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Attitudes towards mental health and help seeking.

A qualitative study investigating students' attitudes towards mental health and help seeking.

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Sammendrag

Det har lenge vært kjent at en del mennesker som kan få utbytte av psykisk helsehjelp ikke søker denne hjelpen. Selv om ca. halvparten av mennesker vil oppleve psykiske utfordringer søker kun en liten del av disse menneskene hjelp. Forskere har i årevis prøvd å forstå hvorfor noen mennesker ikke søker hjelp når de strever med psykiske vansker. Likevel finnes det ikke noe klart svar på dette spørsmålet. Derimot har holdninger til psykisk helse og hjelp søking blitt foreslått som en mulig forklaring på hvorfor noen velger å ikke søke hjelp. Denne studien undersøkte hvordan studenter beskriver sine holdninger til psykisk helse og det å søke hjelp enten fra en rådgiver eller en psykolog. For å besvare dette spørsmålet, ble seks studenter intervjuet. Tematisk analyse ble brukt for å analysere resultatene som viste at studentene beskrev psykisk helse som påvirket av media, tabubelagt og privat. Videre, beskrev studentene deres opplevelse av terskelen for å søke hjelp og det å søke hjelp fra en psykolog eller en rådgiver. Terskelen ble vurdert som for høy og det var mangel på forståelse for rådgivere, psykologer og deres fagfelt. Disse resultatene ble diskutert i sammenheng med det å søke hjelp og stigmatisering. Anbefalinger for videre forskning er foreslått for å forstå studenters holdninger på et dypere nivå og skaffe innsikt i de mulige konsekvensene av denne mangelen på kunnskap. For å konkludere, dette studiet har vist at negative holdninger mot mennesker som sliter med psykiske utfordringer og det å søke hjelp fortsatt eksisterer. Resultatene indikerte også at studentene har lite kunnskap om psykisk helse og psykisk helsevern.

Nøkkelord: Kvalitativ studie, psykiske plager, søke hjelp, psykisk helse, stigmatisering

Abstract

It has long been known that some people who are perceived to be in need of mental health care do not actively seek out such help. While approximately half of all people will experience mental health concerns, only a small part seek help with their mental health concerns. Researchers have for years attempted to understand why some people do not seek help when they experience mental health concerns. Yet, there is no clear answer to these questions. However, attitudes towards mental health and help seeking have been found as one of the possible explanations for why some people refrain from seeking help. This study investigated "how students describe their attitudes towards mental health and help seeking from a counsellor or psychologist". To answer this question, six students from Norway were interviewed. Thematic analysis was used to analyse the results which showed that students described mental health as influenced by media, suffering under a taboo and as private. Moreover, students described their perception of the help seeking threshold and help seeking from a counsellor or a psychologist. The threshold was considered too high and there was a clear lack of knowledge about mental health professionals and their area of expertise. These results were then discussed in relation to help seeking literature and stigmatization. Recommendations for future research are made as students attitudes needs to be investigated more in depth and the consequences of their gap in knowledge needs to be better understood. To conclude, this study has shown that there are existing negative attitudes towards people struggling with mental health concerns and help seeking. Furthermore, the results indicate students have poor mental health literacy.

Keywords: mental health, mental illness, stigmatization, help seeking, qualitative research

Preface

After two years of working towards this thesis it is now coming to an end. Throughout my years as a student I have received a lot of support and I now wish to thank those who have helped me.

First, I would like to thank the participants who have taken part in this study and allowed me access to their thoughts and perspective.

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1 Introduction

1.1 Chosen research topic

Research has shown that approximately half of the Norwegian population will at one point in their lives experience mental health concerns (Kringlen, Torgersen, & Cramer, 2001). Similar results have been found in the US (Sickel, Seacat, & Nabors, 2014) suggesting that mental illness and mental health concerns will affect all of us at one point in our lives, either through personal experience or from close relations (Jorm, 2000). However, years of research have shown that few of those estimated to benefit from mental health treatment seek help from mental health professionals (Vogel, Wade, & Haake, 2006). The estimated percentages vary from study to study (Mackenzie, Gekoski, & Knox, 2006), however, there seems to be a consensus that less than half of individuals who experience a mental health concern seek help (Vogel et al., 2006; Wichstrøm, 2009). This is consistent with research from Norway were a study investigating help seeking for mental illness found the percentage of people who had sought help to be very low (Roness, Mykletun, & Dahl, 2005). Attitudes towards mental health help seeking have repeatedly been found to influence help seeking and as such remains vital in understanding why some people choose not to seek help.

It is important that people seek help as untreated mental illness or mental health concerns can have negative consequences for social life, finances and wellbeing in general (Rickwood, Deane, Wilson, & Ciarrochi, 2005; Sickel et al., 2014). Delay of treatment or avoidance of treatment can lead to worse outcomes in the longer run (Clement et al., 2015). For young adults, especially students, mental illness may influence productivity, academic success and substance abuse (Hunt & Eisenberg, 2010). Kessler et al. (2001) suggested the unmet need for treatment was even greater among young adults. Moreover, Gulliver, Griffiths, and Christensen (2010) pointed out that prevalence of mental illness is greatest in the 16-24 year range. Additionally, they note that there is a strong unwillingness to seek help. Similarly, Eisenberg, Golberstein, and Gollust (2007, p. 594) wrote that “most mental disorders first emerge between the ages of 15 and 24”. Young adults are in an important stage of development, and mental health concerns may therefore impact their whole future negatively (Eisenberg et al., 2007; Rickwood et al., 2005).

This area has peaked my interest because if counsellors and psychologists are to prevent further development of mental health concerns and give early treatment, people need to seek

help, and therefore it becomes increasingly important to understand what attitudes students hold towards mental health, help seeking and mental health professionals.

1.2 Purpose and research question

The purpose of this study is to gain insight into students' attitudes towards mental health and help seeking so that we can better understand the challenges students experience in relation to help seeking. Moreover, gaining insight into how students think about counsellors as opposed to psychologists can give valuable knowledge as to how counsellors are perceived in today's society. By knowing how we as counsellors are perceived in society, we gain the opportunity of influencing peoples' perception if necessary, to create an image that is accurate. To gain insight into young adults' attitudes towards mental health and help seeking, I have chosen to conduct a qualitative study based on the following research question:

How does students describe their attitudes towards mental health and help seeking from a counsellor or psychologist?

For the discussion, I have chosen to view the results in relation to relevant research including stigmatization, mental health professionals, media's influence on people's perception of mental health, mental health literacy and research pertaining to why some individuals refrain from help seeking, such as barriers to help seeking. By viewing the results in such a broad frame of reference I wish to provide an overview to encourage future research into students' attitudes towards mental health and help seeking. Furthermore, to inspire others to recognise the competency counsellors possess and investigate how this can be utilized as a resource in mental health care.

1.3 Previous research

To introduce previous research, the first part of the research question will be considered first; "How does students describe their attitudes towards mental health". In 1999, the Norwegian government implemented "Opptrappingsplanen", a ten year national action plan to "restructure and strengthen" the services offered for people with mental health concerns (Blåka, 2012). One of the goals of the action plan was to increase peoples understanding of mental health/illness and inspire more openness. In light of this action plan, researchers have investigated the campaign's effect on public attitudes towards mental health and mental health services (Blåka, 2012; Myrvold, 2008). Historically mental illness has been closely connected to shameful and uncurable illnesses (Blåka, 2012). Yet, both Blåka (2012) and

Myrvold (2008) found the public's attitudes towards mental health and mental illness were not "very stigmatizing". However, both of these studies used quantitative methods which may have led to a partly understanding of the topics investigated. For example, in relation to stigma, Myrvold (2008) only used five statements to investigate if people held stigmatizing attitudes towards mental health and people who experienced mental health concerns. These questions do not take into account the various forms of stigma, which may have different ways of impacting people's attitudes. Morever, Blåka (2012) suggests that mental health concerns might not be taken very seriously by some people and thus the threshold for help seeking may be heightened. As a way to counteract this, Blåka (2012) suggested to lower people's threshold for mental health help seeking.

Now, the second part of the research question will be considered in relation to previous research; "How does students describe their attitudes towards help seeking from a counsellor or a psychologist". There are various reports on the mental health professionals' attitudes towards the help seeker (Hugo, 2001; Jorm, Korten, Jacomb, Christensen, & Henderson, 1999; Rao et al., 2009), however, reports of people's general attitudes towards mental health professionals are sparse (Manthei, 2005). Leong and Zachar (1999) suggested that awareness of people's opinions on mental health is vital as they are closely related to attitudes towards seeking professional help. Many authors investigating people's attitudes towards mental health professionals focus on people's beliefs about the use of medication, help seeking or the effectiveness of psychotherapy. (Furnham, Wardley, & Lillie, 1992; Jorm, 2000). McGuire and Borowy (1979) found that the public value mental health professionals, but they do not understand their roles within their profession. In contrast, professions tied to physical medicine was better understood. McGuire and Borowy (1979, p. 78) concluded that people appeared "genuinely discriminative in their attitudes toward mental health professionals." In comparison with psychologists, counsellors have been described as helpful, friendly, caring and as good listeners (Warner & Bradley, 1991). Moreover, McKeddie (2013) found counsellors were perceived to work with less severe mental illness, have less attention on diagnosis and have a greater focus on the client.

With the lack of knowledge about students' attitudes towards mental health professionals (in this study counsellors and psychologists), I have observed the need for greater awareness of student's perception of these professions. In order to improve or control mental health professional's reputation, it is necessary to understand what students' perception of them are to begin with (Hartwig & Delin, 2003; Wood, Jones, & Benjamin, 1986). Furthermore, the

use of quantitative research methods (Blåka, 2012; Myrvold, 2008) in investigating Norwegian attitudes towards mental health and stigma has left great gaps in knowledge, which I wish to create more awareness about. With a broad frame of investigation, I hope to gain insight into these questions and recognise potential areas for future research.

1.4 Structure

This thesis has been organised into six chapters; introduction, theory, methodology, findings, discussion and conclusion. First, relevant theory will be presented to create a framework. Then the methodology will be presented along with the scientific view point represented in this study. The decisions made in relation to methodology, ethics and quality will be described to show transparency. Further, the findings will be presented followed by a discussion. Finally, the study will be summarised, the limitations will be described and suggestions for future research will be laid out.

2 Theory

Throughout this chapter, the theoretical framework for the study will be presented. In the discussion, I have chosen to view the findings primarily in relation to help seeking, stigmatization and the media. However, first, mental health and mental illness will be defined in order to clearly separate the constructs and highlight the differences between the two dimensions and perspectives on mental health. Recognizing the differences in mental health and mental illness is important to understand how counselling differs from psychotherapy. This will be explained in the counselling section where counselling as a profession will be defined to clearly illustrate the purpose of counselling and how counsellors work towards growth and development in their clients. Then, previous research in relation to help seeking will be presented to clearly show the importance of help seeking and theories as to why people do not seek help when they experience mental health concerns. Finally, the theoretical underpinnings of stigmatization will be laid out, including the concepts of public stigma and self-stigma.

2.1 Mental health and mental illness

Mental health has been defined in various ways by various authors (Nes & Clench-Aas, 2011; Reneflot et al., 2018; WHO, 2014). Reneflot et al. (2018) defined mental health as a general term including positive mental health, quality of life, psychological distress and mental illness. In comparison, Worlds Health Organisation (WHO, 2014, p. 1) defined mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community". Both WHO (2014) and Nes and Clench-Aas (2011) emphasise mental health as a positive term meaning more than just the absence of disease. It is also the ability to cope with stressors through the use of resources (Nes & Clench-Aas, 2011). Jormfeldt (2011) refers to the positive aspect of health as salutogenesis, which is an approach to mental health treatment is that focuses on positive aspects of the individual's life (Langeland, 2009). In salutogenesis, the emphasis is on creating health, the available resources and how they are used (Lindström & Eriksson, 2005).

Mental illness on the other hand emphasises the negative dimension of mental health and focuses on pathogenesis as opposed to salutogenesis (Jormfeldt, 2011). Pathogenesis emphasises the absence of disease (Keyes, 2007). Broadly, mental illness can be defined as cognitions, behaviours and emotions that disrupt everyday life or quality of life (Overton &

Medina, 2008). Mental illness is identified by mental health professionals through diagnostic criteria internationally defined based on research (Reneflot et al., 2018). The diagnostic manuals, DSM-V and ICD-11 is considered primary tools for diagnosis all over the world (Cromby, Harper, & Reavey, 2013; First, Reed, Hyman, & Saxena, 2015). Primarily the difference between mental health and mental illness is the focus on the positive or negative dimension of health (Reneflot et al., 2018). Throughout this article, mental health will be used to refer to the positive dimension of mental health, while mental illness will be used to refer to the negative dimension of mental health. Mental health concerns will refer to unspecific issues to do with mental health with varying severity.

2.2 Mental health and the media

According to Coverdale, Nairn, and Claasen (2002), media is an important source of information about mental health concerns for the public. As such, there has been conducted numerous studies on the media's presentation of mental health and mental illness, and its effect on the public (Coverdale et al., 2002; Philo, 1997; Stuart, 2006). Stuart (2006) showed the importance of media's presentation of mental health by arguing that people develop opinions and prejudices before they meet other people who struggle with mental health concerns. Research findings have repeatedly shown that stories including mental illness were "outstandingly negative" (Coverdale et al., 2002). Commonly, mental illness was associated with dangerousness and unpredictability (Coverdale et al., 2002; Wahl, 2003). Moreover, the positive stories about people struggling with mental health were few and heavily outnumbered (Wahl, 2003). However, Francis et al. (2004) reported contradicting findings, suggesting that the quality of media reports were rated well. Another aspect to consider is whether the public believe the information provided. Borinstein (1992) show numbers that indicate there are strong differences in how believable people found the media. The importance of media's influence is the suggestions that media contribute negatively by upholding stigma towards mental illness (Knifton & Quinn, 2008; Philo et al., 1994), and thereby limit help seeking (Stuart, 2006).

2.3 Counselling

Counselling has been described as a professional relationship to empower people to achieve mental health and other goals (McLeod, 2013). There have been various definitions of counselling throughout the years, however, McLeod (2013) emphasises the importance of counselling as an activity between two people. Thus, arguing that definitions with focus on

the profession are not as accurate in their descriptions of counselling. To define counselling, McLeod (2013, p. 7) suggested “counselling is a purposeful, private conversation arising from the intention of one person (couple or family) to reflect on and resolve a problem in living, and the willingness of another person to assist in that endeavour”. Similarly, Kvalsund (2015) emphasised the relationship between two people, the counsellor who wants to help and has the competence to help, and the help seeker who has acknowledged the need for help.

Further, Kvalsund (2015) argues that if these aspects are not in place, the counselling cannot be successful. For example, if the help seeker does not believe the counsellor can be of help or is resistant of other reasons, the counsellor will not be able to provide the means for improvement (Kvalsund, 2015). As McLeod (2013, p. 8) wrote, “Counselling is fundamentally based on conversation, on the capacity of people to ‘talk things through’ and to generate new possibilities for action through dialogue”. Therefore, without the willingness of the help seeker to listen and apply the advice given, counselling will be less effective (Kvalsund, 2015; McLeod, 2013). Besides the willingness of both participants, research has repeatedly shown the quality of the relationship between the counsellor and the client to be a great predictor of the perceived helpfulness of the counselling (Kvalsund, 2015).

Another important aspect when defining counselling is how counselling differs from psychotherapy. Although there are similarities and overlaps between counselling and psychotherapy, McLeod (2013) states that a clear distinction can be made. The psychotherapists main area of focus is arguably what separates psychotherapy strongest from counselling. Psychotherapists primary goal is to treat their clients by finding out what is wrong, usually diagnosing the client and then administering treatment (Kvalsund, 2015; McLeod, 2013). The goal of the treatment is to make the client well again and reduce symptoms (Kvalsund, 2013; McLeod, 2013). Additionally, psychotherapists work with more disturbed clients, usually over a longer period of time (McLeod, 2013). Thus, those who seek help from a psychotherapist often struggle with more severe mental health concerns.

In contrast, those who seek help from a counsellor often experience an issue in their everyday life that they have not been able to solve with their own existing resources (McLeod, 2013). Further, the issue may have consequences for social life and prevent the client from living a meaningful or satisfying life. In many ways, counsellors view the concerns experienced by the clients as challenges to overcome instead of illness to be treated. Thus, counsellors

concentrate on development and different ways to approach the challenges brought forward by the client (Kvalsund, 2015).

The goal is to improve self-awareness and work in a satisfying way towards growth. As Kvalsund (2013, p. 26) wrote; "growth and development can halt without being defined as illness". Therefore, it can be argued that therapy is not only for those who experience mental illness, suggesting that therapy can be a resource for people going through critical stages of life either in private or professional settings (Kvalsund, 2013). Consider this example; Martha is experiencing increasing difficulties maintaining a positive relationship to her colleagues and friends. This is beginning to impact her ability to work efficiently and communicate properly with her colleagues and friends, which is causing Martha discomfort and dissatisfaction.

The example above is referring to a challenge that could be explored together with a counsellor as Martha is not necessarily mentally ill. Yet, it is important that Martha can seek help for her concerns and achieve greater life satisfaction. It is likely that she could benefit from seeing a counsellor on this subject to reach her goals. However, there is little place for counsellors as a mental health resource in Norway, and Martha may not necessarily be able to see a psychologist due to the long waiting lists and gatekeeper process (Wichstrøm, 2009). Moreover, the line between who is mentally ill and who is not, is unclear (Kvalsund, 2015; Rüsch, Angermeyer, & Corrigan, 2005). Can we then deny people help when they ask for it? Johannessen, Vedeler, and Kokkersvold (2010) argued that counselling is not only for those who are defined as mentally ill, suggesting that therapy should be available for all difficult stages of life. In other countries, for example England and Australia, counselling has become an important part of the mental health care system (Bower, Knowles, Coventry, & Rowland, 2011; Corrie & Callahan, 2000; Sharpley, Bond, & Agnew, 2004) and counsellors are often working with those who do not meet the criteria for serious mental illness (McKeddie, 2013). Thus, those who are experiencing mental health concerns or are in a difficult stage of life may be able to see a counsellor. However, in order for a counsellor or a psychologist to help, the person experiencing mental health concerns needs to actively seek help (Rickwood et al., 2005), thus help seeking will now be described in more depth.

2.4 Help seeking

Mental health help seeking can be defined as formally seeking contact with mental health care services and mental health professionals (Kuhl, Jarkon-Horlick, & Morrissey, 1997).

Although many researchers define help seeking as mainly referring to mental health professionals, others emphasize the difference between formal and informal help seeking (Rickwood et al., 2005). Examples of formal help seeking are mental health clinics, counsellors and psychologists (Rickwood et al., 2005). Informal help seeking takes place when a person approaches friends, family, or others in the community with their mental health concerns. Commonly, someone struggling with a mental health concern turn to their friends and family first (Gourash, 1978). Due to the various definitions of the concept help-seeking, Rickwood and Thomas (2012, p. 180) proposed "In the mental health context, help-seeking is an adaptive coping process that is the attempt to obtain external assistance to deal with a mental health concern." Throughout this article, this definition of help-seeking will be used, however, the main focus will be on help-seeking as formal help-seeking from mental health professionals.

Mental health help seeking is important because research has showed that a great part of those who is perceived to be in need of or could benefit from mental health care do not seek help (Mackenzie, Erickson, Deane, & Wright, 2014; Rickwood et al., 2005). Henderson, Evans-Lacko, and Thornicroft (2013) uses the term treatment gap to refer to the difference in the existing prevalence of mental health concerns and those who receive mental health care. According to various authors, the treatment gap is considered too great, resulting in unwanted consequences (Mackenzie et al., 2014; Mykletun, Knudsen, & Mathiesen, 2009). Referring to previous research, Vogel et al. (2006) stated that less than 40% of people who have a mental health concern seek professional help. The possible consequences of not seeking help with mental health concerns are many (Eisenberg et al., 2007; Hom, Stanley, & Joiner Jr, 2015; Mykletun et al., 2009). Some of the most common consequences of mental health concerns are lower quality of life, failure to attend work or stay in education and difficulties in social relationships (Eisenberg et al., 2007; Mykletun et al., 2009; O'connor, Martin, Weeks, & Ong, 2014). As well as being significant for people on an individual level, mental health concerns cost the government billions in government support each year (Mykletun et al., 2009), and it is therefore of great importance for society that people seek help with their mental health concerns. Yet, numbers internationally and in Norway show that few of those who could potentially benefit from mental health care seek such care (Rickwood et al., 2005; Roness et al., 2005).

With such low use of available services, attempts have been made to understand why people do not seek help with their mental health concerns. The reasons why people do not seek help

have in literature been referred to as barriers. Mackenzie et al. (2014) categorised barriers to mental health care as; (1) structural, referring to for example, availability and costs, (2), knowledge-based referring to ability to recognise symptoms and knowledge of how to get help, and (3) attitudinal barriers which includes stigma, fear and other negative attitudes towards mental health care.

Thompson, Hunt, and Issakidis (2004) compared structural, knowledge-based and attitudinal barriers, and found structural barriers to be the least cited reason for why people did not seek help. Similarly, other authors found attitudinal reasons for not seeking help to be much more often cited as barriers (Sareen et al., 2007; Wells, Robins, Bushnell, Jarosz, & Oakley-Browne, 1994). A more recent review by Gulliver et al. (2010) also show structural barriers as less important in relation to help seeking.

Knowledge-based barriers refer to the individual's capability of recognizing their mental health concerns and knowledge of how to seek help. Thompson et al. (2004) found that people's lack of knowledge of mental health concerns and symptoms was a major reason for delay of help seeking. The authors further argue that people's recognition precedes help seeking and therefore faster problem recognition could lead to shorter delays. Lack of knowledge and problems with recognition of mental health concerns could potentially mean that some individuals never receive help.

Jorm and colleagues (Jorm et al., 1997 as cited by Jorm, 2000) introduced the term 'mental health literacy' to describe people's understanding of mental health and the maintenance of mental health. Mental health literacy was defined as "knowledge and beliefs about mental disorder which aid their recognition, management or prevention" (Jorm, 2000, p. 396). Jorm (2000, p. 398) further acknowledge that there is little research describing "how people acquire their knowledge and beliefs about mental health". Although, media, websites, television and the cinema are mentioned as potential sources of information. Friends and family have also been suggested as sources of information (Jorm, 2000). They are especially important as research has shown that people experiencing mental health concerns turn to their friends and family first (Kelly, Jorm, & Wright, 2007), therefore theses supporters need knowledge of symptoms, how to properly support them and recognise when professional help is needed (Wilson, Bushnell, & Caputi, 2011).

Moreover, research has shown that one of the most common reasons for not seeking help is the belief that treatment is not needed and that the troubles will pass on its own (Hom et al.,

2015). Finally, Burns and Rapee (2006) pointed out that people's lack of knowledge about mental health and mental health services includes mental health professionals and their background. In practice, this means that people cannot separate counsellors and psychologists from their area of expertise (Burns & Rapee, 2006).

The third barrier to help seeking is the attitudinal barrier which include for example, negative attitudes towards mental health, fear and stigma. Attitude has been described as having a favourable or unfavourable perspective on something, and is usually connected to evaluation (Olson & Zanna, 1993). Moreover, attitudes are existing in memories and can influence behaviour (Olson & Zanna, 1993). Negative attitudes towards help seeking has been found to impact people's intention to seek help, suggesting negative attitudes may lead to avoidance of help seeking (Vogel, Wester, Wei, & Boysen, 2005). This is especially important as young adults (15-24 years old) have been found to have a significantly higher negative attitude towards help seeking (Jagdeo, Cox, Stein, & Sareen, 2009). Students are commonly in this age group and as such, a proportion of students may hold negative attitudes towards help seeking (Zachrisson, Rödje, & Mykletun, 2006).

Stigma is one of the aspects most often mentioned in relation to attitudinal based barriers. Based on a systematic review of existing qualitative and quantitative research literature, Gulliver et al. (2010, p. 5) found stigma to be "the most prominent barrier to help-seeking for mental health problems". As such, stigmatization has become one of the most researched and widespread barriers to help-seeking (Vogel et al., 2006). Stigma will now be further described.

2.5 Stigma and mental health

As one of the barriers to mental health help seeking, stigmatization has inspired decades of research (Brohan, Slade, Clement, & Thornicroft, 2010). The concept of stigmatization can be traced back to Erving Goffman who proposed stigma as a "… process of global devaluation of an individual who possesses a deviant attribute (Kurzban & Leary, 2001, p. 187). This attribute is described by Goffman as "deeply discrediting" (Goffman, 1986, p. 13). Similarly, (Vogel et al., 2006, p. 325) more recently defined stigma as "the perception of being flawed because of a physical characteristic that is regarded as socially unacceptable". It is thereby suggested that stigma is dependent on social measures of what is accepted. Thus, stigma is experienced when an individual's attributes or social identity do not meet the demands or norms of society in a social interaction (Kurzban & Leary, 2001).

Since Goffman (1986) introduced the concept of stigmatization, the concept of stigma has been further developed in two different directions. Link and Phelan (2001) focus their theory on the cognitive and behavioural aspects of stigma while Corrigan (2004) defines stigma in relation to the individual and the society through distinguished types of stigma; public stigma and self-stigma. Various other authors have identified additional types of stigma (Barney, Griffiths, Jorm, & Christensen, 2006; Brohan et al., 2010; Clement et al., 2015). However, a full review of all the suggested types of stigma is not within the scope of this article, thus the most relevant types of stigma, public and self-stigma will be described. First, Link and Phelan's (2001) theory of stigma will be presented.

2.4.1 The interrelated components of stigma

Link and Phelan (2001) describe the six elements they have provided as a fundamental part of stigma and further argue that these elements are interrelated and together create a setting for stigma to occur. Their first is labelling the differences perceived. Labelling happens when an individual's difference is perceived as deviant from the norm and through social processes is singled out as important. By using the word 'label' the authors (Link & Phelan, 2001) attempt to show the difference between a prefixed condition in the individual (e.g., attributes) and an inaccurate description of the stigmatised individual (the label or category associated with). For example, the stigma a person may experience by being labelled mentally ill.

According to Link and Phelan (2001), the label is what connects the individual to undesirable stereotypes (component 2). This happens automatically through a cognitive process that is part of our unconsciousness. Once a label has been attached to an individual that individual is then associated with the stereotype that is connected to the label. For example, if a person through previous experience or influence have come to associate mentally ill people with instability and danger, then someone labelled mentally ill will instantly be connected with this perception of instability and danger (Link & Phelan, 2001).

The third component of the stigma process is separating 'us' from 'them'. The first components are used as a rationale for separating us from them. By separating ourselves from the negative category, we simultaneously remove ourselves form the stereotype. We ourselves cannot be inflicted by this process. For example, 'I am not mentally ill, therefore I am none of those things associated with him/her'. Link and Phelan (2001) names the fourth component status loss and discrimination. They argue that most definitions of stigma have overlooked status loss and discrimination. However, I would argue that this notion of

discrimination and status loss was included in the stigma concept from the start in Goffman's first descriptions of the term. As mentioned above, Goffman (1986) referred to stigma as a process of global devaluation of the individual, which in my opinion would suggest status loss and discrimination. Link and Phelan's (2001) work expands this early description of the phenomena by explaining how status loss can occur in group settings. People carry their expectations of stigmatized groups with them and in meeting with a stigmatized individual these expectations will lead to judgement about the stigmatised individual's capability to perform certain tasks. For example, a person who is known to seek counselling may through stereotyping be perceived as less capable of doing the job, even if there is no evidence to suggest so. This is also a clear example of how labelling and stereotyping can lead to discrimination.

Power is perhaps the most important aspect of stigma discussed by Link and Phelan (2001). Stigma would not occur without the presence of power. This is because without power, the stigmatizing attitude would have no effect on the stigmatized individual. It would probably be considered no more than simple mocking (Link & Phelan, 2001). For example, job seekers may view the job interviewer as narrow minded and incompetent. However, their labelling and stereotyping would most likely lead nowhere. The job interviewer on the other hand holds the power, his thoughts about the individual (with a mental health concern) seeking a job would matter very much. They could potentially lead to the job seeker being labelled, and through the process of stigmatising be discriminated against and loose an opportunity based on the stereotype of his capabilities rather than his actual abilities. As seen in this example, power is crucial for the stigma to have a serious effect on the individual.

2.4.2 Public stigma

Public stigma can be defined as fear of judgement from society (Owen, Thomas, & Rodolfa, 2012). Eisenberg, Downs, Golberstein, and Zivin (2009, p. 523) defined public stigma as "negative stereotypes and prejudices about mental illness held by people in a society or community". Corrigan (2004) argued that public stigma is more than fear of judgement because there is an evident risk of discrimination. This discrimination is initiated by negative attitudes (prejudice) held towards individuals because of the stigmatization (Corrigan, Watson, & Barr, 2006). These attitudes are often based on wrongful perceptions of how mental illness affects people which in turn leads to discrimination (Corrigan & Watson, 2002). Three main components of public stigma have been recognized; stereotypes, prejudice

and discrimination (Corrigan & Watson, 2002). Therefore, the notion of public stigma can be argued to be closely related to the theory presented by Link and Phelan (2001). Additionally, Coppersmith, Dredze, and Harman (2014) suggest mental health has become taboo due to the longstanding public stigma.

While public stigma refers to the existing stigma in society there is also perceived public stigma which refers to an individual's perception of public stigma (Eisenberg et al., 2009). Perceived stigma is important because even if public stigma does not exist in society a person can believe it does and therefore act in the same way as though it existed. Consequently, the person may not seek help due to the perceived risk of discrimination (Vogel, Wade & Hackler, 2007).

2.4.3 Self-stigma

Self-stigma has been described as closely linked to social stigma and public stigma, although it differs significantly in the way the stigma is perceived (Eisenberg, Hunt, & Speer, 2012; Vogel, Wade, & Hackler, 2007). In contrast to public stigma, the negative attitudes are in self-stigma internalized by the individual (Barney et al., 2006). According to Vogel et al., (2007, p. 41) self-stigma is "the perception held by the individual that he or she is socially unacceptable". This idea of what is socially acceptable and what is not, comes from the society and culture in which the individual is part of (Corrigan et al., 2006). Most cultures include stereotypes which are readily available for the individual (Corrigan et al., 2006). When the individual accepts these stereotypes as their own, the process of internalizing self-stigma has begun. This process happens quite naturally as our self-concepts are socially constructed through our perceptions of how other see us as persons (Lucksted & Drapalski, 2015). Similarly, Brohan et al. (2010) describes self-stigma as an internalisation of shame, blame, hopelessness, guilt and fear of discrimination. Hence, it can be said that self-stigma affects the individual on multiple levels.

Most importantly, self-stigma is widely recognized as lowering an individual's self-esteem (Vogel, Wade, & Hackler, 2007). This happens when an individual attribute themselves a label of having a mental health concern, and thus being someone who is less valuable in society (Vogel et al., 2006). Self-stigma has also been associated with lower self-concept and self-efficacy (Vogel et al., 2006).

Self-stigma has been connected to help-seeking (Vogel, Wade, & Hackler, 2007) and is therefore considered a vital aspect of the many reasons people do not seek help for their

mental health (Corrigan et al., 2006). Seeking help for mental health concerns is often identified as confirming of those stereotypes believed to be connected to help seeking, and put the individual at risk of public stigma and discrimination (Vogel et al., 2006). Seeking help could then be considered as a submission to the idea of weakness and failure (Vogel et al., 2006). Avoiding help seeking can in this process be viewed as a way of protecting oneself from the possible negative consequences of seeking help. Additionally, research suggests that higher levels of self-stigma is connected to poorer working alliance which can have a negative impact on the outcome of the counselling (Owen et al., 2012). Owen et al. (2012) suggests that this is due to an internal conflict between possible outcomes of going to see a counsellor and the possible negative social consequences.

3 Methodology

Throughout this chapter I will explain the methodological choices I have made and describe the research process. I will define my scientific point of view and clarify the use of qualitative methodology including; the interview process, the transcription and recruitment of participants. Further, my use of thematic analysis will be explained, followed by the ways in which my pre-existing knowledge may have impacted the research process. The ethical considerations made in relation to this project will be laid out, and finally the study's validity, reliability and generalisability will be discussed.

3.1 Qualitative methodology

To investigate, how students describe their attitudes towards people who seek help with their mental health from a counsellor or a psychologist, I have chosen qualitative methodology. Qualitative methodology pursue insight and understanding instead of overview and explanation as with quantitative methodology (Tjora, 2017). Qualitative methodology gives the researcher opportunity to delve deeper into social phenomena (Thaagard, 2013). Thaagard (2013) suggested that qualitative interviews are especially useful to gain access to people's experiences, views of opinion and self-understanding, which is appropriate as the purpose of this study is to gain greater understanding of how students understand mental health in relation to help seeking.

An important aspect of using qualitative methodology is the researcher's role. How the researcher interprets the information given and which scientific approach the researcher is using will influence the researchers understanding and interpretation of results (Thaagard, 2013). Therefore, the epistemological point of view underpinning this study, namely phenomenology and hermeneutic phenomenology will now be described.

3.1.1 Phenomenology

Phenomenology dates back to Edmund Husserl who was interested in how phenomena appeared in a person's consciousness (Laverty, 2003). Laverty (2003, p. 22) defined phenomenology as "…the study of lived experience or the life world". Therefore, it can be said that reality is the way a person perceives it to be and as such, it is essential to describe the world as it is experienced by the participant (Thaagard, 2013). In this study, I want to delve deeply into the participants understanding of mental health and how it influences people's daily life. In order to describe the world as seen by the participant, Husserl argued that it was necessary to put pre-existing knowledge in "brackets" (Laverty, 2003, p. 23).

Bracketing can be defined as "suspending one's natural assumptions about the world so that what is essential to a phenomenon can be understood without prejudice" (Sorsa, Kiikkala, & Åstedt-Kurki, 2015, p. 10). However, many authors have argued that pre-existing knowledge can never be filtered out completely (Kvale & Brinkmann, 2009; Thaagard, 2013). As a researcher I am aware that I will play an active role and that my pre-existing knowledge on the topic will influence the interview and the interpretation. Hence, I have also based this study on hermeneutic phenomenology.

Heidegger believed consciousness to be constructed by a person's lived experience. This includes the way a person's culture has contributed to shaping the person throughout upbringing, resulting in the person's unique way of understanding the world (Laverty, 2003). It is this unique perspective on mental health that is sought after in this study.

An essential part of conducting a qualitative study are the choices the researcher makes based on pre-existing knowledge that continuously shape the study from the interview, to the analysis and write up. In contrast to phenomenology, in Heidegger's description of hermeneutic phenomenology, he recognised that interpretation would always take place, however, the researcher could take measures to diminish the effects by focusing on awareness (Laverty, 2003). Although, the participants' experience of the world and the phenomenon in question will be in focus, I recognise that my existing world view will influence how I conduct this study and interpret the data. Thus, in line with hermeneutic phenomenology, I continue to seek awareness within myself and place great importance on transparency while I attempt to convey the participants' perspective on mental health. More details regarding reflexivity will be provided in 'the researcher pre-existing knowledge' section.

3.2 Data collection

Based on the research question I have decided to use qualitative interviews as a means of collecting data. The purpose of the study was to investigate the participants experiences in relation to the research question. As group interviews can limit the depth of the information retrieved from the participants, the individual interview was chosen to elicit more personal responses that was not limited by social norms (DiCicco-Bloom & Crabtree, 2006).

For the purpose of gaining a greater understanding of participants experiences, the semi-structured interview was used (Kvale & Brinkmann, 2009). One advantage of the semi-structured interview is that it can be used to attain specific information that is comparable (Knox & Burkard, 2009; Turner III, 2010). According to Qu and Dumay (2011, p. 246), "the

semi-structured interview involves prepared questioning guided by identified themes in a consistent and systematic manner interposed with probes designed to elicit more elaborate responses”. Additionally, the semi-structured interview is flexible as it allows the researcher to follow up on the participants statements if necessary (Knox & Burkard, 2009). Although I as a researcher will be influenced by my existing knowledge on the topic (Finlay, 2002), I wanted to study the participants experience and how they made meaning of them. Therefore, the interview guide was created by brainstorming important topics to cover in the interview. These topics were then adapted into questions with suggested probes. Based on the recommendations by DiCicco-Bloom and Crabtree (2006), the questions were developed to be open ended and non-leading. For more information on the interview guide, see appendix 3.

A pilot interview was undertaken to assess the effectiveness of the interview guide. During the pilot interview it became clear that some topics of the interview guide could be rearranged to create a more natural flow of conversation and some questions were deemed repetitive and thus removed. I also saw the need to inform the participants explicitly beforehand that in general it was their opinion I was interested in learning about, not how they perceived the general public’s opinion. Although some questions are directed at how the participant perceive others’ opinions, it is then explicitly stated within the question. For example: ‘Can some colleagues choose to distance themselves from a person they know struggle with mental health?’ I will come back to the interview process after the recruitment process has been described.

3.3 Participants

Whereas quantitative studies seek to gain statistically generalisable data, qualitative studies seek a social understanding (Thaagard, 2013). Using a qualitative method, thus entails that the researcher delves deeper into the data collected which can place a great demand on time and resources (Kvale & Brinkmann, 2009; Thaagard, 2013). Based on this, Thaagard (2013) recommends that the number of participants do not exceed the capacity to complete a full analysis. In a study by Ando, Cousins, and Young (2014), it was found that after participant six, the number of new themes discovered, decreased. Although, they argued that twelve was the ideal number of participants to achieve saturation within thematic analysis, twelve participants would be exceeding the capacity of the researcher’s time and resources. Thus, six participants will provide a great number of codes and be within the capacity of this study.

Convenience sampling (Robinson, 2014) was used to recruit 6 participants, 3 males and 3 females to counteract any gender effect (Thaagard, 2013). Quota sampling was used to limit and balance the selection of participant based on gender (Thaagard, 2013). All participants were students from varying disciplines and backgrounds who studied full time or part time. Age ranged from 20-30 years and all participants were of Caucasian ethnicity.

As the topic of interest was students' honest opinion about people who sought help with mental health issues, the inclusion criteria were that the participants studied full time or part time. Participants who studied counselling or psychology were excluded from the study due to a concern that their expanded knowledge and awareness of mental health would allow them to adapt their answers and as such their answers could potentially be biased (Van de Mortel, 2008).

Thaagard (2013) claims that the selections most important aspect is whether the participants have knowledge about the topic of interest and can answer the research question. Mental health is considered relevant for everyone, including both the negative and positive experiences related to mental health (Nes & Clench-Aas, 2011). Therefore, there were no further inclusion criteria that qualified participants to partake in the study.

During the recruitment process, I reached out to potential participants. The first person to accept my invitation, were invited to partake in the pilot study. Due to the relatively small changes made in the procedure, the pilot interview was included in the data collection and later analysed.

3.4 The Interview process

All interviews were conducted within a week after the participant agreed to partake in the study. The interviews took place in group rooms across The Norwegian University of Science of Technology campuses. As a researcher I adapted to the participants timetables and scheduled the interview at the most convenient meeting point for the participant. These group rooms provided a natural setting with minimal risk of being disturbed as recommended by Tjora (2017). However, due to the nature of such group rooms, the setting may have been formal and as such may have been a limitation that caused the participant discomfort. King, Horrocks, and Brooks (2010, pp. 42-43) recommendations of positioning were used to counteract these effects.

During the pilot interview, it was discovered, based on feedback from the interviewee that the questions could be experienced as quite intense as they covered personal opinions among other topics. Therefore, I began to schedule a short break about thirty minutes into the interview as I expected the interviews to last approximately one hour. However, some participants declined the offer of a break.

After all the questions in the interview guide had been covered to the researcher's satisfaction and the participant had nothing more to add, the tape recorder was shut off.

3.5 Transcription

Transcription is a method of transforming audio recordings into text (Davidson, 2009). The process of transcription demands that the researcher make choices upon what to transcribe, and what to exclude from the transcription (Tjora, 2017). Davidson (2009) refer to this as selectivity, which is deemed essential for both practical and theoretical reasons. Including excess information in a transcript may divert focus away from the most important aspects of the conversation, namely those pertaining to the purpose of the research (Davidson, 2009). Vice versa, the lack of detail in a transcript can cause the researcher to miss out on important information during analysis (Lapadat, 2000). Lapadat (2000, p. 205) wrote that the greatest challenge for the researcher during the transcription phase is "to reduce the data selectively while still preserving the potential for 'rich interpretations'". Further, it has been suggested that a researcher's selectivity must be recognised and justified in relation to the purpose of the research (Davidson, 2009).

In this study I have chosen to use naturalized transcription which resembles the conventional rules of literacy writings (Bucholtz, 2000). In contrast denaturalized transcription (e.g. verbatim transcription such as the Jefferson Notation) retains oral discourse by preserving pauses, changes in pitch, overlaps and more (Davidson, 2009). Although denaturalized transcription preserves additional details from the interview, it is considered difficult to read (Davidson, 2009). Thus, since the purpose of the present research is the interpretation of the participants perspective on the topic, naturalised transcription was considered sufficient for the analysis. In line with naturalised transcription, oral language such as "uhm" were not transcribed (Davidson, 2009). Sentences and words uttered in dialect were adapted to bokmål as part of the anonymization, and for the readers benefit (Tjora, 2017). After the transcription, each tape was reviewed once for accuracy (Davidson, 2009).

In order to protect the participants anonymity, pseudonyms were used to refer to a particular transcript. Additionally, other specific details that could have led to recognition of people, places or organisations were changed.

3.6 Data analysis

Thematic analysis is a qualitative method used to identify and analyse patterns across data, which are then described as patterns or themes (Alhojailan, 2012; Braun, Clarke, & Terry, 2014; Vaismoradi, Turunen, & Bondas, 2013). Further, thematic analysis has been recommended for novel researchers because of its flexibility and systematic analysis that can be reviewed in relation to existing theory (Braun et al., 2014). Due to the flexibility connected with thematic analysis, the researcher is required to make decisions while applying the method (Braun et al., 2014; Vaismoradi et al., 2013). The decisions made in relation to thematic analysis and the process of analysing the data will now be described.

Throughout this study, the goal has been to present the participants point of view, which is consistent with an inductive approach. However, Braun et al. (2014) argues that coding and analysis tends to combine an inductive and a deductive approach to the data. As a researcher with pre-existing knowledge of the topic at hand, it can be argued that it is impossible to have a purely inductive approach and as such I recognise that this may have influenced the data analysis.

For the analysis, the six-step approach as presented by Braun et al. (2014) was used; (1) familiarise yourself with the data, (2) generalizing initial codes, (3) searching for themes, (4) reviewing potential themes, (5) defining and naming themes, and (6) producing the report. I will now describe each of these steps in greater detail.

For the first step, to familiarise myself with the data, I first transcribed the audio recordings and then listened to the recordings to check the quality of the transcriptions. Once satisfied with the quality, the transcripts were printed. In the second step, I read through the transcripts while taking notes and highlighting keywords and passages of interest. The highlighted parts became important when generalizing the initial codes, which were generalized manually. Examples of coding are “media”, “taboo” and “private”.

I reread the transcripts to ensure all codes had been identified, also searching for latent codes that might not have been as easily discovered as sematic codes (Braun, Clarke, & Rance, 2015). The second search for codes also functioned as a quality check. All the potential codes

were then exported into a sheet of paper to search for themes. To ensure rich data associated with each of these codes and potential themes, I created an overview with each code and text associated with the code for each participant. This allowed for easy comparison of the potential themes and codes, and the participants relationship to these themes. Codes without rich data to support them were eliminated. Some codes were found to be overlapping and were therefore merged.

After reviewing the codes, a great number of potential themes had already emerged for step three. For step four, I returned to the research question to decide which themes to explore further. Three themes were chosen; (1) students' descriptions of mental health in society, (2) students' descriptions of mental health in relation to other individuals, and (3) students' attitudes towards people who seek help with their mental health from psychologists or counsellors. In line with Braun et al's (2014) six step guide, the three themes were controlled for coherence and that the themes were in representation of the data. For the fifth step, a description was made for each theme, clearly defining the focus of the theme. As for the last step of Braun et al's guide, "producing the report", I have considered their recommendations throughout the writing of this report.

To clarify the process relating to language (Temple & Young, 2004), I will give a short description of the process of translations. All collection of data and data analysis was conducted in Norwegian. Further, the quotes used in the write-up were selected from the raw interview data and was then translated to English to be used in the report. For transparency in relation to the translation process and potential quality control, the translation of quotes can be found in appendix 4. Note that some quotes have been simplified to be used in the text.

Finally, the three themes; (1) students' descriptions of mental health in society, (2) students' descriptions of mental health in relation to other individuals, and (3) students' attitudes towards people who seek help with their mental health from psychologists or counsellors, and their subthemes will be presented in the findings chapter.

3.7 The researcher's pre-existing knowledge

Well known phenomenologists have cautioned against pre-existing knowledge of theories and their influence in the belief that "lived experience" cannot be discovered unless the researcher bracket these beliefs (Dahlberg, Dahlberg, & Nyström, 2007, p. 135). Dahlberg et al. (2007) stated that pre-existing knowledge without awareness can lead to biased results. Thaagard (2013) pointed out that all knowledge builds on pre-existing knowledge and as

such, authors have recognised researchers influence as a central aspect of the research process (Finlay, 2002). For example, Finlay (2002) and Sorsa et al. (2015) considers the interview as a co-construction between participant and researcher, suggesting different researchers would achieve different results. Thus, authors have proposed ways of controlling for researchers pre-existing knowledge by asking for awareness and transparency through reflective strategies (Berger, 2015; Finlay, 2002).

One such strategy is referred to as reflexivity (Berger, 2015; Finlay, 2002). "Reflexivity is commonly viewed as the process of a continual internal dialogue and critical self-evaluation of researcher's positionality as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome" (Berger, 2015, p. 220). Further, reflexivity is argued to improve the quality of a study (Berger, 2015). Therefore, I will now disclose some of my thoughts regarding the research process as a part of being transparent (Berger, 2015; Finlay, 2002).

Throughout this research process I have tried to reflect on my background as a student (psychology and counselling), my experience of mental health, and how this may have impacted this study. Going into this project, I wanted to remain neutral and without in-depth knowledge of the topic. However, as the study proceeded I began researching for this project and wrote an essay on the topic which gave me great insight into the existing research. My knowledge of this conflicted with my wish to stay open for new information and perspective which in this case may have caused me to adhere strictly to the interview guide in fear of asking leading questions or projecting my own ideas onto the participant. This may have led to lost opportunities for follow up questions and thus in-depth answers. It is also important to acknowledge that my pre-existing knowledge may have influenced what statements caught my attention for follow-up. My first interest in this topic was based on a question I had been asking myself for a long time; when does someone need help? Based on my readings and my experience of the society, I had a growing idea that external factors were influencing people when it came to help seeking and this may have impacted the way I as a researcher asked questions and identified codes in the transcripts. Furthermore, my strong quantitative background, may have impacted the way I perceive of research and the truth, although, in line with phenomenology, I realise that there is no absolute truth. In this case it is about the participants perspective and their experience of the world.

3.8 Quality of the research

Quality within qualitative studies have been largely based on the same values as in quantitative studies (Kvale & Brinkmann, 2009; Silvermann, 2011). For the purpose of qualitative research, validity, reliability and generalisability have been given new names and new meaning. Based on Kvale and Brinkmann (2009) I have chosen to use reliability, validity and transferability.

3.8.1 Reliability

The term reliability was originally used in relation to quantitative methods and "…refers to the ability of a research method to yield consistently the same results over repeated testing periods" (Brink, 1993, p. 35). Within qualitative research, reliability is concerned with the quality and trustworthiness of the research (Thaagard, 2013). Silvermann (2011, p. 360) refers to two methods of assuring reliability within qualitative research. The first is transparency which is about the researcher's openness about the research process. By giving a detailed account of the research process (including the strategy, interview and analysis) the researcher is providing others with the opportunity to assess the quality of the study (Golafshani, 2003). It also allows for replication. The second, is theoretical transparency, which details the researcher's theoretical background and how it might affect the study (Silvermann, 2011; Thaagard, 2013). To create awareness, I have continuously tried to reflect on my choices, and throughout the methodology chapter, I have strived to give as detailed descriptions as possible of the research process, my pre-existing knowledge and theoretical background going into this research project, to show transparency. Additionally, various authors (Ryen, 2002; Silvermann, 2011; Thaagard, 2013) highlight the importance of using verbatim accounts of the participants statements to illustrate, instead of retelling the participants opinions. This serves as a way to protect the report from the researcher's subjectivity, which I have attempted in my analysis.

3.8.2 Validity

Within quality, the term validity concerns whether the analysis and the results presented are accurate and based on the data (Thaagard, 2013). Kvale and Brinkmann (2009) refers to the quantitative use of validity and asks if we are measuring what we intended to measure. Silvermann (2011) makes two suggestions to control for validity. The first, triangulation is a combination of more than one method to see if they yield the same results. The second, is to bring the conclusions to the participants for respondent validation. Thereby, the researcher

asks the participants whether the interviews have been correctly interpreted (Creswell & Miller, 2000). For this study, respondent validation was used to control for validity. The participants were given an opportunity to give their opinion on the interpretation of the results. All participants confirmed that they were satisfied with the interpretation of their responses.

3.8.3 Transferability

Transferability refers to whether findings from one study will apply to another population, place and time (Kvale & Brinkmann, 2009; Thaagard, 2013), thus extrapolating from a sample to a population (Firestone, 1993; Nadim, 2015). Firestone (1993) discussed three types of generalisation in relation to qualitative research; sample-to-sample population extrapolation, analytic generalization and case-to-case transfer. Further, Firestone (1993) concludes that case-to-case transfer, also called transferability (Polit & Beck, 2010), shows great promise for generalisation within qualitative research. Transferability is based on providing the reader with rich description about the participants and the research process. Subsequently, the reader can make decisions about extrapolating the findings (Payne & Williams, 2005; Polit & Beck, 2010). Regarding transferability, I have included as much detail as possible while simultaneously protecting the participants anonymity. The ethical considerations undertaken will now be further discussed.

3.9 Research ethics

While conducting research it is the researcher's responsibility to protect the participants from any potential harm as a result of participation (Guillemin & Gillam, 2004). Guillemin and Gillam (2004, p. 263) argue "that there are at least two major dimensions to ethics in qualitative research". The first is a process of applying to an ethics committee for the approval of a specific research project. In relation to this, the current study was approved by Norsk Samfunnsvitenskapelige Datatjeneste (project number: 844160) (see appendix 5). The other dimension was named 'ethics in practice' which refer to how ethics are considered and exercised throughout the research project. In relation to ethics in practice, situations sometimes arise in which you cannot always look up what to do (Guillemin & Gillam, 2004). Throughout the project I have therefore used my experience from various research projects conducted in the UK to make choices as I went along. Additionally, I have continuously considered the participants and how my actions potentially could affect them and allowed this

to influence my decisions. Two important aspects of their protection were the informed consent and confidentiality, both of which will now be described in further detail.

3.9.1 Informed consent

The participants were provided with an information sheet (appendix 1) and asked to sign a consent form (appendix 2) before taking part in the study.

In the information sheet, the participants were informed that their names and other identifying information would not be connected to the interview data. Further, the participants were provided with information on how the data were to be handled and who were to have access to it. This included information about password protected, offline storage of tape recordings and that transcriptions were stored on a password protected computer without any personal information that could connect the transcript to the participant.

During the pilot interview, it became clear that not all participants would go through the trouble of reading the information sheet, and therefore I took time to inform the participants verbally of their rights before allowing the participants to sign the consent form. The verbally presented information included the participants rights to withdraw from the study, confidentiality agreements and the audio recordings (Kvale & Brinkmann, 2009). The participants were then informed again about the purpose of the study and presented with an opportunity to ask questions. After the interview, the participants were given a few minutes to talk about their experience of the interview as a short debrief session.

3.9.2 Confidentiality

Confidentiality is about protecting the participants identity by ensuring it remains hidden (Thaagard, 2013), in other words, conserving the participants anonymity. Researchers have great responsibility in protecting the participants private information which includes the storage of such information (Kvale & Brinkmann, 2009). The project was pre-approved by NSD, an organisation who concerns itself with research quality and privacy regulations (see appendix 5). Further, NTNU's (Norges Teknisk- Naturvitenskapelige Universitet) guidelines for storage of data were followed (see appendix 6). This meant that audio recordings were stored on a memory stick and password protected using 7-Zip. The transcriptions were stored on a password protected computer, without any identifying information.

As mentioned in the transcription section, all information that could identify the participant or specific places were removed and replaced by a word indicating why the word was removed.

For example, “But I think the threshold here at (School)”. The participants were then given pseudonym names for easy referral to transcripts. Additionally, all transcripts were written in bokmål to anonymise the participants dialects.

4 Findings

This study is focusing on students' attitudes towards mental health and help seeking with the purpose of gaining awareness of students experiences and perspective. In this chapter I will present the findings from the thematic analysis. Three main themes were identified in relation to the research question: "How does students describe their attitudes towards mental health and individuals who seek help from a counsellor or psychologist?" The findings are:

1) Students' description of mental health in society.
2) Students' descriptions of mental health in relation to other individuals.
3) Students' attitudes towards help seeking and people who seek help with their mental health from a counsellor or a psychologist.

In unison, these themes tell the story of how students experience mental health and help seeking in their lives. Although these themes are all interrelated they cover different situations and areas of life in which students must relate to mental health and help seeking. The first theme covers students experiences of how they are presented with mental health in society and their perception of others attitudes towards mental health. The second theme centres arounds the students individual experience or thoughts about how to relate to other people who experience mental health concerns, including the possible consequences for the relationship. The third theme focuses on students' descriptions of when to seek help and who to seek help from. Additionally, the difference between seeking help from a psychologist or a counsellor is described in relation to societal perceptions.

4.1 Students' description of mental health in society

This theme captures the participants experience of how mental health is perceived in the society. The focus is on how mental health is perceived in the greater pictured as opposed to on the individual level which will be described later. The participants indicated that they were aware of how mental health was presented in the media and that media acts as an influencer of how mental health is perceived by other individuals. Participant also described mental health and media in close relation to shame and taboo. Closely tied in with these notions were the description of mental health as a private affair, something in which a person did not necessarily present to the general society due to a vulnerability. The three subthemes; "Media", "Taboo" and, "Mental health as private" will now be further presented.

4.1.1 Media and mental health.

Many of the participants indicated media as an influence on the topic of mental health. This means that what they hear about on the radio, television or see in magazines for example, can influence their perception of mental health. It also means that mental health or mental health related subjects are being addressed in the media. As Harry said, *"...it is a great focus today on mental health in social media and Internet and such*". Additionally, John said, *"Now we are influenced a lot by media and social media…*". These influences can be described as having both a positive and a negative effect. The positive effect can be viewed mainly as opening society for mental health as a topic to be discussed. For example, Harry talks about mental health in the future when he says;

> *Like social media has become a big thing and there has been a lot of focus on mental health around it and, it is more in the media the more we talk about it, the smaller, the easier it is to talk about it for others. So, I think it's a kind of a generational change, that when we take over, it is easy for our kids talk about it again.* (Harry)

In support of this, Jane stated that, "But from the media and such, there is greater and greater openness about mental health, so it does indicate that people are being influenced to talk more openly about mental health". While it is clear the participants view media as an important factor influencing individuals in society, one participant suggested mental health is becoming even more relevant than it has been through media's cover of the prime ministers' new year's speech (Erna Solberg, 2019), and thus it can also be argued that mental health is becoming more politically relevant. Emily said;

> *It is a bit more discussed now in society and politically, and it is something, the Prime Minister mentioned in the New Year's speech. It is more relevant now than I feel it has been earlier when we were young and yes, a little before when I might have needed it but didn't quite know that it was there, or that it was a challenge that many struggled with.* (Emily)

Emily describes here that mental health was not something she knew many people struggled with which shows there has been an increase in awareness. Sophie on the other hand says she would have liked that talking about the topic of mental health increased, "Well, it is very much in the media I think. There is a lot of talk about it, but I think it should be talked more about". The participants seem to agree that media can influence our society in a positive way by making way for mental health as a topic. While media is described as a positive influence

in becoming more open about mental health, it is also described as a negative influence. Harry talked about incidents like school shootouts in relation to mental health, “Here in Norway there are not so much such things, but it also, there are bad things happening here too and that is of great focus in the media too.” Sophie explained how newspapers as a part of the media often write about stabbings and murders in connection to mental illness which may in turn influence how the individual perceives of mental health.

> *But as you see very often in the newspapers, it is very often like these, knife stabbings, murder is also explained by mental disorders and it, people think in a way. If that is what is often presented by mental disorders in the media. So yes. I want to think someone pulls conclusions there. But certainly not all, certainly not most.* (Sophie)

It is important to emphasise here that Sophie does not state that all individuals are influenced negatively by media, but that some possibly are. However, this is a great example of how very serious actions are linked to mental health. Another example of this is told by Emily,

> *No because I do not have a clear example, but it is more that the things one hears about in the media is a bit like, yes, she had struggled with depression for five years and now she chose to kill herself.* (Emily)

This is another example of how a worst-case scenario is remembered about media and mental health. Sophie mentioned that some individuals concluded based on this media induced knowledge which in turn may lead to a misinterpretation of mental health and a misinformed picture of mental health.

4.1.2 Mental health as a taboo.

Taboo will in this section be defined as a social practice that restricts or prohibits association with mental health. The participants suggested that mental health was tightly connected to taboo through media and otherwise. Jane said that mental health was “tabooed, but it is something everyone has”. It is suggested that everyone has a relationship to mental health, but that even so, mental health as a topic is tabooed. Furthermore, this taboo is upheld when individuals avoid talking about mental health. However, the participants do not seem to agree with the underlying attitudes that upholds this social practice of having a negative association with mental health and help seeking. Jane refers to the absence of talking about mental health when she says, “It is a bit of shame, because it contributes to the taboo”. Emily supports the idea that one should be able to talk about mental health;

> *Not that it should be such a tabooed secret that you do, but one should be able to tell friends, but it is not necessary to shout it to everyone, but yes, close friends and family one should be able to tell.* (Emily)

Not only do the participants support mental health as something that should not be tabooed, but they also suggest that the taboo is decreasing. By this, the participants are trying to explain that there is a change happening in society now that is reducing the taboo. As Sophie said, “I think it has been a tabooed topic for many years and maybe it is beginning to clear up now”. Harry supported this statement:

> *It is a pretty sore topic still, but I think that’s because it’s been a bit taboo for a long time, but now I think it is like a turning point, that it is starting to go the other way.* (Harry)

Sophie put a timeframe on this change, suggesting it would happen over the next 10-20 years. While Harry meant this change had already happened, he also indicated the taboo was related to the older generation, “And in the older generation it was very hush hush, taboo. Kind of just suck it up and continue”. Overall, the participants described mental health and help seeking as suffering under a taboo. However, this taboo is experienced as decreasing.

4.1.3 Mental health as private.

As mentioned above, the participants hoped that mental health would be spoken about more in society. Yet, mental health is described as a private matter. Jane says, “One’s own mental health is very private. There is a reason for why you don’t talk about it in the media and other places”. Further, mental health issues are described as information only shared with selected individuals. As Sophie explained;

> *It is, at least in our society I think it is very, very personal. Yes, mental health. So, it is something you might only tell those closest to you, perhaps not even that. I believe there are many who does not tell their family, for example, that there is something they struggle with.* (Sophie)

Although, the participants express a wish for mental health to be spoken of more, they also show great understanding for why people would want to keep it private. They recognise that the person is having a difficult time. Jane said, “…I understand that one does not want to talk about it because it is personal and private, and one is at a most painful place if one is struggling with serious mental health and or mental health issues”. The participants also

speak of mental health as a place of vulnerability, especially if it is known to others that one is experiencing mental health issues. Isac said, “That you, yes that vulnerability, so you don’t want anyone to know about it”. John similarly explained, “They feel a bit naked then. A bit like, now I don’t have anything to protect myself with for they might know”. John is also referring to a “façade” that everyone is trying to uphold in relation to society. Further, John suggested that failing to uphold this façade can lead to unwanted consequences for social relationships which I will come back to later.

4.2 Students’ descriptions of mental health in relation to other individuals.

This theme focuses on the participants descriptions of how mental health and help seeking is experienced in relation to others. One of the questions that will be answered in this section is what it means for relationships with friends, family and co-workers if one individual of the relation learns about the other individual’s mental health concerns. The participants talk about openness and trust when disclosing mental health concerns and how the knowledge of others mental health issues may impact the relation. The possible influences or consequences for the relationship are uncertainty, discomfort, experience and understanding. Further, the participants explain how they adapt to the situation based on their knowledge of the other person’s mental health issues.

As seen earlier, mental health was considered a private matter by the participants, something in which you did only relate to the people closest to you. Therefore, when participants were told of someone else’s mental health concerns they saw it as a sign of trust. Sophie said, “Yes because, as I said earlier, it is very personal when people confide in you and it shows that you are a close friend and that you are trustworthy”. Emily further states that she appreciates that she can become more aware of the other person’s mental health, “I think it is very much a vote of confidence really as a friend, and I think it is very nice that they do, that I can become more aware of it”. Isac also describes openness as important for how he relates to a person with mental health concerns.

> *…it’s a bit situational but, in some cases, you can say that if there is anything you are wondering about then that is okay, or I just wanted to tell you, but I do not want to talk more about it. That it’s quite tidy, and it can make it alright to relate to if you add that extra information, I don’t want to talk about it. Okay, then you don’t do so either, but if*

there is anything you're wondering you can just ask, then the line has been made clearer. (Isac)

As you can tell from Isac's example, it is easier for him to relate to a person if the person has been open with him. Yet, he does not need to know the details of what the person is struggling with, just that there is something going on.

The participants also described it as difficult to relate to a person when they became aware that the person was struggling with mental health and that it could help them relate to the person if the person was open about their mental health concerns. This was described similarly by Emily, "One opens up to something happening and then one can, friends can relate to it more too". The participants also described such information as creating uncertainty in relation to how they behave around that person. Sophie said, "Then it becomes more difficult, I don't think everyone knows how to act around them when they learn they struggle with something like that". Further, this uncertainty could lead to a person creating distance between themselves and the person struggling with mental health. As Emily described it;

> *"I hope no one distances themselves from it, but that too can be a reaction to knowing that someone is struggling. That you pull away slightly because you think of it as difficult, do not have knowledge about it and do not know what to do."* (Emily)

Here, Emily talks about having the knowledge of how to behave in relation to someone who is experiencing mental health concerns. Without this knowledge, it could lead to distance. Having experience and knowledge about mental health is something the other participants also describe as an important factor. As Sophie said, "But it is mostly because I cannot put myself in their situation, so I don't know how to respond to it". Here Sophie talks about the discomfort she feels in relation to others. The main reason for the discomfort seems to be a lack of knowledge of how to behave towards the other person in the relation. Yet, this uncertainty may be decreased if the other person is open about their mental health, thus creating a framework for how this will be addressed within the relation, as illustrated previously by Isac.

As the participants experience discomfort in their relations after they learn of the other persons mental health issues, it may indicate that they feel a need to behave or communicate differently with a person with mental health issues. There would be no uncertainty of how to behave if they were to behave as before. As such, it became important to understand what the participants did differently in meeting with persons with mental health concerns. For

example, as Sophie says, "In some cases, I might try to overperform and thus be very happy around those people, and, yes talk a bit more and think a bit more about how I appear when I am with friends who struggle." Other participants also indicated that their adaptations were out of kindness towards the other person. Emily gave another example of this, "To a certain degree, that I might be more inclusive, a little more careful if there is anything I know to trigger the person or that will cause the person to feel discomfort."

Mainly, the adaptations the participants made were concerning how they communicated with the other person. As Jane said, "In my subconsciousness I might be a little bit more careful with my words if I know someone is struggling with mental health." Similarly, Isac said, "You might have to think a bit more about how you formulate yourself". Although the participants were aware of their change in communication or behaviour it was argued that this was not necessarily due to the other persons mental health. This argument was based on the idea that all communication is adapted to the person who is at the receiving end. Thus, a person adapts their communication based on who they are speaking to, meaning a grandmother would receive different communication than a sister or a brother. As Jane said;

> *That you talk different? Perhaps you do. But I don't believe it is conscious. It is not conscious because like I said, you have to look at the dynamics you have with the person you are talking to. You have to choose, no matter which situation you are in, you have to choose your words wisely. You cannot just blurt out. You have to look at the situation. It is simply that communication must fit how the other person are doing.* (Jane)

To summarize, learning of another person's mental health concerns may lead to discomfort and in some cases distance in the relation. However, it may also help people become closer through openness and trust. Lack of experience with mental health seems to be one of the factors involved in how well friends, family and co-workers handle this information.

4.3 Students' attitudes towards help seeking

"Students' attitudes towards people who seek help with their mental health from psychologists or counsellors" is about how students describe the threshold for help seeking in relation to psychologists or counsellors. Students describe the difference between seeing a counsellor and a psychologist as a great factor in how others are perceived and the thresholds for help seeking. This theme has two subthemes; (1) the help seeking threshold, and (2) students' descriptions of help seeking from a counsellor or psychologist.

4.3.1 The help seeking threshold

Students described the need to seek help as arising when a person can no longer handle their situation on their own. This was further described as when the mental health concerns or the situation became so "big" it could no longer be handled alone. As Jane said;

> *"I think it is because the situation is too, you feel the situation you are in, or the mental health you are in, it is too big for you to handle on your own or with friends and family. And that is why you need some help from the outside too."* (Jane)

Mental health was also described as a topic you could talk to other relations about (such as friends and family), however, this suggests that friends and family are not always capable of providing the help and support needed. Another way to recognise the need for help was described as the point where mental health was negatively influencing a person's quality of life. Jane said, "When the problems are a bit too big, when it takes over your own quality of life". Emily also referred to quality of life;

> *…if you think everyday life is so difficult that you, you struggle in a way with, yes. Even simple everyday things, that you can't walk out the door, that you find it difficult to walk to the shop, that you find it difficult to take part in social arrangements, find things that maybe are nice or just normal to be difficult. That it disrupts the quality of everyday life. Then you should seek help."* (Emily)

It is clear from the examples above that these opinions refer to what the participants consider the threshold for when to seek help for mental health concerns. However, the participants also acknowledge that some might find it difficult to admit or recognise that they need help. For that reason, people might not seek help when they need it. As Emily said, "And it might be difficult when you are in pain and then acknowledge that you need help". Jane suggested that this might also have something to do with the taboo and shame connected to mental health, "For some it might be very shameful to admit to oneself and others that they need professional help." These expressions of shame can be viewed as stigma related barriers to mental health help seeking.

Another barrier to help seeking was the knowledge of when to seek help. As Harry said, "That I think is 100 percent from person to person, and I do not believe everyone understands when they should have sought help". Not understanding when to seek help can be a sign that there is a lack of knowledge about mental health or that there are other barriers like stigma

stopping people from seeking help. Further, it was said that it was easier to seek help if you were told by others that you needed it. Sophie said, "I am inclined to believe it is easier to seek help if you are told by people you need it." Jane considered this a point of perspective, awareness and knowledge; "…is this really serious enough that I can go to a psychologist, but others who view the situation from the outside just, yes you should go to a psychologist sort of." This highlights the importance of perspective and indicates that there might be a variance in accurateness when it comes to self-evaluation.

Moreover, it was suggested by the participants that it is more acceptable for others to seek help than it is for yourself. This indicates that there is a different set of social rules for yourself compared to others. Jane said, "You are stricter towards yourself than you are strict towards others" and, "That the threshold is higher for yourself maybe, because you do not want to realise that you are struggling a bit more than normal". However, it was also very important for the participants that the threshold for when to seek help should not be high. Meaning they did not want there to be a limit for how "ill" you had to be to seek help. Sophie said, "It really should be a small threshold for people to seek help. But I do not think it is." In Emily's words, "No, the threshold should probably be lower than I feel it is now, at least for your own sake." In addition to believing the threshold for people to seek help is too high, participants suggest other people's opinions, shame and taboo are part of the reason for why some might choose not to seek help. Isac referred to this when he said, "No, I think that the way it is now, the threshold is too high. There are many who thinks that maybe they should have or want to, but do not dare because of what I said earlier." Additionally, there may be a relationship between the perceived taboo and shame connected to help seeking. As revealed in the "Student's descriptions of mental health in society" section about taboo, the participants suggested that the taboo connected to mental health and help seeking was decreasing. This is further supported by Sophie's statement, "But yes as I said, I think the threshold is becoming much lower to seek professional help. And there should be less shame connected to it, then it could be much more natural."

4.3.2 Students attitudes and knowledge of mental health professionals

As previously mentioned, there are many influencing factors when a person is deciding whether to seek help with mental health concerns. Students' knowledge and perceptions of mental health professionals, their own knowledge about mental health and how they perceive others' reactions to help seeking will now be presented.

Findings indicated that students did not know very much about what a counsellor was in relation to mental health. John said, “I didn’t know before I entered this room that a counsellor could be a resource for mental health” and “Now I know you study to become a counsellor, but I do not absolutely know what a counsellor does to be completely honest”. This suggests that students are not very aware of the mental health resources tied to a counsellor or the counsellor educational programme at NTNU. Further, the participants described a counsellor’s role more as an advisor, a person who would give specific advice on how to precede in situations tied to work and school related concerns. In Emily’s words;

> *Automatically I think like, choices for studying. You can be uncertain for example which rights you have as an employee, advice about. More practical purposes really. More practical information about different choices and rights and duties and rules you must relate to.* (Emily)

Isac had similar thoughts about what a counsellor could help with;

> *No, I had just thought like in job and study context there are a lot of uncertainty about choices to be made, what is the best for me, were can I find the best opportunities. That it does not have to be about the inner within yourself, it is more you in relation to something else in a way.* (Isac)

As can be seen from these two quotes, the students find that the counsellor can mainly help with choices to be made for the future. Jane went further by comparing a counsellor to a psychologist, “Counsellor is like, you come to them and get advice about it and then you take the advice with you, but when you see a psychologist you kind of try to dig out the underlying problem perhaps.” The participants also believed the reason for seeking help to be more serious when a person was seeing a psychologist as opposed to a counsellor. John explained that there was difference between coach, counsellor and psychologists, “Now we connect it with a coach and that’s okay, a counsellor is okay, but perhaps not okay in that sense, but psychologist is more serious, very much more serious.” Emily referred to the areas of responsibility as described by the participants. Meaning counsellors were closer related to organisational concerns while psychologists dealt with mental health. As Emily said;

> *“Yes, and counsellor, then it is more, it can be concrete advice that do not necessarily have to do with psyche really, but with a psychologist it is right away thinking like, yes. Here there are some big psychological thoughts, depression, anxiety, yes.* (Emily)

Due to the counsellor's connection to organisational and occupational decisions, it seems that other people cannot draw a conclusion about mental health as they can with a psychologist. If someone is seeing a counsellor it may be about something less serious as the participants find mental health concerns to be and therefore, seeing a counsellor seems more harmless compared to seeing a psychologist. Here in Isac's words, "It is a lot less taboo to say that you have been to a counsellor. Because it does not need to be linked instantly to mental health. That it is career guidance or such." One of the important aspects of this is how it is perceived by others. Isac further said, "It seems much milder to say that I went to a counsellor last week than that I went to my psychologist." For Emily this has to do with what is associated with the words' psychologist and counsellor, "Even if they can say the exact same things. I feel that, just the word has a different, yes. Safer sound then." The association with the word psychologist also seems to account for some of the help seeking attitudes. As the participants did not have personal experience with mental health help seeking they therefore refer to their beliefs. Emily said, "…and for me it is far away too seek help from a psychologist. So, I will automatically think that the threshold is high and therefore it is big issues it is about." Emily also said that the threshold to seek help from a counsellor was lower. This suggests that psychologists are associated with a certain type of problem and that the threshold to seek help from a psychologist is higher than from a counsellor. John also talks about the difference between a counsellor and a psychologist when he says;

> *I think that to go, because a counsellor is not a psychologist and a psychologist, then you know that it sounds really serious. Then it sounds like it has become a big thing, but with a counsellor it might be, the threshold is a little lower then.* (John)

In summary, there seems to be a connection between how a person is perceived in society and how that information is used in relation to others. Meaning the participants thoughts about mental health seems to be related to how they are influenced by media and societal norms. Although they do not always agree with the information presented to them, they are very aware of it. Further, the participants seem to know very little about counsellors and psychologists and their roles as mental health professionals. Their opinions on counsellors and psychologists are highly dependent on the information they have available or the lack thereof. In relation to this, I will finish the findings section with a quote from Harry that I think is very describing;

> *It is just movie culture, pop culture, all such things. That it is sort of trendy, it has been a, been made a lot of movies about it, many books, songs, music and such things, and when terrible incidents have happened psychologists have been in focus. But I have at least not heard about a counsellor that, yes. There are no horror movies with a counsellor sort of.* (Harry)

This quote highlights the complicated relationship between media, culture, stigma and help seeking which will be further discussed below.

5 Discussion

This study sought to investigate how students describe their attitudes towards mental health and help seeking from a counsellor or psychologist. The findings showed that students experience mental health as highly influenced by media, suffering under a taboo and as private. Becoming aware of others mental health concerns can influence a relation both positively and negatively. In relation to the help seeking threshold, students describe the threshold as too high. They believe people should be able to seek help no matter the severity of their mental health concerns. Students awareness of counsellors and psychologist's area of expertise is inaccurate and important knowledge seems to be missing. Furthermore, psychologists are described as treating more severe mental health concerns. Based on the research question the discussion will be split into two parts. The first part will address students' descriptions of attitudes towards mental health while the second part will address the student's descriptions of attitudes towards help seeking and mental health professionals. Implications for practice will be discussed throughout the discussion.

5.1 Students descriptions of attitudes towards mental health

In their description of mental health, students describe media as a great influencer of attitudes towards mental health and mental illness. Media has long been recognised as a common source of information regarding mental health and mental illness (Coverdale et al., 2002; Philo et al., 1994; Stuart, 2006; Wahl, 2003), however, previous research has yielded varying results as to the extent and results of media's influence (Francis et al., 2004). Wahl (2003) refer to a survey in which 74% of the respondents cited newspapers as their primary source of information on mental illness. Coverdale et al. (2002, p. 698) asserted that media was "the public's primary source of information on mental illness." Similarly, (Philo, 1997) argued that the media did hold great influence over the public and could elicit strong responses and potentially contribute to the stigma connected to mental illness. As a major source of information, it can be argued that media's presentation of mental health is critical for the layperson's understanding, and as such students. Stuart (2006) claims that opinions and prejudices about people with mental illness exists already before a person has had any contact with mental illness or mental health professionals. Therefore, the accuracy of the information provided by the media can be seen as highly relevant to the public's understanding of mental health.

Media's influence has in this study been described as both positive and negative. For the negative influence, the participants gave examples of how media published articles on extreme cases of violence in connection to mental health, which is consistent with previous research (Coverdale et al., 2002; Wahl, 2003). In general, media has been accused of focusing greatly on negative attributes in relation to mental illness (Coverdale et al., 2002). For example, Wahl (2003) maintained that one of the most supported findings are the media's report of dangerousness and unpredictability in relation to mental illness. Corrigan and Penn (1999) urged the public to protest against media's inaccurate picture of mental health to reduce the public stigma associated with mental health. They further argued that a reduction in harmful media articles could lead to improved attitudes towards mental health. In contrast to the proposition of protesting against media, Wahl (2003) suggested ways in which mental health professionals could cooperate with media to present a more accurate picture of mental health. Some programs already exist in the US where mental health advocates are working to inform media of ways to improve their news coverage (Philo, 1997). However, anti-stigma campaigns should be tested before implemented (Corrigan & Penn, 1999).

In addition to the enhanced negative picture of mental health in media, Wahl (2003) pointed out that positive depiction of mental illness was being left out, meaning that people cannot easily access information that disproves of the currently prevalent stereotypes, thus the stereotypes are instead reinforced (Corrigan & Penn, 1999). As Link and Phelan (2001) wrote, it is an automatic cognitive process. Altogether, there is strong evidence to suggest that media tends to overrepresent negative attributes of people struggling with mental health (Coverdale et al., 2002). The participants, however, suggested that overly negative articles could influence some people, but not all which suggests that the participants themselves may be capable of taking distance from such articles. Similarly, Borinstein (1992) noted that some people thought media reports were not believable. Likewise, Philo (1997) highlighted the notion of the public as people embedded in a social culture and therefore they were not merely passive receivers of knowledge. Corrigan (2004) also suggested that people could be aware of stereotypes without agreeing with them. Whether the public in general are aware of and capable of taking a critical stance towards such information in their day to day life needs to be further investigated.

Considering the awareness of mental health stigma in society, there has been little improvement over the last decades (Mackenzie et al., 2014). Knifton and Quinn (2008, p. 23) explored the evolvement of medias influence on public attitudes, arguing that it has gone

from “direct transmission into a dynamic process involving selective reinforcement of pre-existing bias”. The reference to pre-existing bias can be seen in relation to schemas, and as such it could explain why stigma has consequently been resistant to change in society. If mental health stigma is perceived during upbringing, it may be cognitively developed as a schema (Axelrod, 1973). Schemas are automatically developed to sort information to help understand and make meaning of the world (McVee, Dunsmore, & Gavelek, 2005), however, after being developed, much of the new information received is shaped to fit into already existing cognitive categories (Axelrod, 1973). A category can for example be, ‘people who are mentally ill are violent’. Information that contradict this theory may then be excused as exceptions to the rule or in some cases, accepted as a new schema. It could be that with medias emphasis on negative attributes of those struggling with mental health, the media is potentially reinforcing the negative attitudes associated with mental health as part of existing schemas. Perhaps schemas can explain why mental health education is showing less effectiveness than expected with arguably only short-term results. However more research is needed to understand the intricate relationship between schemas, stigma and mental health help seeking.

The participants also described mental health as taboo in today’s society, and that talking about mental health contributed to the removal of this taboo. Knapp, McDaid, and Mossialos (2006) support the notion of mental health as taboo in society and argues for mental health concern to be included in the public policy debates, thus requesting a greater discussion of mental health in society. Literature suggests that the underlying reason for the taboo surrounding mental health is due to stigmatization in relation to mental health concerns (Coppersmith et al., 2014; Hadlaczky, Hökby, Mkrtchian, Carli, & Wasserman, 2014). The main consequence of stigma is the perception of being flawed and downgraded in society which in turn can lead to discrimination (Corrigan, 2004; Goffman, 1986). These severe consequences of stigma have been argued to be the reason why people hide their mental health concerns and do not seek help (Vogel et al., 2006).

Similarly, the results showed that students described mental health as something private only to be discussed with close relations. Similarly, Borinstein (1992) found mental illness was a topic often treated as private by families and individuals. In this study, one of the reasons it was to be kept private was that it left the person vulnerable and without protection. As one of the participants pointed out, it could be experienced as shameful for a person to admit their need for help. It was further suggested that others knowledge of a person’s mental health

concerns could lead to consequences in social relationships. Vogel, Wade, Wester, Larson, and Hackler (2007, p. 412) refer to the term anticipated risk which can be defined as a person's "perception of the potential dangers of opening up to another person". Self-disclosure therefore becomes a dilemma where a person must choose between the potential winnings of help seeking, and the potential downfall of stigma. Some individuals may find self-disclosing as more threatening than the actual mental health concern (Vogel & Wester, 2003). Corrigan and Rao (2012) highlights the cultural context as important for this evaluation, as stigma is a social product. Through the perception of how others see you as a person, a person's self-concept can be changed (Lucksted & Drapalski, 2015). This can be connected to self-stigma and the internalisation of stigma. Believing that the stigmatised aspects are connected to you as a person can be a reason to avoid self-disclosure and admitting the struggle to others, because if there is no mental health concern, you as a person cannot be identified in relation to mental health stigma (Vogel et al., 2006). Thus, avoiding help seeking be a way to defend against the perceived negative consequences of stigma, as seeking help would be confirming the connection to mental health concerns and public stigma. This makes another conflict of interest with the possible winnings of seeking help on one side and the possible negative social consequences on the other hand (Owen et al., 2012).

The consequences of self-disclosure do not have to be as major as stigma and discrimination, they can be noticed in everyday interactions. Participants described adaptations in communication, small changes in behaviour and creating distance, as possible consequences of learning of other people's mental health concerns. However, they mainly described these changes as adapting to the situation out of concern for the other person. These changes in behaviour could potentially be experienced by the other person as offensive or discriminatory in nature although they are not intentionally meant to be so. If the person with the mental health concern held pre-existing knowledge of public stigma associated with the topic of self-disclosure, it is likely that the changes in behaviour could be interpreted in a negative way.

Altogether, the participants statements suggest that stigma and discrimination are still highly prevalent in today's society. Despite of this, the participants also believe there is a societal change ongoing that is decreasing the current stigma and taboo connected to mental health. Whereas there are various ways in which the media can have a negative influence on the public's attitudes towards mental health, the results also suggested that media can have a positive influence. This positive impact was described in connection to openness about mental health in society. The participants suggested that through medias' focus on mental

health, it became easier for others to talk about mental health in society. More specifically, it was indicated that it was easier for others to open up, and talk about mental health when a few were brave enough to act as examples, stepping up and admitting their struggles in public.

The participants further encouraged people to talk more openly about mental health. In contrast to this, Blåka (2012) found young people to want less openness than older people both in relations with friends, family and colleagues. As a possible explanation for the lack of wanted openness Blåka (2012) suggested that the wish for openness increased with age. However, it could be that there is indeed an ongoing change in society, decreasing the need for secrecy in relation to mental health that can explain the varying results. Whereas the data for Blåka's (2012) report was collected over ten years from 2002-2012, the present data was collected in 2019. In support of the present findings, Knifton and Quinn (2008) referred to a Scottish survey in which public attitudes towards mental health concerns were developing in a positive direction. Schomerus and Angermeyer (2008) also suggested based on surveys from the US, Australia and Germany that attitudes towards mental health were changing. Research on a larger scale is necessary to determine if this is the case in Norway as suggested by the participants of this study.

5.2 Students descriptions of attitudes towards help seeking

Findings showed that the threshold for help seeking from mental health professionals were considered too high by the participants. They wanted anyone to be able to seek help no matter how small or great their mental health concerns were. Interestingly their views of when a person should seek help held similarities with the definition of mental illness (Overton & Medina, 2008). Suggesting that the participants were at some level able to identify when a person needed professional help. Without naming specific details in regard to emotional, cognitive or behavioural concerns, the participants stated that a person should seek help when their everyday life or quality of life was interrupted. Yet, they also suggested that anyone should be able to seek help no matter how small their mental health concern was considered. In relation to this, Leong and Zachar (1999) suggested that people seek help when they believe their life can improve as a result of the help.

Students opinions of when to seek help seems vital in understanding the barriers to help seeking. Especially, since most studies have focused on help seeking behaviour with researchers determining who could have benefited from treatment based on screening surveys

and guidelines such as the DSM-V and the ICD-10 (Cromby et al., 2013; First et al., 2015; Hunt & Eisenberg, 2010). The issues with survey's like these are the likely exclusion of those who could have benefitted from seeing a counsellor or a psychologist who does not meet criteria for mental health illness. Especially considering the fact that in order to prevent mental health concerns from developing further, the person must be able to seek help at an early stage (Johannessen et al., 2001; Sickel et al., 2014).

Moreover, the knowledge of when to seek professional help can be viewed as an issue of knowledge. Gulliver et al. (2010), found failure to recognise the need for mental health treatment as one of the most common barriers to help seeking. In order to seek help, a person must be able to recognise that they have something to gain from such services, thus recognising their state of mental health (Jorm, 2000; Leong & Zachar, 1999; Thompson et al., 2004). Rüsch et al. (2005) argued that there is no clear separation between mental health and mental illness, which can make it difficult for a person to recognise the cause or extent of their mental health concerns. Mackenzie et al. (2014) defined this as a knowledge-based barrier to mental health help seeking. The knowledge-based barrier includes the ability to recognise mental health concerns and knowing how and where to seek help (Mackenzie et al., 2014).

The knowledge-based barrier can also be seen in relation to mental health literacy as described by Jorm (2000). Mental health literacy can be defined as having knowledge about mental disorders that will help a person recognise, prevent or take control of their mental health concerns (Jorm, 2000). It is further argued that mental health literacy is important because friends and family are likely sources of information about mental health (Angermeyer, Matschinger, & Riedel-Heller, 1999; Jorm, 2000), and as previously mentioned, many people rely on unreliable sources like the media as their prime source of information (Coverdale et al., 2002; Philo et al., 1994; Wahl, 2003). On the basis of Ajzen's (Ajzen, 1991) theory of planned behaviour, Angermeyer et al. (1999, p. 203) argue that "normative expectations of the patient's significant others are oriented to the ideas currently prevalent in society." Compared to the general population this is particularly important for young adults as they are highly influenced by their peers (Eigel & Kuhnert, 2016; Rickwood, Deane, & Wilson, 2007). Further, there is evidence to suggest that people do in fact consult their friends and family before turning to professional mental health care (Gourash, 1978; Saunders, 1993), which again underlines the importance of people's attitudes towards mental health. This is in line with the present findings which showed that the participants themselves

were more likely to seek help if the help seeking was recommended by a close relation. Further, it was indicated by one participant that this was due to an inability to perceive one's personal need for professional help. The belief that treatment is not needed and that the mental health concerns will disappear on its own is a common reason for why some people refrain from help seeking (Hom et al., 2015). This can be viewed as a gap in knowledge in relation to the knowledge-based barrier and mental health literacy as discussed above.

Moreover, participants described a desire to help their family, friends or colleagues who struggled with a mental health concern. Their wish to help was restrained by insecurity and a lack of knowledge of how to help which suggests that with greater mental health literacy in the community, people are better equipped at helping each other (Kelly et al., 2007). Since most people struggling with a mental health concern turn to family and friends first, it is important that friends and family can recognise the need for professional help or help the person themselves (Rickwood et al., 2005). As Kelly et al. (2007) pointed out, if mental disorders are recognised and treated early, it may improve the likelihood of a more positive long-term result. Research, however, suggests young adults have serious shortcomings in relation to identifying mental health concerns and mental health literacy (Kelly et al., 2007). Similarly, Jorm et al. (2006) argued that young people lack knowledge about how to respond to a friend's mental health concerns and facilitate appropriate help seeking.

Educating the public about mental health and mental illness has also been proposed by Corrigan (2004) who argued that education could increase positive attitudes towards people with mental health concerns and reduce stigma. Other authors have questioned the usefulness of mental health education in reducing stigma (Jorm et al., 2006; Mackenzie et al., 2014). Jorm et al. (2006) concluded that even though it is well known that stigma is a barrier to help seeking, evidence of how to reduce it is scarce. One of the points made by Jorm et al. (2006) is the finding that mental health care personnel well educated in relation to mental health also held stigmatizing attitudes. On the other hand, Jorm et al. (2006) also suggested that increasing mental health literacy may be able to reduce stigma. In Norway, campaigns aimed at increasing knowledge of mental health seems to have had little impact on stigmatizing attitudes towards people struggling with mental health concerns (Myrvold, 2008).

After years of attempting to reduce stigma and improve attitudes towards mental health help seeking from professionals (Mackenzie et al., 2014), it may be worth investigating the opportunity of using young adults preferred channels of communication to influence people's

ability to help and support mental health help seeking. Expanding young adult's mental health literacy could play into young adults' preferred pattern of dealing with mental health concerns and their wish to help their friends. Kelly et al. (2007) suggested training for younger adults so that they could better help their peers with support and address the need for mental health help seeking. All in all, this may suggest that friends and family are first line of support in many cases and thus, mental health literacy may be highly relevant in helping people achieve understanding, knowledge of how to help and to decide whether the person need professional help.

Taking the importance of mental health literacy into consideration, it makes sense to question what students know about mental health professionals. In this study, students described counsellors as people you could visit for advice about studies, rights and duties. It was further indicated that students considered counsellors as a group of people you could ask for concrete advice on specific questions determined in advance. More importantly, as one of the participants stated, "I didn't know before I entered the room that a counsellor could be a resource for mental health." Further, he noted that he was not aware of a counsellor's area of expertise. These results are strikingly similar to a study in Australia that found a large part of the public believing a counsellor's job was to give people advice (Rogers & Sharpley, 1983 as cited by Sharpley, Bond & Agnew, 2004). Further, those who consulted a counsellor did so seeking vocational advice. A more recent study (Sharpley et al., 2004) found that the public's view of counsellors had increased in accuracy resulting in awareness of counsellors' listening skills, support and ability to facilitate problem-solving. By taking a closer look at this positive development in Australia, it may be possible to use the same strategies to improve awareness towards counselling in Norway.

In relation to psychologists, participants discussed their work roles as administration of drugs and talking therapy. However, psychologists do not by definition administer drugs as those tasks are preserved for psychiatrists. This would suggest the participants lack knowledge about the roles of psychologists in treating mental health concerns. One of the reasons this is particularly concerning is that one of the participants in this study held a negative attitude towards psychologist because of their administration of drugs. Harry said, "…there are so many diagnoses out there that it is easy to just put one on someone to get them on a medicine, then that problem is gone". With this statement the participant was also referring to the labelling effect, and the issue of wrongful diagnosis. However, the point here is that this proposed negative stereotype of psychologists was built mainly on inaccurate information.

McKeddie (2013) also wrote that the public did possess some knowledge, however, he further concluded that vital information and understanding was missing. Similar results were presented by McGuire and Borowy (1979) who found mental health personnel as highly valued by the public, but there was a clear difference in knowledge about the roles and specialisations of the mental health personnel compared to personnel dealing with physical injuries. Even though the participants in McGuire and Borowy's (1979) study were psychology students, they were more aware of the roles of a nurse than of a psychiatrist. The authors further recommended mental health professionals to continuously educate the public about how mental health services are delivered. The knowledge of the training of different mental health professionals has also been shown to be poor (Burns & Rapee, 2006).

Furthermore, in relation to talking therapy, the participants ideas of what a psychologist did can be described as limited to treating "large" issues and thoughts. Some participants mentioned mental disorders like anxiety and depression in relation to psychologists. Although the participants were aware that a person did not have to have a mental illness to seek help, it was implied that for a person to seek help from a psychologist their problems had to be serious. This implies an association between psychologists and mental disorders or serious mental health concerns. McKeddie (2013) found similar results in a survey investigating knowledge and attitudes towards counselling psychologists in 25-34-year old laypeople. Interestingly the statements presented in this study are strikingly similar to those presented here. For example, as presented in the study by McKeddie (2013, p. 113) "Counselling psychologist deals with emotional issues of relationships, everyday conflicts. Clinical psychologist treats issues of mental disorders". While the current study took place in Norway with Norwegian participants, McKeddie's (2013) participants lived in Australia. Burns and Rapee (2006) argued that media do not separate between the types of treatment offered by counsellors and other mental health professional. Possible explanations of these similarities are that the public simply do not know more than the main gist of the mental health services available or they have the same informational sources or lack thereof. As these results seems consistent across borders, a lack of formal sources of information could lead the public highly receptive to media, including movies, social media, songs and other global sources of influence. However, more research is necessary to determine how Norwegian students gain information about mental health services and to what extent their knowledge reaches.

Another important aspect of the results of this study was the participants suggestions that for a person to seek help from a psychologist, their mental health concerns would have to be

serious. This is important for those considering help-seeking as it can potentially lead to delayed or avoidance of mental health services (Blåka, 2012). In terms of stigma, the participants were more likely to jump to conclusions regarding the severity of mental health issues if the person was seeing a psychologist as opposed to a counsellor. Thus, seeking help from a psychologist may lead to unwanted labelling (Corrigan, 2004), meaning a person could be labelled as mentally ill even if the reason for visiting the psychologist was as common as, for example grief. This perception of the severity of mental health concern could play a large part in deciding whether the risk of stigma is greater than the potential benefits of mental health treatment (Vogel & Wester, 2003).

Subsequently, the impression that mental health concerns must be serious to seek help from a psychologist increases the threshold for when to seek help. Considering Mackenzie et al.'s (2014) suggestion that people strive to normalize their symptoms instead of accepting their need for help, this may further increase the threshold for help seeking. As argued by Manthei (2005) people try to 'self-heal' before seeking professional mental health services. Self-heal strategies includes everything from talking to friends and family to meditation and alcohol consumption, and it is likely to at least delay the help-seeking. Seeking professional help is often seen as the final option, only to be considered after everything else has fallen short (Gourash, 1978; Manthei, 2005). Saunders (1993) found that problems usually had to be long-standing for people to seek help, suggesting that they at least have had time to try strategies of self-healing. The consequences of avoiding or delaying mental health treatment for students can influence development and thus carry long-term effects that affect adulthood (Rickwood et al., 2005)

Moreover, early help seeking can prevent further development of mental disorders and decrease risk of suicide (Wilson et al., 2011). As such, it would be beneficial to increase help-seeking and avoid delays. However, it can be argued that delay and efforts of self-healing are natural reactions to mental health concerns. As has already been established, for an individual to seek help, he or she must be aware of and able to identify the need for help (Rickwood et al., 2005). For a person to know that the mental health concerns are not simply a part of the normal fluctuations of mental health, it is natural to wait in case the experienced mental health concerns are short-term. Then, a person might decide that actions need to be taken and resort to self-healing since professional help usually is considered as a last resort (Gourash, 1978; Vogel & Wester, 2003; Vogel et al., 2005). Nevertheless, this cannot explain why some people wait up to 14 years before seeking help (Thompson et al., 2004). Another

explanation offered by Mackenzie et al. (2014) is that people living in Western societies are developing an acceptance or tolerance of distress, and as such they are learning to adapt to the increased distress brought on by the changes in society. However, more research is needed to confirm this.

Whereas the participants described psychologists as more serious, they described counsellors as more accepted because there was no direct line between counsellors and mental health, meaning there was still a chance the person seeking counselling was simply asking for vocational guidance or something unrelated to mental health. Another essential factor to consider, is how this relates to actual help seeking in Norway. Wichstrøm (2009) reported that of those who had received help for their mental health, over half had been to a psychologist while some had visited general practitioners, psychiatrists and so on. However, there is no mention of counsellors, although there is a small group of unspecified treatments. Compared to other countries, some might find this surprising. In Australia for example, 60% of those who seek help with mental health concerns receive counselling, and counselling is established as a fundamental part of mental health treatment (Sharpley et al., 2004). As the results suggests that the threshold for mental health help-seeking from a counsellor is lower than from a psychologist, it may be worth investigating the opportunities of using counsellors more active in mental health treatment. Counsellors could be able to help those struggling with smaller mental health concerns and help decrease the long waiting lists to see a psychologist (Wichstrøm, 2009).

Further, Langaard (2006) emphasises the need for conversational therapy to be accessible for Norwegian youth as an option to drugs. Research has shown that adolescents struggle with various mental health concerns (Langaard, 2006) and there is reason to believe these concerns do not simply disappear as students move from upper secondary school to university. Thus, counselling services could help diminish some of these mental health concerns. Gourash (1978, p. 414) suggest that people who seek help are “usually looking for comfort, reassurance and advice”. To make it easier for people to seek help, Vogel, Wester, and Larson (2007) highly recommended reframing counselling as education, consultation and coaching. More investigation is needed to determine if and how counsellors could help reduce the queue for mental health services and lower the threshold to seek help with mental health concerns. Nonetheless, this study suggests that there is unexplored potential in relation to attitudes towards mental health and counselling.

6 Conclusion

In summary, this article has focused on the following research question: “How does students describe their attitudes towards mental health and help seeking from a counsellor or psychologist?**”** To investigate this question, six students at NTNU in Norway were interviewed about their attitudes towards mental health and mental health professionals. The goal of the interviews was to get an understanding of the participants perspective and experience of mental health and mental health professionals. The findings were then discussed in relation to mental health help seeking, stigma and counselling. In this final chapter, a summary of the findings will be presented in connection with previous findings in relation to attitudes towards mental health and help-seeking. Then, limitations associated with the current study will be laid out and potential areas for future research will be suggested. Finally, my own reflections in relation to the study will be offered.

6.1 Summary

The research in question was interested in how students describe their attitudes towards mental health and help seeking from a counsellor or psychologist? In relation to mental health, students described people experiencing mental health concerns as stigmatized, and that mental health was considered private in today’s society. Furthermore, the participants viewed media as a great influencer of attitudes towards mental health. In contrast, Blåka (2012) and Myrvold’s (2008) reported little stigmatizing attitudes in the society. This may be explained by a change in society as participants of this study described or a difference in perspective. Whereas the previous studies (Blåka, 2012; Myrvold, 2008) used qualitative methods to investigate attitudes towards mental illness in their participants, the current study used qualitative methods. While the quantitative method elicited a more direct response to the question, the participants in the present study may have spoken from two different perspectives, meaning it cannot be concluded whether the participants referred to their personal attitude or their perceptions of existing attitudes in society (perceived stigma). However, the results do indicate that stigma is still present in society or perceived to be present which may have similar effects.

For the question as to when a person should seek help, the participants meant that help should be sought after when the mental health concern was having negative effect or disturbing the person’s everyday life. Regarding the student’s attitudes towards the help seeking threshold, the results showed that students considered the threshold to be too high. Although, in

reference to Blåka's (2012) suggestions, there was no evidence to support the idea that this was due to the fact that people did not take mental health concerns seriously. Furthermore, the students wanted more openness in relation to mental health.

Previous research about attitudes towards mental health professionals have shown that people lack knowledge about the various roles and responsibilities (McGuire & Borowy, 1979). Similar results were found in this study, suggesting that students know very little of the competency and work roles of a counsellor or a psychologist. However, the students did describe the psychologist area of responsibility as working with more severe cases of mental illness and counsellors as working with less severe cases which is consistent with McLeod (2013) and Kvalsund's (2015) descriptions of the field of counselling. What the students did not mention in relation to this, was the counsellor's ability to facilitate growth and development that did not directly involve vocational or work-related advice. Altogether, these results indicate that students lack vital information in relation to mental health literacy. Now that these gaps in knowledge has been pointed out, awareness of such issues could lead to future research and efforts to increase student's mental health literacy. Throughout the next section, I will provide information about the present study's limitations and suggest areas for future research.

6.2 Limitations and suggestions for future research

There were some limitations in this study that must be brought to attention. To begin with, the participants had none or little experience with mental illness and help seeking and as such the information the participants provided were based on their understanding of the subject and their perception of other people's attitudes towards mental health and help seeking. This also means that people who actually perceive themselves as in need of mental health services may have different opinions on the subject, thus the barriers the participants described must be seen as perceived barriers to mental health help seeking. However, the results are a good indication of students' general description of attitudes towards mental health and help seeking which can inform future research and promote awareness.

Future research should aim to investigate students lack of knowledge about mental health and mental health professionals in more detail and explore the possible consequences of the gaps in knowledge. As this study only investigated attitudes of students who had not sought help for mental health concerns, future research should consider the possibility that students who have experience with mental health services may have a different perspective than the

participants of this study. Finally, efforts should be made to further explore the impact of students view of counsellors and psychologists. As results showed that counselling was described as less stigmatizing it may be easier for students with smaller mental health concerns to seek help from a counsellor, and as such there might be potential for counsellors to be utilized as a mental health resource to a greater extent, as it is in some other countries.

6.3 Concluding remarks

Students are at an important point of transition into adulthood during their time at university and important groundwork for the future takes place throughout these years. At the same time, this period of life relates to the highest emergence of mental disorders. Therefore, the goal of this study was to investigate students' attitudes towards mental health and mental health help seeking from a counsellor or psychologist. The results indicated that students have to little knowledge about mental health and that they do not feel comfortable seeking help. This tells me that more resources should be used to improve mental health literacy so that we can better help our friends and our friends can better help us if we are experiencing difficulties in our lives. Going to university can be challenging enough for most students and there is no reason why students should not have all the possible resources available to support them during this challenging period of transition. But for students to benefit from the support available they need to know the support exists, they need to know when they might benefit from seeing someone, and most importantly, they need to feel comfortable seeking out mental health services.

If more people did seek out mental health services, there would be an increased need for mental health personnel. Counsellors graduated from the Master program and NTNU might be a great resource in meeting these demands and take some pressure of study supervisors, as some students today approach their study supervisors about their mental health concerns (Volle, 2016). The counsellor's broad area of expertise and focus on development and growth could potentially help students achieve their full potential during a challenging time.

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Appendixes

Appendix 1: Information sheet

Appendix 2: Informed consent

Appendix 3: Interview guide

Appendix 4: Translation of quotes

Appendix 5: Approval from the NSD

Appendix 1: Information sheet

Informasjonsskriv

For deg som ønsker å delta i forskningsprosjektet: «Hvordan beskriver studenter sine holdninger til psykisk helse og mennesker som søker hjelp fra rådgiver eller psykolog?»

Formålet med dette prosjektet er å utforske hvordan det oppleves av andre når mennesker søker hjelp med deres mentale helse, enten det er fra en psykolog eller en rådgiver. Du vil nå få informasjon om prosjektet og hva det innebærer for deg hvis du velger å delta i dette prosjektet.

DEL A

Bakgrunn og hensikt

Som nevnt ovenfor er formålet med dette prosjektet å utforske hvordan det oppleves av andre når mennesker søker hjelp med deres mentale helse, enten det er fra en psykolog eller en rådgiver. Denne informasjonen vil kunne bidra med å forstå hvorfor vi har stigma og hvordan denne opprettholdes samt gi en bedre forståelse for de eksisterende holdningene i samfunnet i sammenheng med hjelpsøking for mental helse.

For å undersøke dette ønsker jeg å intervjue 3-5 studenter som ikke studerer eller har tett tilknytning til psykologi eller rådgivning. I intervjuet vil det bli stilt spørsmål om hvordan du opplever det når andre mennesker søker hjelp eller ikke søker hjelp med deres mentale helse. I tillegg vil jeg spørre litt om hva du mener om dette temaet og hvordan du tenker hjelpsøking kan påvirke et menneskes hverdag.

Prosjektet er del av en masteroppgave i rådgivningsvitenskap, ved institutt for pedagogikk og livslang læring på NTNU. Veileder for studien er Ottar Ness, professor i rådgivningsvitenskap, NTNU.

Hva innebærer studien?

Dersom du samtykker til å delta i studien vil jeg kontakte deg for å avtale et intervju. Intervjuene vil ta sted i februar og mars 2019. Dette intervjuet vil ta rundt en time å gjennomføre. Intervjuet vil bli tatt opp på bånd og skrevet ut. Din kontaktinformasjon vil ikke bli oppbevart sammen med intervjuet og navn og andre detaljer vil bli endret for å bevare din identitet og anonymitet.

Hva skjer med informasjonen om deg?

Informasjonen du oppgir i sammenheng med studiet vi behandles konfidensielt i samsvar med Personopplysningsloven og Datatilsynets retningslinjer. Dette innebærer blant annet taushetsplikt for forskeren i forhold til alle personopplysninger som oppgis i sammenheng med studiet. Etter prosjektet er avsluttet vil datamateriale bli slettet. Hvis du ønsker å trekke

deg fra studiet, vil din informasjon bli slettet ved forespørsel. Resultatet fra studiet vil bli rapportert i masteroppgaven.

Studien er meldt til Personvernombudet for forskning, NSD – Norsk senter for forskningsdata AS.

Frivillig deltakelse
Deltakelsen i prosjektet er frivillig og du kan trekke deg når som helst uten å oppgi årsak. Hvis du ønsker mer informasjon om prosjektet eller ønsker å trekke deg kan du kontakte:

Masterstudent Kristine Edvardsen
Tlf: 938 33 177
Epost: Krisedva@stud.ntnu.no

Veileder Ottar Ness
Tlf: 415 79 332
Epost: ottar.ness@ntnu.no

DEL B
Oppbevaring av dine personlige opplysninger
Opplysningene du oppgir vil kun bli brukt til formålet oppgitt i dette skrivet. Informasjonen vil bli behandlet konfidensielt i samsvar med personregelverket. Informasjonen du oppgir i intervjuet vil derfor bli behandlet uten navn eller annen informasjon som kan identifisere deg som informant.

Utlevering av materiale og opplysninger til andre

Det er kun undertegnede som har adgang til informasjonen og som kan finne tilbake til deg. Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres.

Utlevering av materiale og opplysninger til andre

Dersom du velger å delta i studien har du rett til innsyn i hvilke opplysninger som er registrert om deg og beholder retten til å korrigere feil i disse opplysningene. Om du velger å trekke deg fra studien har du rett til å få alle innsamlede opplysninger slettet med unntak om de allerede er brukt i analyser eller vitenskapelige publikasjoner. Som deltaker har du også rett til å få informasjon om resultatene av studiet hvis ønskelig.

Kontakt
Ved spørsmål eller andre henvendelser kan du kontakte:
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Dersom du ønsker å delta, vil du bli bedt om å bekrefte dette ved å underskrive samtykkeerklæringen.
Med vennlig hilsen

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Appendix 2: Consent form

Samtykkeerklæring

Jeg har fått informasjon om studien og er villig til å delta i intervju. Jeg bekrefter at jeg:

- ☐ Har lest og forstått informasjonsskrivet.
- ☐ Er informert om at samtalen vil bli tatt opp.
- ☐ Er informert om at min deltakelse er frivillig og at jeg kan trekke meg uten å oppgi årsak.
- ☐ Forstår at min anonymitet er avhengig av at jeg ikke deler min deltakelse i prosjektet med andre.

(Signert av prosjektdeltaker, dato)

Jeg bekrefter å ha gitt informasjon om studien

(Signert, rolle i studien, dato)

Appendix 3: Interview guide

Psykisk helse generelt

- Hva er psykisk helse for deg?
- Snakker du med andre om psykisk helse? Hvem da? Hvorfor ikke?
- Er psykisk helse noe andre snakker om?
- Snakket foreldrene dine om psykisk helse under oppveksten din? Vennene dine?
- Hvordan oppleves det om noen du kjenner snakker om psykisk helse? Hvorfor?
- Opplever du det som positivt å snakke om psykisk helse?
- Opplever du det som negativt å snakke om psykisk helse?
- Hva fører til at noen søker hjelp med psykiske helse?
- Kjenner du noen som oppsøker hjelp for deres psykiske helse? Hvordan opplever du dette?
- Hva betyr det om noen har fått en diagnose på for psykisk lidelse?
- Hva forteller det deg hvis noen du kjenner søker profesjonell hjelp med deres psykiske helse?
- Hva forteller det deres venner? familie?
- Tenker du at det er helt naturlig å søke profesjonell hjelp for alle? Er det noen du tenker det er vanskeligere eller lettere for?
- Hvorfor tenker du at det kan være lett å oppsøke hjelp?
- Hvorfor tenker du at det kan være vanskelig å oppsøke hjelp?
- Endrer en person seg når han/hun mottar hjelp med sin psykiske helse? Hvorfor/Hvordan?
- Hvor går grensen for når en person burde søke hjelp med psykisk helse?
- Tror du at du tenker på psykisk helse annerledes enn de rundt deg?

Venner og familie

- Hva tror du venner tenker om at en person søker hjelp med psykisk helse?
- Hvordan påvirker det forholdet til venner om en person søker hjelp med psykisk helse?
- Vil venner se på det som positivt at personen søker hjelp med psykisk helse? Enn hvis det har påvirket forholdet deres lenge negativt fordi personen ikke har gjort det?
- Er det å søke hjelp en bekreftelse på at personen sliter psykisk?

- Hvordan påvirker det deg hvis du vet at en av vennene dine sliter med psykisk helse? Er du annerledes overfor denne personen? Er noen du kjenner annerledes overfor denne personen?
- Hvordan tror du hjelpsøkingen vil påvirke personens forhold til andre venner?

Studier

- Hvordan tror du det påvirker forholdet til de andre elevene i klassen om det blir kjent at en person søker hjelp med psykisk helse?

I forhold til jobb

- Hvordan tror du det oppleves å gå på jobb når en søker hjelp med psykisk helse?
- Kan det oppleves annerledes å gå på jobb når en søker hjelp fra rådgiver eller psykolog? Hvorfor?
- Hvordan behandler kollegaer en som søker hjelp for psykisk helse?
- Behandler kollegaer en person annerledes om de vet han/hun søker hjelp?
- Kan noen kollegaer velge å ta avstand til en person de vet sliter med psykisk helse?
- Hvordan tror du sjefen behandler den ansatte om den søker hjelp for sin psykiske helse?
- Kan sjefen behandle den ansatte annerledes?
- Tror du kunnskapen om at en ansatt sliter med psykisk helse kan påvirke fremtidige avgjørelser i forhold til den personen? F. eks. Forfremmelser, troverdighet, osv.
- Er det riktig av en sjef/bedrift å ta en persons psykiske helse i betraktning for store avgjørelser?

Rådgiver

- Hva forteller det deg om en person dersom du vet personen søker hjelp fra psykolog? Rådgiver?
- Er det forskjell på å søke hjelp fra psykolog og rådgiver?
- Hva får en person til å oppsøke en rådgiver?
- Hva får en person til å oppsøke en psykolog?
- Behandlers en person annerledes dersom han/hun søker hjelp fra en psykolog enn fra en rådgiver?

Appendix 4: Translation of Quotes

Norwegian	English
Men det er et stort fokus i dag på sosiale media og internett og sånt.	But it is a great focus today on mental health in social media and Internet and such.
Nå blir vi jo påvirket veldig mye av media og sosiale media og det tror jeg kanskje påvirker mye …	We are influenced a lot by media and social media and that I think might influence a lot…
Sånn som sosiale medier har blitt en stor ting og det har blitt veldig mye fokus på psykisk helse rundt det og det kommer mer i media som jo mer vi snakker om det, jo mindre, jo enklere er det å snakke om det for andre da. Så jeg tror det er en sånn generasjonsskifte ting da, at når det er vi som tar over så har ungene våre det veldig lett for å snakke om det igjen.	Like social media has become a big thing and there has been a lot of focus on mental health around it and, it is more in the media the more we talk about it, the smaller, the easier it is to talk about it for others. So, I think it's a kind of a generational change, that when we take over, it is easy for our kids talk about it again.
Men ut ifra media og sånt så er det jo større og større åpenhet om psykisk helse så det tegner jo på at folk blir påvirket til å snakke mer åpent om psykisk helse.	But from the media and such, there is greater and greater openness about mental health, so it does indicate that people are being influenced to talk more openly about mental health".
Det er jo litt mere tatt opp nå i samfunnet og politisk og det er jo noe som, ja statsministeren har jo nevnt det i nyttårstalen at det er. Det er mer aktuelt nå enn det jeg føler at det har vært tidligere når vi var unge og ja, litt før når jeg kanskje hadde behov for det men ikke helt visste at	It is a bit more discussed now in society and politically, and it is something, the Prime Minister mentioned in the New Year's speech. It is more relevant now than I feel it has been earlier when we were young and yes, a little before when I might have needed it but didn't quite know that it was

det fantes eller at der var en utfordring som mange slet med.	there, or that it was a challenge that many struggled with.
Tja det er jo veldig mye oppe i media synes jeg. Det blir jo snakket mye rundt, men jeg tror nok det skulle snakket en del mer om da.	Well, it is very much in the media I think. There is a lot of talk about it, but I think it should be talked more about".
Her i Norge er det ikke så mye sånne ting, men det er jo også, det skjer jo dårlige ting her også og det blir jo satt stort fokus på i media også da.	Here in Norway there are not so much such things, but it also, there are bad things happening here too and that is of great focus in the media too."
Men som man ser veldig ofte i avisene så er det veldig ofte sånne, knivstikkinger, drap også forklares det med psykiske lidelser og det, folk tenker jo på en måte. Hvis det er det som ofte blir presentert av psykiske lidelser i media. Så ja. Vil jeg tro at noen drar de slutningene der. Men absolutt ikke alle, absolutt ikke de fleste.	But as you see very often in the newspapers, it is very often like these, knife stabbings, murder is also explained by mental disorders and it, people think in a way. If that is what is often presented by mental disorders in the media. So yes. I want to think someone pulls conclusions there. But certainly not all, certainly not most.
Nei for jeg har egentlig ikke noe konkret eksempel med det, men det er mer det at det man hører om i mediene kanskje er litt sånn, ja hun hadde slitt med depresjon i fem år og nå valgte hun å ta livet sitt. (p. 7)	No because I do not have a clear example, but it is more that the things one hears about in the media is a bit like, yes, she had struggled with depression for five years and now she chose to kill herself.
Det er tabubelagt men det er noe alle har.	…tabooed, but it is something everyone has.
Det er jo litt synd da, at det, fordi det bidrar jo til tabuet.	It is a bit of shame, because it contributes to the taboo.

Ikke at det skal være en sånn tabubelagt hemmelighet at man gjør, men man burde kunne si til venner, man trenger jo ikke å rope det ut til alle og enhver, men ja, nære venner og familie burde man jo kunne si det.	Not that it should be such a tabooed secret that you do, but one should be able to tell friends, but it is not necessary to shout it to everyone, but yes, close friends and family one should be able to tell
Jeg tror det har vært et tabubelagt emne ganske mange år og det begynner kanskje å nøste litt opp nå.	I think it has been a tabooed topic for many years and maybe it is beginning to clear up now.
Det er et ganske sårt tema enda, men det tror jeg er fordi det har vært litt tabu veldig lenge, men nå tror jeg at det begynner å bli sånn turning point da, at det begynner å gå andre veien.	It is a pretty sore topic still, but I think that's because it's been a bit taboo for a long time, but now I think it is like a turning point, that it is starting to go the other way.
Og at i den eldre generasjonen var det veldig hysj hysj, tabu. Bit det ti deg liksom og bare fortsett.	And in the older generation it was very hush hush, taboo. Kind of just suck it up and continue.
Sin egen mentale helse er jo veldig privat. Det er jo en grunn til hvorfor man ikke snakker så mye om det i media og andre steder.	One's own mental health is very private. There is a reason for why you don't talk about it in the media and other places.
Det, hvert fall i vårt samfunn så tror jeg det er veldig, veldig personlig. Ja psykisk helse. Så det er kanskje noe du bare sier til de aller nærmeste, kanskje ikke det engang. Jeg tror det er mange som ikke sier til familien sin for eksempel at det er noe de sliter med.	It is, at least in our society I think it is very, very personal. Yes, mental health. So, it is something you might only tell those closest to you, perhaps not even that. I believe there are many who does not tell their family, for example, that there is something they struggle with.

Men likevel, jeg skjønner at man ikke vil snakke om sånt fordi det er jo personlig og privat og man er på det aller vondeste kanskje hvis man sliter med alvorlig psykisk helse og eller psykiske problemer.

"…I understand that one does not want to talk about it because it is personal and private, and one is at a most painful place if one is struggling with serious mental health and or mental health issues".

At man, ja den sårbarheten, så man vil ikke at noen skal få vite om det.

That you, yes that vulnerability, so you don't want anyone to know about it

Dem føler seg litt naken da. Litt sånn, nå har jeg ingenting å beskytte meg med for kanskje dem vet.

They feel a bit naked then. A bit like, now I don't have anything to protect myself with for they might know

Ja fordi som sagt så er det veldig personlig så at folk betror det i deg det viser jo at du er en nærme venn og at du er til å stole på da.

Yes because, as I said earlier, it is very personal when people confide in you and it shows that you are a close friend and that you are trustworthy.

Da synes jeg det er veldig sånn tillitserklæring egentlig som venn og synes det er veldig fint at de gjør, at jeg kan bli mer oppmerksom på det.

I think it is very much a vote of confidence really as a friend, and I think it is very nice that they do, that I can become more aware of it.

…det er jo litt situasjonsbetinget men at i noen tilfeller så kan man si, at hvis det er noe dere lurer på så er det greit eller at jeg ville bare si det men har ikke lyst til å snakke mer om det. At det er, det blir ganske ryddig da og at det kan gjøre det for så vidt greit å forholde seg til hvis man kommer med den tilleggsinfoen, jeg har ikke lyst til

…it's a bit situational but, in some cases, you can say that if there is anything you are wondering about then that is okay, or I just wanted to tell you, but I do not want to talk more about it. That it's quite tidy, and it can make it alright to relate to if you add that extra information, I don't want to talk about it. Okay, then you don't do so either, but if

å snakke om det. Okei, da gjør man ikke det eller, men hvis det er noe du lurer på så er det bare å spørre, så er den satt klarer da, den linjen da.

there is anything you're wondering you can just ask, then the line has been made clearer.

Man åpner for at det er noe som skjer og da kan man, vennene mer forholde seg til det også.

One opens up to something happening and then one can, friends can relate to it more too.

Da blir det litt mer vanskelig for det, jeg tror ikke alle vet helt hvordan de skal opptre rundt de når de får vite at de sliter med et eller annet sånn.

Then it becomes more difficult, I don't think everyone knows how to act around them when they learn they struggle with something like that.

Jeg håper ikke at noen tar avstand til det, men det og kan være en reaksjon på det å vite at noen sliter. At man trekker seg litt unna fordi man synes at det er vanskelig, ikke har kunnskap om det, ikke vet hva man skal gjøre.

I hope no one distances themselves from it, but that too can be a reaction to knowing that someone is struggling. That you pull away slightly because you think of it as difficult, do not have knowledge about it and do not know what to do.

Men det er mest fordi at jeg ikke kan sette meg inn i situasjonen selv så jeg vet ikke helt hvordan skal jeg respondere på det.

But it is mostly because I cannot put myself in their situation, so I don't know how to respond to it.

Jeg prøver kanskje i noen tilfeller og liksom overprestere og på den måten å være veldig glad rundt de personene og, og ja prater kanskje litt mer og tenker litt mer over hvordan jeg fremstår når jeg er med venner som sliter kanskje.

In some cases, I might try to overperform and thus be very happy around those people, and, yes talk a bit more and think a bit more about how I appear when I am with friends who struggle.

Til en viss grad, at jeg er kanskje mer inkluderende, mer, litt mer forsiktig hvis det er noe jeg vet at trigger den personen eller som gjør at den føler mer ubehag.

To a certain degree, that I might be more inclusive, a little more careful if there is anything I know to trigger the person or that will cause the person to feel discomfort.

I underbevisstheten så er jeg kanskje litt mer var med ordene mine hvis jeg vet noen sliter med psykisk helse.

In my subconsciousness I might be a little bit more careful with my words if I know someone is struggling with mental health.

Du må kanskje tenke over litt mer hvordan formulerer du deg.

You might have to think a bit more about how you formulate yourself.

At man snakker annerledes? Man gjør kanskje det. Men jeg tror ikke det er bevisst. Det er ikke bevisst for man må jo som sagt se an den dynamikken man har med den man snakker med. Man må jo velge, uansett hvilken situasjon man er i så må man jo velge ordene sine med omhu. Man kan jo ikke bare buse ut med alt uansett. Jeg tenker litt, det er jo samme om det er psykisk lidelse eller ikke, man kan jo ikke bare buse ut. Man må se an situasjonen. Det er rett og slett at kommunikasjonen må lesse hvordan den andre personen har det.

That you talk different? Perhaps you do. But I don’t believe it is conscious. It is not conscious because like I said, you have to look at the dynamics you have with the person you are talking to. You have to choose, no matter which situation you are in, you have to choose your words wisely. You cannot just blurt out. You have to look at the situation. It is simply that communication must fit how the other person are doing.

Jeg tror det er fordi at en situasjon er for, man føler at situasjonen man er i, eller den psykiske helsen man er i, den er for stor til at man klarer å takle det alene eller sammen med venner og familie. Og at det er derfor man trenger litt hjelp utenfra å.

I think it is because the situation is too, you feel the situation you are in, or the mental health you are in, it is too big for you to handle on your own or with friends and family. And that is why you need some help from the outside too.

Når problemene blir litt for stor, når det tar over egen livskvalitet.	When the problems are a bit too big, when it takes over your own quality of life
…visst man synes hverdagen er så vanskelig at man, man sliter på en måte med ja. Selvsagte enkle hverdags ting da, at man ikke kan gå ut av døren, at man synes det er vanskelig å gå på butikken, at man synes det er vanskelig å være med i sosiale sammensetninger, synes ting som kanskje er hyggelig eller bare helt vanlig er vanskelig. At det går utover hverdagskvaliteten da. Så bør man jo oppsøke hjelp.	…if you think everyday life is so difficult that you, you struggle in a way with, yes. Even simple everyday things, that you can't walk out the door, that you find it difficult to walk to the shop, that you find it difficult to take part in social arrangements, find things that maybe are nice or just normal to be difficult. That it disrupts the quality of everyday life. Then you should seek help. "
Og det er jo kanskje litt vanskelig når man selv har det vondt og da erkjenne at man trenger hjelp.	And it might be difficult when you are in pain and then acknowledge that you need help.
Det kan være at for noen andre så er det veldig skambelagt å innrømme for seg selv og for andre at man trenger profesjonell hjelp.	For some it might be very shameful to admit to self and others that they need professional help.
Det tror jeg er 100 prosent fra person til person og jeg tror heller ikke alle skjønner når de burde ha søkt hjelp.	That I think is 100 percent from person to person, and I do not believe everyone understands when they should have sought help.
Man er mer streng mot seg selv enn man er streng mot andre.	You are stricter towards yourself than you are strict towards others.

At terskelen er mye høyere hos seg selv kanskje, fordi man vil ikke innse selv at man sliter litt mer enn normalt.	That the threshold is higher for yourself maybe, because you do not want to realise that you are struggling a bit more than normal.
Det burde egentlig vært en liten terskel for at folk oppsøkte hjelp da. men det er det jo ikke tror jeg.	It really should be a small threshold for people to seek help. But I do not think it is.
Nei altså terskelen burde jo sikkert være mye lavere enn det jeg føler den er nå, hvert fall for egen del.	No, the threshold should probably be lower than I feel it is now, at least for your own sake.
Nei jeg tenker jo sånn som det er nå er grensen for høy da. Det er jo mange som tenker at de kanskje burde ha eller har lyst men tørr ikke på grunn av det jeg sa i stad.	No, I think that the way it is now, the threshold is too high. There are many who thinks that maybe they should have or want to, but do not dare because of what I said earlier.
Men ja som sagt så synes jeg at terskelen blir mye lavere for å kunne gå til profesjonell hjelp da. Og det burde vært knyttet mye mindre skam til det da, så det kunne blitt mye mer naturlig.	But yes as I said, I think the threshold is becoming much lower to seek professional help. And there should be less shame connected to it, then it could be much more natural.
Jeg visste ikke før jeg kom inn her at en rådgiver kan være en ressurs for mental helse.	I didn't know before I entered this room that a counsellor could be a resource for mental health.
Nå vet jeg at du studerer for å bli rådgiver da men jeg vet ikke helt hva en rådgiver gjør for å være helt ærlig da.	Now I know you study to become a counsellor, but I do not absolutely know what a counsellor does to be completely honest.

Automatisk tenker jeg sånn, studievalg. Du kan være usikker på for eksempel hvilke rettigheter du har som arbeidstaker, råd om ja. Mer sånn praktiske formål egentlig ja. Ja. Mere praktiske informasjon av ulike valg og rettigheter og plikter og regler du skal forholde deg til.

Automatically I think like, choices for studying. You can be uncertain for example which rights you have as an employee, advice about. More practical purposes really. More practical information about different choices and rights and duties and rules you have to relate to.

Nei jeg hadde bare tenkt sånn i jobb og studiesammenheng så er det mye usikkerhet rundt valg som skal tas, hva er det beste for meg, hvor er det størst muligheter. At det trenger ikke handle om sånn det indre i deg selv, det er mer deg i forhold til noe annet på et vis.

No, I had just thought like in job and study context there are a lot of uncertainty about choices to be made, what is the best for me, were can I find the best opportunities. That it does not have to be about the inner within yourself, it is more you in relation to something else in a way.

Rådgiver er sånn at man kommer til dem og så får man råd om det også tar man med seg rådet da, mens når man går til psykolog så prøver man liksom å grave frem det som er det underliggende problemet kanskje.

Counsellor is like, you come to them and get advice about it and then you take the advice with you, but when you see a psychologist you kind of try to dig out the underlying problem perhaps.

Nå knytter vi det opp til en coach e greit, en rådgiver e greit, men kanskje ikke greit i den forstand, men psykolog er, da er det plutselig mer alvorlig, veldig mye mer alvorlig.

Now we connect it with a coach and that's okay, a counsellor is okay, but perhaps not okay in that sense, but psychologist is more serious, very much more serious.

Ja og at rådgiver, så er det mer, kan det være mer konkrete råd som ikke nødvendigvis dreier seg om psyke

Yes, and counsellor, then it is more, it can be concrete advice that do not necessarily have to do with psyche really, but with a

egentlig, mens på psykolog så er det med en gang sånn tenke, ja at. Her er det noen svære psykiske tanker, depresjoner, angst, ja.	psychologist it is right away thinking like, yes. Here there are some big psychological thoughts, depression, anxiety, yes.
Det er mye mindre tabu å si at man har vært til en rådgiver. For det trenger ikke å kobles opp kjapt til psykisk helse. At det er karriereveiledning eller altså.	It is a lot less taboo to say that you have been to a counsellor. Because it does not need to be linked instantly to mental health. That it is career guidance or such.
Det virker mye mildere å si at jeg var til rådgiveren i forrige uke enn jeg var til psykologen min.	It seems much milder to say that I went to a counsellor last week than that I went to my psychologist.
Selv om de kan si akkurat det samme. Så føler jeg at, bare ordet har en annen, ja. Tryggere klang da.	Even if they can say the exact same things. I feel that, just the word has a different, yes. Safer sound then.
…og for meg så ligger det veldig langt fra å søke hjelp hos en psykolog. Så jeg vil automatisk tenke at terskelen er høy og derfor er det store problemer det dreier seg om.	…and for me it is far away too seek help from a psychologist. So, I will automatically think that the threshold is high and therefore it is big issues it is about.
Jeg tror at å gå, fordi at en rådgiver er ikke en psykolog og en psykolog da vet du at da høres det skikkelig alvorlig ut. Da høres det ut som at det har blitt en stor greie, mens hos en rådgiver så er det kanskje, terskelen er litt lavere da.	I think that to go, because a counsellor is not a psychologist and a psychologist, then you know that it sounds really serious. Then it sounds like it has become a big thing, but with a counsellor it might be, the threshold is a little lower then.
Det er bare filmkultur, popkultur, alt sånt da. At det liksom er litt sånn trendy, det har	It is just movie culture, pop culture, all such things. That it is sort of trendy, it has been a,

vært en, vært laget mye filmer om det, mye bøker, sanger, musikk og sånne ting da, og fæle hendelser har skjedd så har psykologer blitt fokuset da. Men jeg har i hvert fall ikke hørt noe om en rådgiver som ja. Det er ingen skrekkfilmer med en rådgiver liksom.

been made a lot of movies about it, many books, songs, music and such things, and when terrible incidents have happened psychologists have been in focus. But I have at least not heard about a counsellor that, yes. There are no horror movies with a counsellor sort of.

Jeg vil kanskje tro det er litt lettere å søke opp hjelp hvis du får høre det av folk at du trenger det.

I am inclined to believe it is easier to seek help if you are told by people you need it.

Og sånn, og nei er dette egentlig alvorlig nok til at jeg kan gå til psykolog, men andre som ser situasjonen utenfra bare, ja du burde gå til psykolog liksom.

And like, and no is this really serious enough that I can go to a psychologist, but others who view the situation from the outside just, yes you should go to a psychologist sort of.

…det er så mange diagnoser der ute nå at det er så lett å bare sette en på noen for å få dem på en medisin så er liksom det problemet borte da.

…there are so many diagnoses out there that it is easy to just put one on someone to get them on a medicine, then that problem is gone.

Appendix 5 – Approval from the NSD

NSD Personvern

22.01.2019 15:38

Tilbakemelding på meldeskjema med referansekode 844160:

FORENKLET VURDERING MED VILKÅR
Etter gjennomgang av opplysningene i meldeskjemaet med vedlegg, vurderer vi at prosjektet har lav personvernulempe fordi det ikke behandler særlige kategorier eller personopplysninger om straffedommer og lovovertredelser, eller inkluderer sårbare grupper. Prosjektet har rimelig varighet og er basert på samtykke. Vi gir derfor prosjektet en forenklet vurdering med vilkår.

Du har et selvstendig ansvar for å følge vilkårene og sette deg inn i veiledningen i denne vurderingen.
Dersom du følger vilkårene og prosjektet gjennomføres i tråd med det som er dokumentert i meldeskjemaet vil behandlingen av personopplysninger være i samsvar med personvernlovgivningen.

VILKÅR
Vår vurdering forutsetter:
1. At du gjennomfører prosjektet i tråd med kravene til informert samtykke
2. At du ikke innhenter særlige kategorier eller personopplysninger om straffedommer og lovovertredelser
3. At du følger behandlingsansvarlig institusjon (institusjonen du studerer/forsker ved) sine retningslinjer for datasikkerhet
4. At du laster opp revidert(e) informasjonsskriv på utvalgssiden(e) i meldeskjemaet og trykker «bekreft innsending», slik at du og behandlingsansvarlig institusjon får korrekt dokumentasjon. NSD foretar ikke en ny vurdering av det reviderte informasjonsskrivet.

1. KRAV TIL INFORMERT SAMTYKKE
De registrerte skal få skriftlig og/eller muntlig informasjon om prosjektet og samtykke til deltakelse. Du må påse at informasjonen minst omfatter:
- Prosjektets formål og hva opplysningene skal brukes til
- Hvilken institusjon som er behandlingsansvarlig
- Hvilke opplysninger som innhentes og hvordan opplysningene innhentes
- At det er frivillig å delta og at man kan trekke seg så lenge studien pågår uten at man må oppgi grunn
- Når prosjektet skal avsluttes og hva som skal skje med personopplysningene da: sletting, anonymisering eller videre lagring
- At du/dere behandler opplysninger om den registrerte basert på deres samtykke
- Retten til å be om innsyn, retting, sletting, begrensning og dataportabilitet (kopi)
- Retten til å klage til Datatilsynet
- Kontaktopplysninger til prosjektleder (evt. student og veileder)
- Kontaktopplysninger til institusjonens personvernombud

På nettsidene våre finner du mer informasjon og en veiledende mal for informasjonsskriv:
nsd.uib.no/personvernombud/hjelp/informasjon_samtykke/informere_om.html

Det er ditt ansvar at informasjonen du gir i informasjonsskrivet samstemmer med dokumentasjonen i meldeskjemaet.

2. TYPE OPPLYSNINGER OG VARIGHET
Prosjektet vil behandle alminnelige kategorier av personopplysninger frem til 15.5.2019.

3. FØLG DIN INSTITUSJONS RETNINGSLINJER
NSD legger til grunn at behandlingen oppfyller kravene i personvernforordningen om riktighet (art. 5.1 d), integritet og konfidensialitet (art. 5.1. f) og sikkerhet (art. 32).

Dersom du benytter en databehandler i prosjektet må behandlingen oppfylle kravene til bruk av databehandler, jf. art 28 og 29.

For å forsikre dere om at kravene oppfylles, må dere følge interne retningslinjer og/eller rådføre dere med behandlingsansvarlig institusjon.

NSD SIN VURDERING
NSDs vurdering av lovlig grunnlag, personvernprinsipper og de registrertes rettigheter følger under, men forutsetter at vilkårene nevnt over følges.

LOVLIG GRUNNLAG
Prosjektet vil innhente samtykke fra de registrerte til behandlingen av personopplysninger. Forutsatt at vilkår 1 og 4 følges er det NSD sin vurdering at prosjektet legger opp til et samtykke i samsvar med kravene i art. 4 og 7, ved at det er en frivillig, spesifikk, informert og utvetydig bekreftelse som kan dokumenteres, og som den registrerte kan trekke tilbake. Lovlig grunnlag for behandlingen vil dermed være den registrertes samtykke, jf. personvernforordningen art. 6 nr. 1 bokstav a.

PERSONVERNPRINSIPPER
Forutsatt at vilkår 1 til 4 følges vurderer NSD at den planlagte behandlingen av personopplysninger vil følge prinsippene i personvernforordningen om:

- lovlighet, rettferdighet og åpenhet (art. 5.1 a), ved at de registrerte får tilfredsstillende informasjon om og samtykker til behandlingen
- formålsbegrensning (art. 5.1 b), ved at personopplysninger samles inn for spesifikke, uttrykkelig angitte og berettigede formål, og ikke behandles til nye, uforenlige formål
- dataminimering (art. 5.1 c), ved at det kun behandles opplysninger som er adekvate, relevante og nødvendige for formålet med prosjektet
- lagringsbegrensning (art. 5.1 e), ved at personopplysningene ikke lagres lengre enn nødvendig for å oppfylle formålet

DE REGISTRERTES RETTIGHETER
Så lenge de registrerte kan identifiseres i datamaterialet vil de ha følgende rettigheter: åpenhet (art. 12), informasjon (art. 13), innsyn (art. 15), retting (art. 16), sletting (art. 17), begrensning (art. 18), underretning (art. 19) og dataportabilitet (art. 20).

Forutsatt at informasjonen oppfyller kravene i vilkår 1 vurderer NSD at informasjonen om behandlingen som de registrerte vil motta oppfyller lovens krav til form og innhold, jf. art. 12.1 og art. 13.

Vi minner om at hvis en registrert tar kontakt om sine rettigheter, har behandlingsansvarlig institusjon plikt til å svare innen en måned.

MELD ENDRINGER
Dersom den planlagte behandlingen av personopplysninger endrer seg, kan det være nødvendig å melde dette til NSD ved å oppdatere meldeskjemaet. På våre nettsider informerer vi om hvilke endringer som må meldes. Vent på svar før endringer gjennomføres.

OPPFØLGING AV PROSJEKTET
NSD vil følge opp ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet.

NSD vil følge ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet.

Lykke til med prosjektet!

Tlf. Personverntjenester: 55 58 21 17 (tast 1)

Appendix 6: NTNU guidelines for data storage

Rutine for behandling av data i masterprosjekter ved IPL

Desember 2018

Direkte eller indirekte personidentifiserende informasjon skal behandles fortrolig. Student og veileder har ansvar for at datamaterialet behandles i tråd med retningslinjene, både med hensyn til lagring, tilgangskontroll, håndtering og sletting av data.

Eksempler på datamateriale er lyd, video, bilder, transkripsjoner, data fra spørreskjema.

1. Studentene skal sende **melding til NSD** om prosjektet er meldepliktig.

   I skjemaet til NSD skal det krysses av for *Hvor behandles opplysningene?*

   Fordi studentene ikke jobber på «maskinvare tilhørende behandlingsansvarlig institusjon», må de krysse av for «Privat enhet». Da kommer det opp et varsel fra NSD om at dette ikke er anbefalt med mindre det er avklart med NTNU. Derfor legger vi inn *Tilleggsopplysninger* der vi forklarer hvordan datamaterialet skal behandles.

   Dersom studenten jobber med sensitive personopplysninger (iht. Datatilsynets definisjon), skal studenten jobbe på maskinvare som tilhører NTNU. Dvs. at studenten må låne en NTNU-PC med innlogging.

2. **Lyd- og bildeopptak** skal gjøres på en separat enhet som ikke er koblet til internett. Dvs. at du *ikke* kan bruke telefonen til å gjøre opptak. IPL har opptakere til utlån, ta kontakt med administrasjonen ved IPL.
   a. Opptaket skal så raskt som mulig overføres til sikker lagring, se neste punkt.
   b. Opptaket skal slettes fra minnebrikken så snart det er overført til lagring.

3. Dataene skal lagres på en passordbeskyttet og kryptert måte, enten på studentens hjemmeområde i en kryptert fil eller på en kryptert minnepinne.
   a. **7-Zip** er et arkivering- og komprimeringsprogram som er gratis og som kan brukes for å kryptere filene. Du kan bruke 7-zip på alle datamaskiner. Du trenger ikke registrere deg eller betale for å bruke det.
   b. **Last ned her:** https://www.7-zip.org/download.html
      i. Velg fil fra den øverste tabellen (2018-versjoner). De fleste skal velge **.exe for 64-bit**, men har du en gammel maskin, kan det hende du skal velge 32-bit.

Secure | https://www.7-zip.org/download.html

Home
7z Format
LZMA SDK
Download
FAQ
Support
Links

English
Chinese Simpl.
Chinese Trad.
Esperanto
French

Download

Download 7-Zip 18.05 (2018-04-30) for Windows:

Link	Type	Windows	Description
Download	.exe	32-bit x86	7-Zip for 32-bit Windows
Download	.exe	64-bit x64	7-Zip for 64-bit Windows x64 (Intel 64 or AMD64)
Download	.7z	x86 / x64	7-Zip Extra: standalone console version, 7z DLL, Plugin for Far Manager
Download	.7z	Any	7-Zip Source code
Download	.7z	Any / x86 / x64	LZMA SDK: (C, C++, C#, Java)
Download	.msi	32-bit x86	(alternative MSI installer) 7-Zip for 32-bit Windows
Download	.msi	64-bit x64	(alternative MSI installer) 7-Zip for 64-bit Windows x64 (Intel 64 or AMD64)

c. Hvis du trenger hjelp til å bruke programmet, ta kontakt med Orakeltjenesten.

4. **Kodenøkkel skal lagres separat** og på sikker måte.

5. **Alle data skal slettes ved prosjektslutt** og sluttmelding skal sendes til NSD. Veileder skal informeres om at dette er gjort.