intended to assist students dealing with stress and distress, rather than those exhibiting suicidal ideation or clinical symptoms of anxiety and depression. Thus, findings of this study suggest students accessing SST have higher levels of mental distress than anticipated. These findings are further supported by therapist interviews, where they describe their role as often providing *"crisis intervention, and there's only so much you can do with that"* (Therapist 2). The prior systematic review findings highlight this as concern, that many students wait until experiencing high levels of psychological distress and suicidal thoughts and behaviours before help-seeking (see Chapter 1). The current research also indicates discrepancies between the student descriptive data and the therapists' experiences in terms of presenting difficulties. All therapists mention receiving referrals that they do not deem appropriate for SST, sharing that they spend a lot of

their sessions *"normalising symptoms, everything's pathologised now"* and students often *"arrive and it's nothing to do with mental health"* (Therapist 3). This disparity between students' self-reported mental health symptoms and therapists' experiences is an interesting area that would benefit from further research with a larger number of participants to ensure the student sample is representative of the population accessing SST. The importance of students' understanding of mental health is emphasised as lower than anticipated, based on therapists' experiences. This finding aligns with the significance highlighted in the previous systematic review, which emphasises the essential nature of improving mental health literacy (see Chapter 1).

In the qualitative analysis of this study, two Group Experiential Themes were identified: the impact of therapeutic expectations and the power of connection in SST. These themes encompass various subthemes. Therapists express their desire to share knowledge and skills with students and emphasise the importance of providing practical tools and resources. Gaining a sense of reward and meaning from improving students' well-being. There is also a sense of uncertainty and discontent among therapists, as SST may not fully align with their core therapeutic values and expectations. Challenges include adapting to SST and feeling drained, but over time, with supervision and team discussions, they gain confidence and flexibility to skills in meeting individual needs. There is an narrative of uncertainty and a loss of achievement, feeling that SST falls short of their expectations and professional values. Therapists with a person-centered core modality particularly struggle to fully embrace SST within their professional identity. One's personal and work values are often explored during workplace recruitment, as having work values met leads to a sense of meaning and job satisfaction and reduction in frustration (Knoop, 1994).

The sub-theme, "Is one enough?", highlights therapists' experiences of providing interventions within a single session as beneficial and challenging. They acknowledge the value of immediate support for students enabling timely access and the opportunity to address specific issues. In agreement with previous research (Dryden, 2020) therapists view SST as a preventative strategy, promoting good mental health through psychoeducation and providing students with coping

mechanisms and self-help techniques. Therapists acknowledge that SST promotes independence and personal responsibility for positive change as students actively participate in their own progress. However, there is uncertainty and internal conflict among therapists regarding the sufficiency of one session. While advantages are acknowledged by all, there is a divide between therapists, with some believing that one session can effectively address students' concerns, while others feel they may not have their needs fully met, reflecting prior research (Hurn, 2005). This conflict may stem from therapists' personal experiences and their core modalities, which typically involve multiple sessions for significant change. Prior research aligns with therapists' preferences for multiple sessions, highlighting that establishing a strong therapeutic relationship takes time and continuity (Bowlby, 1988; Farber et al., 1995). Multiple sessions allow for deeper exploration, resolution of difficulties, and the application of newly acquired skills (Baldwin & Imel, 2013). The complex nature of psychological issues suggests that one session may not be sufficient for significant improvement, emphasising the need for ongoing therapeutic engagement and continuity of care (Norcross & Lambert, 2019). While therapists recognise the benefits of SST in providing more timely support, the question of whether one session is enough remains a point of discussion and reflection which would benefit from further research with client groups with lessor symptoms of distress than has been reported within the quantitative study.

Therapists' frustration at the wider system, stresses the need for a more comprehensive support network within universities and the wider community to prepare students for the transition to university and adulthood. This reflects barriers to help-seeking and implications for practice highlighted in the prior systematic review (see Chapter 1). Therapists feel a sense of responsibility for teaching and providing psychoeducation, feeling that students have not been adequately prepared for the challenges they may face in university, aligning with previous research by Simpson et al. (2019). The transition to university is a critical period for students, encompassing both excitement and stressors that significantly impact their mental well-being. Financial, academic, and social pressures, make students more vulnerable compared to peers not in university (Barbayannis et al., 2022; Kessler et al., 2005; Thorley, 2017). This underscores the significance of addressing academic, financial and

social based anxiety and suggests that SST could be a valuable intervention for first-year students.

Therapists are concerned about a gap in mental health provision within the university and the lack of student literacy and preparation before help-seeking. To address this, therapists and previous research (Simpson et al., 2019) recommend involving personal tutors in supporting students' well-being. While personal tutors primarily focus on academic progress, their involvement can complement the efforts of SST, as a collaborative approach may prove beneficial in providing comprehensive support for students' mental well-being. Despite frustrations, therapists acknowledge the value of SST but propose integrating it into the university's wellbeing services for a more cohesive approach. This highlights the need to align mental health services with existing university structures. However, additional research or pilot programs are needed to determine the optimal placement and integration of SST within the university's support systems, ensuring holistic student well-being.

The power of connection is highlighted through two subthemes: intrinsic connection and the balance of power. Therapists' emphasise time constraints within SST do not impact their experiences of building a therapeutic relationship. Connection with the student occurs almost instantaneously, it is a natural and instinctive process. The therapeutic alliance is seen as vital for creating a safe environment and fostering trust, which is crucial for effective outcomes in SST (McLeod, 2011). Ultimately, therapists value the therapeutic relationship as a cornerstone of their work, believing it to be instrumental in empowering students to share their experiences and collaborate in the therapy process. Therapists also highlighted an understanding of the power imbalance in SST. Therapists are aware of this dynamic and the importance of collaboration and joint work as key elements in SST, where therapists aim to facilitate proactive engagement from students rather than imposing solutions (Dryden, 2020). Therapists want the therapeutic space to be a dialogue, allowing students to participate actively and share their perspectives. They aim to empower students to take ownership of their well-being and recognise the importance of personal effort and change outside of the session. Prior research highlights the importance of building rapport quickly and establishing trust as pivotal elements in effective brief interventions (LeMoyne & Buchanan, 2011). Additionally, the significance of collaboration and shared decision-making in enhancing the therapeutic alliance and treatment

outcomes is emphasised (Ackerman and Hilsenroth, 2003). These findings align with the experiences and perspectives of therapists in the current study, further underscoring the importance of the therapeutic alliance and power dynamics within SST.

Strengths and Limitations

It is important to consider the limitations of this study, including the recruitment challenges within the quantitative study and the exclusion of additional themes that could have been explored within the qualitative study.

Recruitment has been a significant challenge within this research project resulting in the quantitative data not meeting the required power, with 72 recruited at Time 1 and 77 needed at Time 2 to have 80% power for detecting a medium sized effect. Findings do not meet the necessary parametric assumptions for the planned statistical analysis. The research team, and gatekeeper did not anticipate such a low uptake for participation based upon the number of students accessing SST. Numerous changes have been made throughout the study to encourage participation within the restrictions of the ethical approval (and submissions for amendments). Changes included students receiving the study information at three different time points: from the wellbeing team while being advised a referral was being made to the counselling service; while invited to opt-in for an SST; while being sent their appointment for SST. Posters are visible within the student wellbeing offices and the waiting room at the counselling services. Initial renumeration included entry into a prize draw for two vouchers. This has since been amended to include participants also receiving a £5 Love to Shop Voucher upon completion of the three stages. Attrition from Time 2 to Time 3 is high, with only 3 participants completing the questionnaires three-months post SST resulting in this portion of the study being removed preventing the inclusion of longer-term follow up. Due to this project being a part of a thesis, there are limitations with funding and ethical restrictions to make further changes to recruitment or ability to recruit from more sites. There are also time restrictions resulting in a hard deadline for a cut-off point for recruitment. Whilst frustrating, it has led to significant development with the study being adapted to interview therapists' this has provided rich and important data

resulting in a much bigger project than anticipated and a greater sense of enjoyment and connection with the project in being able to interview the therapists' and speak with them first hand, whilst online questionnaires can feel more distanced.

Recruitment and retention challenges with individuals with mental health difficulties is common (Liu et al., 2018). Failure to meet the recruitment goals increases the risk of research being underpowered, closed prematurely, or needing extended recruitment periods, including increased costs and workload. Although there is a helpful compilation of advisable recruitment and retention strategies for child participants, data on effective recruitment sources that specifically focus on adolescents and/or young adults are scarce (Vogel et al., 2020). It would be important to consider barriers and facilitators to recruitment for such studies in future research, volume of questionnaires and possible distress caused by having to talk about painful topics have been reported as barriers for adolescent and young adults to participate in research. Whilst the chosen questionnaires are not reported to cause further distress in literature, participants will not have known this prior to accessing the study. Important to consider within the current study is that the difficulty with recruitment was not only with retention during the study as only six participants were removed due to not completing the first time point, but students not opening and viewing the study information in the first instance or returning to complete Time 2. Due to the specificity of population needed for this study, advertising and recruitment could not occur on social media as has been found to be an effective recruitment strategy for others targeting the same population (Amon et al., 2014; Vogel et al., 2020).

The qualitative study provides valuable and novel insight into exploring therapists' experiences in delivering Single Session Therapy (SST). The specific research aims provide constraints to the data collected from interviews limiting the exploration of other potentially significant themes. While the insights gained provide important knowledge, it is important to acknowledge that there may be additional themes that have not been fully examined in this analysis. Future research has the potential to conduct re-analysis of the transcripts. This could uncover additional themes and provide a more nuanced understanding of the challenges and benefits associated with SST. Despite these limitations, the study highlights the ongoing need for therapists to

engage in reflection, training, and receive support to effectively deliver SST within the counselling service. The significance of the therapeutic alliance and the dynamics of power within SST are emphasised in the findings. Therapists' commitment to providing client-centred care and upholding ethical practices is evident. These findings underscore the importance of establishing a strong therapeutic alliance and maintaining a balanced power dynamic between therapists and clients in SST.

The impact of the COVID-19 pandemic on students in UK universities and how it may affect the findings of this study should be considered. The data collection occurred during the pandemic which had various consequences for students, such as isolation, reduced peer support, and a possible decrease in support from friends and family. This may have influenced self-reported symptoms in the quantitative study potentially resulting in higher levels of distress among students. It is important to acknowledge that this is the first known study of its kind with university students, lacking comparative research to show the impact of COVID-19 on reported psychological distress for those accessing SST. Longitudinal data or a re-run of the study now that face-to-face teaching has resumed and COVID-19 restrictions have ended could provide valuable insights. Notably, the National Student Survey (NSS) revealed that only 41.9% of students believed their university adequately supported their mental wellbeing during the pandemic, with 17% reporting feeling lonely often or always (OfS, 2021). Data collected during the time when the quantitative data was being collected revealed that 36% of students reported a worsening of their mental health and wellbeing during the COVID-19 pandemic (ONS, 2022). These findings highlight the potential impact of the pandemic on student mental health, but without comparative data from before the pandemic or after the lifting of restrictions, it is difficult to fully understand the extent of this impact. Therefore, further research is necessary to review and compare these findings in the post-pandemic context, considering the return to face-to-face teaching and increased contact with staff and peers.

Implications for Practice

The findings of this study have implications for future research and clinical practice. They suggest that individuals accessing SST in the university setting may be reporting higher levels of mental distress than anticipated. This calls for a deeper understanding of the population accessing SST and the appropriateness of the intervention for their needs. Further research with a larger sample size is necessary to explore the discrepancy between students' self-reported mental health symptoms and therapists' experiences. The study also highlights the importance of providing therapists delivering SST with the necessary support and resources to address their uncertainties and align the intervention with their core therapeutic values. This may involve ongoing supervision, training, and discussions within the therapeutic team. The commitment of therapists to maintaining a strong therapeutic alliance and addressing power dynamics is crucial for the effectiveness of SST.

Additionally, the study underscores the need for a comprehensive network of support within the university and the wider community to address students' mental health needs. Collaborative approaches between personal tutors and SST can provide comprehensive support for students' well-being. Exploring the optimal placement and integration of SST within the existing university support systems is essential to ensure a holistic approach to supporting students' mental well-being. Despite the frustrations expressed by therapists, there is a resounding opinion that SST is a positive intervention and has a place within student services. However, based on their extensive experience in delivering SST and other therapies, there is a consensus that SST would be better placed within a different student service setting, such as the Wellbeing service.

Conclusion

This study explores the impact of Single Session Therapy (SST) on students self-reported mental health symptoms and the experiences of therapists delivering SST. Contrary to previous research, no significant changes in students' self-reported anxiety, depression, or distress are found. The relationship between self-reported mental health symptoms and the therapeutic alliance is also not significant. However, the study provides valuable descriptive information about the student

population accessing SST, revealing higher levels of mental distress than anticipated.

Therapist interviews highlight the challenges and benefits of delivering SST with therapists expressing a desire to share knowledge and skills with students. They acknowledge the value of SST in providing immediate support and promoting independence but express concerns about the adequacy of a single session for significant improvement. The therapists emphasise the importance of the therapeutic alliance and continuity of care in facilitating meaningful change. Despite systemic frustrations, therapists' passion, and dedication to helping students remain steadfast. SST has important implications for future practice. It is vital to consider the appropriate population (those with stress and distress, rather than high psychological distress) and strategically place SST within university student support service pathways. This will ensure that SST effectively addresses student needs, reduces barriers to help-seeking, and aligns with its intended purpose.

(Therapist 2) It's been interesting, interesting, I was gonna say ride then, because it does feel like a bit of a ride rather than a journey to be fair.

References

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23*(1), 1-33.

Amon K.L., Campbell A.J., Hawke C., & Steinbeck K. (2014). Facebook as a recruitment tool for adolescent health research: a systematic review. *Academic Pediatrics, 14*, 439–447. https://doi.org/10.1016/j.acap.2014.05.049.

Appleton, R., Loew, J., & Mughal, F. (2022). Young people who have fallen through the mental health transition gap: a qualitative study on primary care support. *The British journal of general practice : the journal of the Royal College of General Practitioners*, *72*(719), e413–e420. https://doi.org/10.3399/BJGP.2021.0678

Baldwin, S.A., & Imel, Z.E. (2013). Therapist effects: Findings and methods. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 258-297). John Wiley & Sons.

Barbayannis, G., Bandari, M., Zheng, X., Baquerizo, H., Pecor, K. W., & Ming, X. (2022). Academic Stress and Mental Well-Being in College Students: Correlations, Affected Groups, and COVID-19. *Frontiers in Psychology*, *13*. https://doi.org/10.3389/fpsyg.2022.886344

Barker, C., & Pistrang, N. (2005). Quality of therapist-delivered services in single-session therapy: An analogue study. *British Journal of Clinical Psychology, 44*(3), 403-415.

Bowlby, J., (1988). Attachment, communication, and the therapeutic process. In : J. Bowlby, A Secure Base (pp. 137-157). *Basic Books*, New York.

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 mental health problems. *Medical Education*, *37*(10), 873–880. https://doi.org/10.1046/j.1365-2923.2003.01627.x

Crowell, J. A., & Treboux, D. (1995). A Review of Adult Attachment Measures: Implications for Theory and Research. *Social Development, 4*, 29-4327

Dryden, W., (2020). *Single-Session Therapy; Distinctive Features*. Routledge, London.

Farber, B. A., Brink, D. C., & Raskin, P. M. (1995). *The psychotherapist's own psychotherapy: Patient and clinician perspectives.* Oxford University Press.

Feldman, D.B., & Dreher, D.E., (2012). Can hope be changed in 90 minutes? Testing the efficacy of a single-session goal-pursuit intervention for college students. *Journal of Happiness Studies, 13,* 745-759.

Frye, D. (2023, February 10). The Mental Health Crisis in Colleges and Universities How can we support the mental health of college students?. *Psychology Today*. https://www.psychologytoday.com/gb/blog/zero-generation-students/202302/the-mental-health-crisis-in-colleges-and-universities

Gawrysiak, M., Nicholas, C., & Hopko, D.R. (2009). Behavioral activation for moderately depressed university students: Randomized controlled trial. *Journal of Counseling Psychology*, *56*(3), 468–475.

Goldsmith, L.P., Dunn, G., Bentall, R.P., Lewis, S.W., & Weardon, A.J., (2015). Therapist effects and the impact of early therapeutic alliance on symptomatic outcome in chronic fatigue syndrome. *PLOS ONE 10*(12), 1-13.

Green J., & Dunn G (2008). Using intervention trials in developmental psychiatry to illuminate basic science. *The British Journal of Psychiatry*, *192*(5), 323–325.

Gulliver, A., Griffiths, K. M., & Christensen, H. (2018). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry, 18*(1), 1-17.

Hall, R. (2022, June 28). Warnings of mental health crisis among 'Covid generation' of students. *The Guardian*. https://www.theguardian.com/society/2022/jun/28/warnings-of-mental-health-crisis-among-covid-generation-of-students

Hatcher, R.L., & Gillaspy, J.A., (2006). Development and validation of a revised short version of the working alliance inventory, *Psychotherapy Research, 16:1*, 12-25.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*(2), 139-149.

Hubble, S., & Bolton, P., (2020). Support for students with mental health issues in higher education in England. *House of Commons Library Briefing Paper*, 8593.

Hurn, R. (2005). Single-session therapy: Planned success or unplanned failure? *Counselling Psychology Review*, *20*(4), 33–40.

Hymen, P., Stalker, C.A., & Cait, C.A., (2013). The case for single-session therapy: Does the empirical evidence support the increased prevalence of this service delivery model? *Journal of Mental Health, 22* (1), 60-71.

Kang H. (2021). Sample size determination and power analysis using the G*Power software. *Journal of educational evaluation for health professions, 18,* 17. https://doi.org/10.3352/jeehp.2021.18.17

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *62*(6), 593–602. https://doi.org/10.1001/ARCHPSYC.62.6.593

Knoop, R(1994). Work values and job satisfaction. *The Journal of Psychology, 128* (6), 683-690.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of general internal medicine*, *16*(9), 606-613.

Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training, 38*(4), 357-361.

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.). *Bergin and Garfield's handbook of psychotherapy and behaviour change* (5th ed.). New York: John Wiley.

LeMoyne, T., & Buchanan, T. (2011). Does "Brief Therapy" Work? An Analysis of Treatment Outcomes. *Journal of Counseling & Development, 89*(3), 288-298.

Liu Y., Pencheon E., Hunter R.M., Moncrieff J., & Freemantle N. (2018). Recruitment and retention strategies in mental health trials - A systematic review. *PLoS One, 13*(8),1-17. https://doi.org/10.1371/journal.pone.0203127

McLeod, B.D., (2011) Relation of the alliance with outcomes in youth psychotherapy: A meta-analysis. *Clinical Psychology Review, 31*(4): p. 603–616

Michael, K. D., Huelsman, T. J., Gerard, C., Gilligan, T. M., & Gustafson, M. R. (2006). Depression among college students: Trends in prevalence and treatment seeking. *Counseling and Clinical Psychology Journal, 3,* 60–70.

Mikulincer, M., Gillath, O., & Shaver, P. R. (2002). Activation of the attachment system in adulthood: Threat-related primes increase the accessibility of mental representations of attachment figures. *Journal of Personality and Social Psychology*, *83*(4), 881–895. https://doi.org/10.1037/0022-3514.83.4.881

Miller, J.K. (2008). Walk-in single session team therapy: A study of client satisfaction. *Journal of Systemic Therapies*, *27*(3), 78–94.

Misra, R., & McKean, M. (2000). College students' academic stress and its relation to their anxiety, time management, and leisure satisfaction. *American Journal of Health Studies, 16,* 41–51.

Murphy, R., & Hutton, P. (2018). Practitioner Review: Therapist variability, patient-reported therapeutic alliance, and clinical outcomes in adolescents undergoing mental health treatment – a systematic review and meta-analysis. *Journal of Child Psychology and Psychiatry*, *59*(1), 5–19. https://doi.org/10.1111/jcpp.12767

National Academies of Sciences, E. and M., Health and Medicine Division, Division of Behavioral and Social Sciences and Education, Board on Children, Y. and F., & Committee on the Neurobiological and Socio-behavioral Science of Adolescent Development and Its

Applications. (2019). *The Promise of Adolescence: Realizing Opportunity for All Youth* (R. J. Bonnie & E. P. Backes, Eds.). National Academies Press. https://doi.org/10.17226/25388

National Survey of Student Engagement (NSSE). (2007). Experiences that matter: Enhancing student learning and success, *2007 annual report*.

Norcross, J. C., & Lambert, M. J. (2019). Evidence-based psychotherapy relationships: The third task force. In J. C. Norcross & M. J. Lambert (Eds.), *Psychotherapy relationships that work: Evidence-based therapist contributions* (pp. 1–23). Oxford University Press. https://doi.org/10.1093/med-psych/9780190843953.003.0001

Office for National Statistics (ONS). (2022). Coronavirus and higher education students:25 February to 7 March 2022. Census 2021. https://www.ons.gov.uk/

Office for Students (2019). Mental health: Are all students being properly supported? *Insight 5,* November 2019. https://www.officeforstudents.org.uk/publications/

Perkins, R., & Scarlett, G. (2008). The effectiveness of single session therapy in child and adolescent mental health. Part 2: An 18-month follow-up study. *Psychology and Psychotherapy: Theory, Research and Practice, 81*(2), 143–156.

Pietkiewicz, I., & Smith, J. A. (2012). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal, 18*(2), 361–369. https://doi.org/10.14691/ CCPJ.20.1.7

Ramsden, B. (2014). Institutional diversity in UK Higher Education. In *Higher Education Policy Institute* . https://www.hepi.ac.uk/wp-content/uploads/2014/02/Institutional-diversity-in-UK-Higher-Education-final.pdf

Roth, A. J., Kornblith, A. B., Batel-Copel, L., Peabody, E., Scher, H. I., & Holland, J. C. (1998). Rapid screening for psychologic distress in men with prostate carcinoma: a pilot study. *Cancer, 82*(10), 1904–1908.

Seligman, M. E. P., Schulman, P., & Tyron, A. M. (2007). Group prevention of depression and anxiety symptoms. *Behavior Research and Therapy, 45*, 1111–1126.

Simpson, V., Halpin, L., Chalmers, K., & Joynes, V. (2019). Exploring well-being: medical students and staff. *The Clinical Teacher*, *16*(4), 356–361. https://doi.org/10.1111/tct.13080

Smith, J., Flowers, P., & Larkin, M. (2022). *Interpretative Phenomenological Analysis: Theory, Method and Research*. 2nd Edition. SAGE Publications Ltd.

Smith, J., & Osborn, M. (2007). Qualitative psychology: A practical guide to research methods. Thousand Oaks, CA: Sage Publications.

Spitzer R.L., Kroenke, K., Williams, J. B., & Lowe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of internal medicine, 166 (10)*, 1092-1097.

Talbot, N. L., Chaudron, L. H., Ward, E. A., Duberstein, P. R., Conwell, Y., & O'Hara, M. W. (2011). A randomized effectiveness trial of brief cognitive-behavioral therapy for depressed mothers. *Journal of Consulting and Clinical Psychology, 79*(5), 795-805.

Talmon, M. (1990). Single session therapy: Maximizing the effect of the first (and often only) therapeutic encounter. *San Francisco: Jossey-Bass*.

The University of Liverpool (2020). *Counselling Service*. Retrieved May 28, 2020, from, https://www.liverpool.ac.uk/studentsupport/counselling/

Thorley, C. (2017, September). *Not by degrees: Improving student mental health in the UK's universities*. Institute for Public Policy Research. https://doi.org/https://www.ippr.org/publications/not-by-degrees

Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the Working Alliance Inventory. *A Journal of Consulting and Clinical Psychology*, *1*(3), 207–2010. https://eds-s-ebscohost-com.liverpool.idm.oclc.org/eds/pdfviewer/pdfviewer?vid=0&sid=8e34335d-48fb-4748-b23b-444c79f24cf2%40redis

Tresolini C, & Pew-Fetzer Task Force (1994). Health professions education and relationship-centered care. *San Francisco: Pew Health Professions Commission*.

Universities UK (2018). Minding our future: Starting a conversation about the support of student mental health. https://www.universitiesuk.ac.uk/node/810

Universities UK (2020). Stepchange: Mentally healthy universities. https://www.universitiesuk.ac.uk/node/815

Vogel, A., Comtesse, H., & Rosner, R. (2020). Challenges in recruiting and retaining adolescents with abuse-related posttraumatic stress disorder: Lessons learned from a randomized controlled trial. *Child and Adolescent Psychiatry and Mental Health*, *14*(1), 1–13. https://doi.org/10.1186/S13034-020-00320-Y/TABLES/5

World Health Organization, Organization for Economic Cooperation and Development, & The World Bank Group (2018). Delivering Quality Health Services: A Global Imperative for Universal Health Coverage. https://www.worldbank.org/en/topic/universalhealthcoverage/publication/delivering-quality-health-services-a-global-imperative-for-universal-health-coverage.

Zigmond, A. S., & Snaith, R. P. (1983). The hospital anxiety and depression scale. *Acta psychiatrica scandinavica, 67(*6), 361-370.

Appendices

Appendix 1: Key words for systematic review database searches

Due to this study's inclusion criteria being for UK based students, the UK definition of 'higher education' (academic establishments providing an Undergraduate or Postgraduate level of education, such as universities) was utilised to expand search terms to include UK based descriptors such as 'undergraduate' and 'postgraduate', rather than terminology of other countries such as 'freshman' or 'sophomore'.

The following five keyword chains were searched within the databases with final searches completed on 6th November 2022:

1. Barrier* OR Hurdle OR Promot* OR Obstruct* OR Facilitat* OR Support* OR Cause* OR Encourag* OR "Treatment Barriers"

AND

2. "Mental Health" OR "Mental Disorders"

AND

3. Helpseek* OR "Seek* help" OR "Seek* treatment" OR "Help-seeking Behavior" OR "Help-seeking Behaviour"

AND

4. "Great Britain" OR "Wales" OR "England" OR "Scotland" OR "United Kingdom" OR "Northern Ireland" OR UK OR Britain OR British

AND

6. Student* OR Undergrad* OR Postgrad* OR Trainee* OR Apprentice*

Limits imposed within the search included, 'English Language'.

Appendix 2: Study advert

Student Study

Do you have 5 minutes? A University of Liverpool student on the Doctorate of Clinical Psychology is hoping you would be interested in sharing your experience of Single Session Therapy

Can I take part in this study?

We are looking to recruit University of Liverpool students who are attending the Student Counselling Services for Single Session Therapy and are:

- ✓ Students aged 18+ years
- ✓ Attending Single Session Therapy for the first time
- ✓ Able to access the internet now and within 48 hours of your appointment

What is involved?

You will complete online questionnaires, sharing about your mental wellbeing before and within 48 hours of your therapy session.

The questionnaire will take you around **5 minutes** to complete at each stage.

By participating, the confidential findings will help contribute to important research. We hope our findings will be shared with the counselling service to inform future practice.

Thank you for taking the time to read this.

Please click the Qualtrics link below if you are interested in taking part

https://livpsych.eu.qualtrics.com/jfe/form/SV_83cXPvwj0Vm2LaK

or scan the QR Code Below

PRIZE DRAW

Enter in to our prize draw at the end of the study for a chance to win one of two vouchers!

If you'd like more information, please contact

Principal investigator: Siobhan Williams
siobhan.williams@liverpool.ac.uk

Supervisors: Dr Warren Donnellan
wjd@liverpool.ac.uk
Dr Victoria Vass
vvass@liverpool.ac.uk

Choosing to participate in this study will not influence your counselling service provision
This study is independent to the counselling service

Appendix 3: Participant information and consent form for quantitative data

Participant Information Sheet

Single Session Therapy for UK University Students; Examining the Self-Reported Impact of the Therapeutic Alliance and Mode of Delivery on Long Term Outcomes for Anxiety and Depression

You are being invited to participate in a research project. This project is being supervised by Dr Warren Donnellan and Dr Victoria Vass, and conducted by Siobhan Williams (doctoral student).
Before you decide to do so, it is important that you understand the purpose of the research and what it will involve. Please take your time to read the following information carefully and discuss it with others if you wish. Feel free to ask any questions if anything is not clear or you would like more information. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

Thank you for reading this.

What is the aim of the research?

The aim of the research is to explore your experience of Single Session Therapy (SST) within the University of Liverpool Student Counselling Service.

Why have I been invited to take part?

We are looking to recruit volunteers who are University of Liverpool students who are attending the Student Counselling Services for a first experience of Single Session Therapy.

- Students aged 18+ years
- Who are attending for their first time for Single Session Therapy (within the next 14 days)
- Have access to the internet now and for a three-month follow-up.
- Have a sufficient understanding of English to provide informed consent and understand the outcome measures.

If you meet these criteria, then you are eligible to take part in this research.

Do I have to take part?

You are under no obligation to take part in this research; this is completely your choice. If you do decide to take part, you will be able to keep a copy of this information sheet and you should indicate your agreement to the online consent form. Also, you are free to withdraw at any time during the study without giving providing any reason or explanation.

What will happen if I take part?

If you consent to take part in the study, you will be asked to complete online questionnaires. After providing a few general details about yourself (e.g., gender, age etc.) you will then answer questions regarding your mental wellbeing (assessing anxiety and depression) and current distress.
Following your Single Session Therapy you will be asked to again access Qualtrics to complete the same questionnaires regarding your mental wellbeing, current distress and questions asking about how

you think or feel about the therapist (counsellor) you saw.

You will be contacted via email three months after having your Single Session Therapy appointment to access Qualtrics to complete the follow-up assessment. This will ask the same questions regarding your mental wellbeing and current distress. There will also be a few questions asking for feedback on your experience of Single Session Therapy (e.g. would you recommend it to a friend).

Each stage (before your therapy, "immediately" after your therapy, and three-months after) is expected to take approximately 5 minutes to complete.

Upon the completion of the questionnaires you will receive a debrief form.

What are the possible disadvantages/risks of taking part?

There are no risks or disadvantages are expected as a result of participation. However, some individuals may find questions regarding their mental wellbeing upsetting. If, for this of any other reason, you should experience any discomfort as part of this research, please let the principal investigator, Siobhan Williams (siobhan.williams@liverpool.ac.uk) or the lead supervisor, Dr Warren Donnellan (wjd@liverpool.ac.uk) know.

Additionally you may contact the student counselling service at counserv@liverpool.ac.uk if you feel distressed and need further counselling support or signposting to additional services.

What are the possible benefits of taking part?

This study provides an opportunity to feed-back regarding your experience of accessing the University's Student Counselling Service for Single Session Therapy. This research will be shared and disseminated with the service and therefore the researchers hope this will help inform future practice.

How will my data be used?

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit.

Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. The [Principal Investigator / Supervisor] acts as the Data Processor for this study, and any queries relating to the handling of your personal data can be sent to Dr Warren Donnellan or Siobhan Williams (please see the contact details below).

Further information on how your data will be used can be found in the table below:

How will my data be collected?	Via Qualtrics (website)
How will my data be stored?	On a University secure server. Any collected paper data will be stored in a locked filing cabinet, located in a locked office at the University of Liverpool.
How long will my data be stored for?	10 years, as-per the University of

	Liverpool's policy.
What measures are in place to protect the security and confidentiality of my data?	An electronic copy of research data will be stored confidentially on a password protected computer in accordance with University of Liverpool Data Management Policy.
Will my data be anonymised in the study?	Yes
How will my data be used?	For inclusion in research - doctoral thesis, viva and possible further dissemination in peer reviewed journals.
Who will have access to my data?	The named research team- Siobhan Williams, Dr Warren Donnellan & Dr Victoria Vass.
Will my data be archived for use in other research projects in the future?	The primary Investigator controls access to the data in order for it to be re-used in the future.
How will my data be destroyed?	Following the viva voce examination in 2022, all paper copies of research data will be destroyed by the University Records Management Service. Following the 10 year data storage period, all data will be deleted from the password protected computer.

Will my participation be kept confidential, and what will happen to the results?

All the information collected during the course of the research will be anonymised by the lead researcher. As such, your initial data may be able to be identified by the lead researcher but following data extraction it will be anonymised for analysis purposes and any prior identifiable information removed from the research teams University secure server. All information will be stored in line with the University of Liverpool's guidelines.

Anonymised raw data will be deposited in the archive for sharing and use by other authorised researchers to support other research in the future.

What will happen if I want to stop taking part?

You are under no obligation to take part in this research. If you do decide to take part, you are free to withdraw at any moment, without giving any reason or explanation.

However, it will be impossible to withdraw results after anonymisation as the research team will not be able to identify which data was yours.

What if I am unhappy, or there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting Warren Donnellan (wjd@liverpool.a.uk) or Siobhan Williams (siobhan.williams@liverpool.ac.uk).

If you have a complaint which you feel you cannot come to us with then you should contact the Research Ethics and Integrity Officer on 0151 794 8290 (ethics@liv.ac.uk). When contacting the

Research Ethics and Integrity Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

The University strives to maintain the highest standards of rigour in the processing of your data. However, if you have any concerns about the way in which the University processes your personal data, it is important that you are aware of your right to lodge a complaint with the Information Commissioner's Office by calling 0303 123 1113.

Will my taking part be covered by an insurance scheme?

Participants taking part in any research has been approved by the University of Liverpool are covered by the University's insurance scheme.

Who can I contact if I have any further questions?

Principal investigator:	Siobhan Williams	siobhan.williams@liverpool.ac.uk
Supervisory investigators:	Dr Warren Donnellan	wjd@liverpool.ac.uk
	Dr Victoria Vass	vvass@liverpool.ac.uk

Renumeration and Prize draw:

Upon completion of the final stage on Qualtrics (after follow-up), you can opt to receive a £5 voucher with Love to Shop as renumeration for your participation. You can also opt to enter a prize draw for one of five Love to Shop vouchers. If you choose to opt in for either or both of these options you will be required to enter your email address, which the lead researcher will then have access to in order to complete renumeration or enter you in to the randomised prize draw and contact the winner. Upon completion of renumeration and the prize draw all email addresses will be destroyed.

If you have any concerns about the topics covered in this survey and/or your general mental wellbeing please seek advice from your GP. There are also a number of support networks that you can contact and a range of information sources available:

https://www.rethink.org

https://www.mind.org.uk/

https://www.samaritans.org

https://www.talkliverpool.nhs.uk/

https://www.nhs.uk/conditions/generalised-anxiety-disorder/

https://www.nhs.uk/conditions/clinical-depression/

Thank you for taking your time to read this.

Participant Consent Form

Research ethics approval number: xxxxx
Title of the research project: Single Session Therapy for UK University Students; Examining the Self-Reported Impact of the Therapeutic Alliance and Mode of Delivery on Long Term Outcomes for Anxiety and Depression
Name of researcher(s): Siobhan Williams (chief investigator), Dr Warren Donnellan (Primary Supervisor) and Dr Victoria Vass (Secondary Supervisor)

Please initial box

1. I confirm that I have read and have understood the information sheet dated [**DATE**] for the above study, or it has been read to me. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that taking part in the study involves answering online questionnaires both now, within 24 hours of attending my SST appointment and in three months.
3. I understand that I will be contacted via email after my SST session and in approximately three months to take part in the follow-up part of this study.
4. I understand that my participation is voluntary and that I am free to stop taking part and can withdraw from the study at any time without giving any reason and without my rights being affected. In addition, I understand that I am free to decline to answer any particular question or questions.
5. I understand that if I withdraw, after completing a questionnaire on Qualtrics, I cannot ask for access to the information I provided or request the destruction of that information as it will have been anonymised.
6. I understand that the information I provide will be held securely and in line with data protection requirements at the University of Liverpool until it is fully anonymised and then deposited in the archive for sharing and use by other authorised researchers to support other research in the future.
7. I understand that signed consent forms and questionnaires will be retained in an encrypted file on the University of Liverpool's network for a period of 10 years.
8. I agree to take part in the above study.

_____	_____	_____
Participant name	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature

Appendix 4: Participant debrief form

Single Session Therapy for UK University Students; Examining the Self-Reported Impact of the Therapeutic Alliance and Mode of Delivery on Long Term Outcomes for Anxiety and Depression

Debrief Form

Thank you for your time and for your participation in the study.

This study was conducted to examine if your reported impact of your relationship with your therapist (therapeutic alliance) and the mode of delivery had a causal relationship with the long-term outcomes for symptoms of anxiety and depression.

The objectives for this study are:

- To assess if there are associated changes in students self-reported ratings of anxiety and/or depression following SST.
- To assess if therapeutic outcomes are associated with the students' perceived therapeutic alliance.
- To assess if therapeutic outcomes are associated with student demographic characteristics (age, gender, previous (if any) contact with mental health services) and method of delivery (face-to-face, telephone, or video).
- To investigate if SST is perceived as beneficial and effective at a three-month follow-up.

Questionnaires were used to enable us to explore these objectives, including the Generalised Anxiety Disorder Screener (GAD-7), the Patient Health Questionnaire (PHQ-9), the Distress Thermometer, the Working Alliance Inventory- Short Form Revised (WAI-SR) and the University of Liverpool Counselling Services Single-Session Therapy forms.

If you have any questions regarding this study please feel free to contact me on the email provided below. I will be more than happy to talk to you about any concerns or doubts that you may have about the study or your participation. Similarly, in the event that you feel distressed by your participation in this study, we encourage you to contact us.

If you feel that you may benefit from psychological therapies or counselling (commonly known as 'talking therapies') please contact the Counselling and Mental Health Advisory Service at the University of Liverpool (0151 794 3304/ counserv@liverpool.ac.uk). You could also ask your Primary Care Doctor (GP) to refer you to Inclusion Matters (website: http://inclusion-matters-liverpool.org.uk/). This is a service staffed by skilled professionals that have been trained to help people with mental health difficulties. They have a vast range of expertise and substantial experience helping people with low mood, anxiety and related problems.

Alternatively, if you feel that due to your distress you or people around may be unsafe please don't hesitate to contact the Access Team at the Royal Liverpool University Hospital (mental health crisis line 0151 706 2782). The team will provide you with professional advice on how to access emergency mental health services out of hours. The team can also quickly engage you with acute mental health services.

Attached to this sheet you will find a range of helplines, information, and services that I hope you find helpful.

Again, thank you very much for your participation,

Siobhan Williams

Institute of Health & Life Sciences

The Whelan Building (Ground Floor)

University of Liverpool

siobhan.williams@liverpool.ac.uk

If you have any concerns about the topics covered in this survey and/or your general mental wellbeing please seek advice from your GP. There are also a number of support networks that you can contact and a range of information sources available:

https://www.rethink.org

https://www.mind.org.uk/

https://www.samaritans.org

https://www.talkliverpool.nhs.uk/

https://www.nhs.uk/conditions/generalised-anxiety-disorder/

https://www.nhs.uk/conditions/clinical-depression/

Appendix 5: Participant information and consent form for qualitative data

Participant Information Sheet for Professionals

Single Session Therapy for UK University Students; Examining the Self-Reported Impact of the Therapeutic Alliance and Mode of Delivery on Long Term Outcomes for Anxiety and Depression

You are being invited to participate in a research project. This project is being supervised by Dr Warren Donnellan, Dr Victoria Vass and Dr Benjamin Gibson and conducted by Siobhan Williams (doctoral student).
Before you decide to do so, it is important that you understand the purpose of the research and what it will involve. Please take your time to read the following information carefully and discuss it with others if you wish. Feel free to ask any questions if anything is not clear or you would like more information. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

Thank you for reading this.

What is the aim of the research?
The study's aim is to explore student and therapist experiences of Single Session Therapy (SST), within the University of Liverpool Student Counselling Service.

Why have I been invited to take part?
We are hoping to recruit University of Liverpool professionals who are currently working within the Student Counselling Services and delivering Single Session Therapy.

- Therapists working within UoL Student Counselling Service
- Who provide Single Session Therapy to UoL students.
- Who provide alternative therapies alongside Single Session Therapy within the Counselling Service.
- Have a sufficient understanding of English to provide informed consent and understand the interview questions

If you meet these criteria, then you are eligible to take part in this research.

Do I have to take part?
You are under no obligation to take part in this research; this is completely your choice. If you do decide to take part, you will be able to keep a copy of this information sheet and you should indicate your agreement to the online consent form. Also, you are free to withdraw at any time during the interview process without providing any reason or explanation.

What will happen if I take part?
If you consent to take part in this project, you will be asked to complete a semi-structured interview lasting between 45 minutes to a maximum or 60 minutes. This interview will be conducted by Siobhan Williams and can be conducted either in person or via video dependent upon your preference. Interviews will be audio recorded using a University of Liverpool password secured iPad. Any identifiable data will be redacted or amended during transcription to provided anonymity both for yourself and any other individuals that may be mentioned.

Upon the completion of the interview you will receive a debrief form.

What are the possible disadvantages/risks of taking part?

There are no risks or disadvantages expected as a result of participation. If you should experience any discomfort as part of this research, please let the principal investigator, Siobhan Williams (siobhan.williams@liverpool.ac.uk) or the lead supervisor, Dr Warren Donnellan (wjd@liverpool.ac.uk) know. Guidance for further support can then be offered (also listed at the end of this information sheet).

What are the possible benefits of taking part?

This study provides an opportunity to feed-back regarding your experience of delivering Single Session Therapy compared to other therapies. This research will be shared and disseminated with the counselling service and plans to be published wider, therefore the researchers hope this will help inform future practice.

How will my data be used?

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit.

Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. The [Principal Investigator / Supervisor] acts as the Data Processor for this study, and any queries relating to the handling of your personal data can be sent to Dr Warren Donnellan or Siobhan Williams (please see the contact details below).

Further information on how your data will be used can be found in the table below:

How will my data be collected?	Via Qualtrics (website)
How will my data be stored?	On a University secure server. Any collected paper data will be stored in a locked filing cabinet, located in a locked office at the University of Liverpool.
How long will my data be stored for?	10 years, as-per the University of Liverpool's policy.
What measures are in place to protect the security and confidentiality of my data?	An electronic copy of research data will be stored confidentially on a password protected computer in accordance with University of Liverpool Data Management Policy.
Will my data be anonymised in the study?	Yes
How will my data be used?	For inclusion in research - doctoral thesis, viva and possible further dissemination in peer reviewed journals.
Who will have access to my data?	The named research team- Siobhan Williams, Dr Warren Donnellan & Dr

	Victoria Vass.
Will my data be archived for use in other research projects in the future?	The primary Investigator controls access to the data in order for it to be re-used in the future.
How will my data be destroyed?	Following the viva voce examination in 2022, all paper copies of research data will be destroyed by the University Records Management Service. Following the 10 year data storage period, all data will be deleted from the password protected computer.

Will my participation be kept confidential, and what will happen to the results?

All the information collected during the course of the research will be anonymised by the lead researcher. As such, your initial data may be able to be identified by the lead researcher but following data extraction it will be anonymised for analysis purposes and any prior identifiable information removed from the research teams University secure server. All information will be stored in line with the University of Liverpool's guidelines.

Anonymised raw data will be deposited in the archive for sharing and use by other authorised researchers to support other research in the future.

What will happen if I want to stop taking part?

You are under no obligation to take part in this research. If you do decide to take part, you are free to withdraw at any moment, without giving any reason or explanation.

However, it will be impossible to withdraw results after anonymisation as the research team will not be able to identify which data was yours.

What if I am unhappy, or there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting Warren Donnellan (wjd@liverpool.a.uk) or Siobhan Williams (siobhan.williams@liverpool.ac.uk).

If you have a complaint which you feel you cannot come to us with then you should contact the Research Ethics and Integrity Officer on 0151 794 8290 (ethics@liv.ac.uk). When contacting the Research Ethics and Integrity Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

The University strives to maintain the highest standards of rigour in the processing of your data. However, if you have any concerns about the way in which the University processes your personal data, it is important that you are aware of your right to lodge a complaint with the Information Commissioner's Office by calling 0303 123 1113.

Will my taking part be covered by an insurance scheme?

Participants taking part in any research has been approved by the University of Liverpool are covered by the University's insurance scheme.

Who can I contact if I have any further questions?

Principal investigator: Siobhan Williams siobhan.williams@liverpool.ac.uk

Supervisory investigators: Dr Warren Donnellan wjd@liverpool.ac.uk
Dr Victoria Vass vvass@liverpool.ac.uk

If you have any concerns about the topics covered in this research and/or your general mental wellbeing please seek advice from your GP. There are also a number of support networks that you can contact and a range of information sources available:

https://www.rethink.org

https://www.mind.org.uk/

https://www.samaritans.org

https://www.talkliverpool.nhs.uk/

https://www.nhs.uk/conditions/generalised-anxiety-disorder/

https://www.nhs.uk/conditions/clinical-depression/

Thank you for taking your time to read this.

Participant Consent Form for Professionals

Research ethics approval number: xxxxx
Title of the research project: Single Session Therapy for UK University Students; Examining the Self-Reported Impact of the Therapeutic Alliance and Mode of Delivery on Long Term Outcomes for Anxiety and Depression
Name of researcher(s): Siobhan Williams (chief investigator), Dr Warren Donnellan (Primary Supervisor), Dr Victoria Vass and Dr Benjamin Gibson

Please initial box

1. I confirm that I have read and have understood the participant information sheet for the above study, or it has been read to me. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that taking part in the study involves me participating in a 30-60minute semi-structure interview.
3. I understand that this interview will be audio recorded and transcribed for qualitative analysis.
4. I understand that my participation is voluntary and that I am free to stop taking part and can withdraw from the study at any time without giving any reason and without my rights being affected. In addition, I understand that I am free to decline to answer any particular question or questions.
5. I understand that if I withdraw, after audio files have been transcribed, I cannot ask for access to the information I provided or request the destruction of that information as it will have been anonymised.
6. I understand that the information I provide will be held securely and in line with data protection requirements at the University of Liverpool until it is fully anonymised and then deposited in the archive for sharing and use by other authorised researchers to support other research in the future.
7. I understand that signed consent forms and questionnaires will be retained in an encrypted file on the University of Liverpool's network for a period of 10 years.
8. I agree to take part in the above study.

_____	_____	_____
Participant name	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature

Appendix 6: Interview Schedule

What are the experiences of therapists in delivering Single Session Therapy including their perceived change in mental health concerns and the impact of the therapeutic alliance?

Thank you for agreeing to talk about your experiences as a therapist in a University mental health service, particularly focussing on your experience delivery Single Session Therapy. I am interested in your own personal experience which may be different from other peoples, so tell me what it has been like for you. As noted in the participant information and consent form, I would like to record the conversation with your permission.

Should you wish to stop the interview at any time, or take a break, please tell me. I anticipate this interview will take around 45 minutes. Recordings will be transcribed to allow for analysis. I can assure you that it will remain confidential. Any mention of identifiable data such as names will be redacted/ provided with pseudonyms to maintain confidentiality.

First of all, I would like to ask you some factual questions and then some more open questions about your experiences.

Initial questions:

How long have you been working as a therapist?

What was the primary therapeutic model you trained in? (e.g CBT)

Have you ever worked as a therapist in other services? (e.g. NHS, private sector)

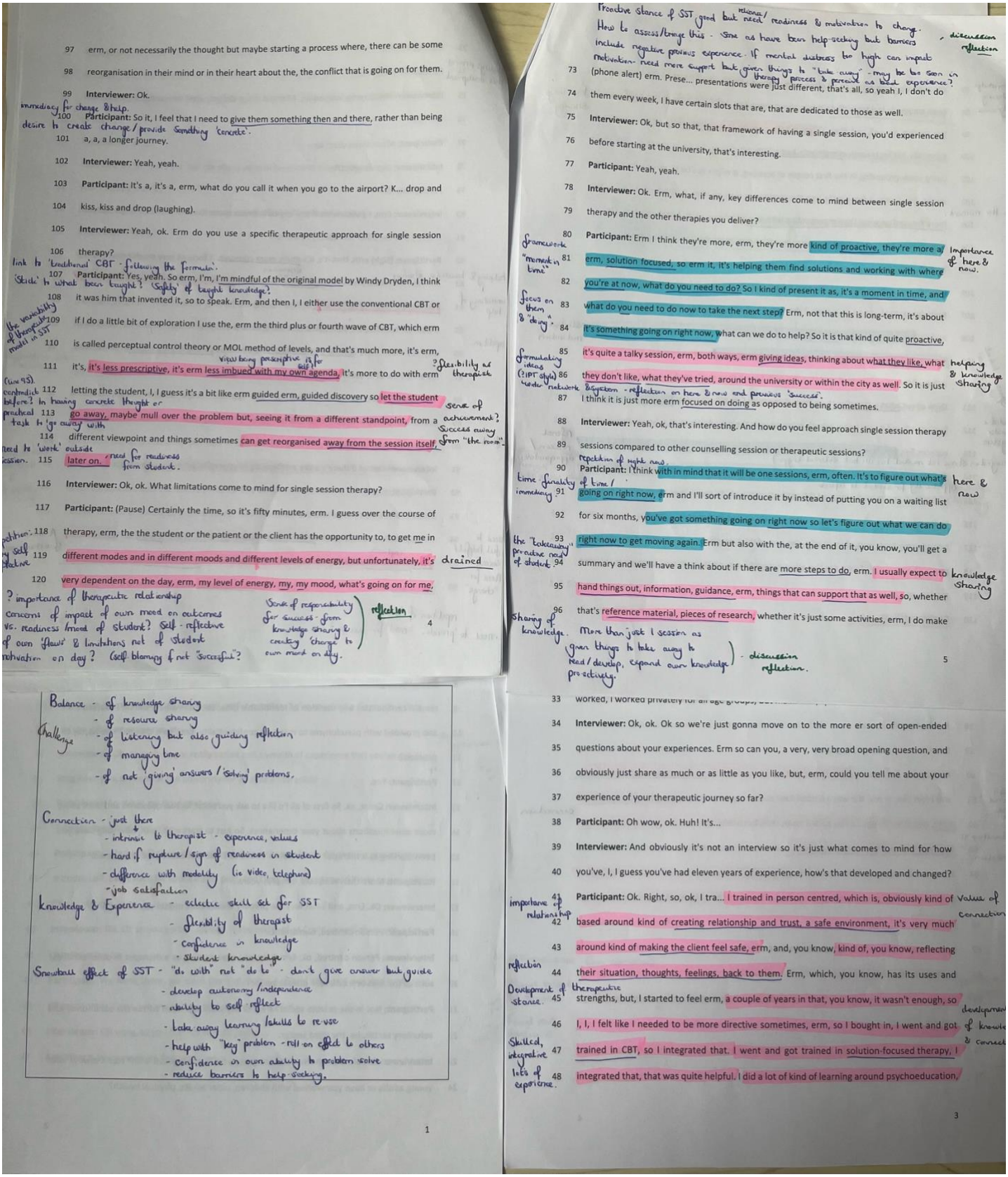
If yes what client group did you work with (e.g. children, adults, older adults, physical health)

What are the experiences of therapists in delivering Single Session Therapy including their perceived change in mental health concerns and the impact of the therapeutic alliance?

Main Questions	Follow up Questions
1. Can you tell me about your experience of your counselling journey so far?	a) What is your experience of SST? b) What, if any key differences come to mind between SST and other therapies you deliver?
Experience of delivering SST	
2. How do you feel you 'approach' SST sessions compared to other counselling sessions?	a) What is the difference in your mindset? b) Do you use a specific therapeutic approach for SST? (e.g. solution focused)
3. What limitations come to mind for SST?	a) How realistic do you find students goals are for a single session of therapy?
4. What benefits of SST come to mind?	a) How do you interpret success from SST? b) How do you determine/ can you tell readiness to change for SST? c) How do you identify a particular problem for SST?
Experience of the Therapeutic Alliance	
5. What is your experience of the therapeutic alliance in SST?	a) How would you describe the impact and quality of the therapeutic alliance in SST? b) How do you approach developing a therapeutic alliance in SST, and is this the same as you do for other counselling sessions? c) Considering all therapy modalities you use, how, if at all does the therapeutic alliance differ?
6. What, if any differences have you noticed or experienced with the hybrid delivery of SST since Covid-19 (March 2020) led to a change in delivery	a) Do you feel there is a different between face-to-face, video and telephone sessions? If yes please can you describe this difference?

7. Is there anything else you would like to add about your experience in delivering Single Session Therapy to University Students or do you have any questions for me?

Appendix 7: Example of IPA initial stages



97 erm, or not necessarily the thought but maybe starting a process where, there can be some
98 reorganisation in their mind or in their heart about the, the conflict that is going on for them.
99 **Interviewer:** Ok.
100 **Participant:** So it, I feel that I need to give them something then and there, rather than being
101 a, a, a longer journey.
102 **Interviewer:** Yeah, yeah.
103 **Participant:** It's a, it's a, erm, what do you call it when you go to the airport? K... drop and
104 kiss, kiss and drop (laughing).
105 **Interviewer:** Yeah, ok. Erm do you use a specific therapeutic approach for single session
106 therapy?
107 **Participant:** Yes, yeah. So erm, I'm, I'm mindful of the original model by Windy Dryden, I think
108 it was him that invented it, so to speak. Erm, and then I, I either use the conventional CBT or
109 if I do a little bit of exploration I use the, erm the third plus or fourth wave of CBT, which erm
110 is called perceptual control theory or MOL method of levels, and that's much more, it's erm,
111 it's, it's less prescriptive, it's erm less imbued with my own agenda, it's more to do with erm
112 letting the student, I, I guess it's a bit like erm guided erm, guided discovery so let the student
113 go away, maybe mull over the problem but, seeing it from a different standpoint, from a
114 different viewpoint and things sometimes can get reorganised away from the session itself,
115 later on.
116 **Interviewer:** Ok, ok. What limitations come to mind for single session therapy?
117 **Participant:** (Pause) Certainly the time, so it's fifty minutes, erm. I guess over the course of
118 therapy, erm, the the student or the patient or the client has the opportunity to, to get me in
119 different modes and in different moods and different levels of energy, but unfortunately, it's
120 very dependent on the day, erm, my level of energy, my, my mood, what's going on for me,

4

Balance - of knowledge sharing
- of resource sharing
Challenge - of listening but also guiding reflection
- of managing time
- of not 'giving' answers / 'solving' problems.

Connection - just there
- intrinsic to therapist - experience, values
- hard if rupture / sign of readiness in student
- difference with modality (ie video, telephone)
- job satisfaction

Knowledge & Experience - eclectic skill set for SST
- flexibility of therapist
- confidence in knowledge
- student knowledge

Snowball effect of SST - "do with" not "do to" - don't give answer but guide
- develop autonomy / independence
- ability to self reflect
- take away learning / skills to re-use
- help with "key" problem - roll on effect to others
- confidence in own ability to problem solve
- reduce barriers to help-seeking.

1

Proactive stance of SST good but need readiness & motivation to change.
How to assess/gauge this - same as have been help-seeking but barriers include negative previous experience. If mental distress too high can impact motivation. Need more support but given things to "take away" - may be too soon in therapy process & perceive as bad experience?
73 (phone alert) erm. Prese... presentations were just different, that's all, so yeah I, I don't do
74 them every week, I have certain slots that are, that are dedicated to those as well.
75 **Interviewer:** Ok, but so that, that framework of having a single session, you'd experienced
76 before starting at the university, that's interesting.
77 **Participant:** Yeah, yeah.
78 **Interviewer:** Ok. Erm, what, if any, key differences come to mind between single session
79 therapy and the other therapies you deliver?
80 **Participant:** Erm I think they're more, erm, they're more kind of proactive, they're more a
81 erm, solution focused, so erm it, it's helping them find solutions and working with where
82 you're at now, what do you need to do? So I kind of present it as, it's a moment in time, and
83 what do you need to do now to take the next step? Erm, not that this is long-term, it's about
84 it's something going on right now, what can we do to help? So it is that kind of quite proactive,
85 it's quite a talky session, erm, both ways, erm giving ideas, thinking about what they like, what
86 they don't like, what they've tried, around the university or within the city as well. So it is just
87 I think it is just more erm focused on doing as opposed to being sometimes.
88 **Interviewer:** Yeah, ok, that's interesting. And how do you feel approach single session therapy
89 sessions compared to other counselling session or therapeutic sessions?
90 **Participant:** I think with in mind that it will be one sessions, erm, often. It's to figure out what's
91 going on right now, erm and I'll sort of introduce it by instead of putting you on a waiting list
92 for six months, you've got something going on right now so let's figure out what we can do
93 right now to get moving again. Erm but also with the, at the end of it, you know, you'll get a
94 summary and we'll have a think about if there are more steps to do, erm. I usually expect to
95 hand things out, information, guidance, erm, things that can support that as well, so, whether
96 that's reference material, pieces of research, whether it's just some activities, erm, I do make

5

33 worked, I worked privately for all age groups,
34 **Interviewer:** Ok, ok. Ok so we're just gonna move on to the more er sort of open-ended
35 questions about your experiences. Erm so can you, a very, very broad opening question, and
36 obviously just share as much or as little as you like, but, erm, could you tell me about your
37 experience of your therapeutic journey so far?
38 **Participant:** Oh wow, ok. Huh! It's...
39 **Interviewer:** And obviously it's not an interview so it's just what comes to mind for how
40 you've, I, I guess you've had eleven years of experience, how's that developed and changed?
41 **Participant:** Ok. Right, so, ok, I tra... I trained in person centred, which is, obviously kind of
42 based around kind of creating relationship and trust, a safe environment, it's very much
43 around kind of making the client feel safe, erm, and, you know, kind of, you know, reflecting
44 their situation, thoughts, feelings, back to them. Erm, which, you know, has its uses and
45 strengths, but, I started to feel erm, a couple of years in that, you know, it wasn't enough, so
46 I, I, I felt like I needed to be more directive sometimes, erm, so I bought in, I went and got
47 trained in CBT, so I integrated that. I went and got trained in solution-focused therapy, I
48 integrated that, that was quite helpful. I did a lot of kind of learning around psychoeducation,

3

Appendix 8: Example of IPA latter stages

Appendix 9: Author guidelines for journal submission

Frontiers in Psychology

As noted from https://www.frontiersin.org/journals/psychology/for-authors/article-types

Chapter 1: Systematic Review

Systematic Review articles present a synthesis of previous research, and use clearly defined methods to identify, categorize, analyze and report aggregated evidence on a specific topic. Included in this article type are meta-syntheses, meta-analyses, mapping reviews, scoping reviews, systematic reviews, and systematic reviews with a meta-analysis. Systematic Review articles are peer-reviewed, have a maximum word count of 12,000 and may contain no more than 15 Figures/Tables. Systematic Reviews should: clearly define the research question in terms of population, interventions, comparators, outcomes and study designs (PICOS), and state which reporting guidelines were used in the study. For design and reporting, systematic reviews must conform to the reporting guidelines (e.g., PRISMA, Cochrane, Campbell), and include the PRISMA flow diagram http://prisma-statement.org/prismastatement/flowdiagram.aspx (if applicable), as well as funding information (if no specific funding to carry out the research, please state so). Systematic Reviews should have the following format: 1) Abstract, 2) Introduction, 3) Methods (including study design; participants; interventions; comparators; systematic review protocol; search strategy; data sources; study sections and data extraction; data analysis), 4) Results (including a flow diagram of the studies retrieved for the review; study selection and characteristics; synthesized findings; assessment of risk of bias), 5) Discussion (including summary of main findings; limitations; conclusions)

Chapter 2: Original Research

Original Research articles report on primary and unpublished studies. Original Research may also encompass confirming studies and disconfirming results which allow hypothesis elimination, reformulation and/or report on the non-reproducibility of previously published results. Original Research articles are peer-reviewed, have a maximum word count of 12,000 and may contain no more than 15 Figures/Tables. Original Research articles should have the following format: 1) Abstract, 2) Introduction, 3) Materials and Methods, 4) Results, 5) Discussion.

Appendix 10: Inter-rater reliability calculation for Systematic Review

		Researcher				
		0	1	3		
Co-rater	0	2	1	0	3	4.76%
	1	0	53	0	53	84.13%
	3	0	1	6	7	11.11%
		2	55	6	63	
		3.17%	87.30%	9.52%		

k= (PrA- PrC/(1- PrC)

Probabilty Agreement	0.97
Probabilty Chance	0.75
k	0.87

Key	
0	Unsatisfactory
1	Satisfactory
3	Cannot Tell