



Testing and Refining a Strategic Marketing Framework for Professional Mental Health Help-Seeking Intention among UK Generation Z Adults

A quantitative SPSS pilot study using empirical evidence obtained in Term 2

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Statement of empirical provenance and originality

The empirical dataset (126 archived survey responses) and the original IBM SPSS Statistics outputs reported in this submission were obtained during Term 2 for the LCDB7010 Converting Research into Practice (CRP) module (Caliendo-Chan, 2026c). No participants were re-contacted, and no responses were recollected for Quantitative Research Methods (QRM) LCDB7011. The present QRM report has been written afresh: its literature synthesis, philosophical justification, methodology, statistical narrative, integrity audit, critical discussion and recommendations are fully paraphrased and materially extended for this module. Reuse is disclosed so that the origin of the empirical evidence is auditable and no part of the dataset is represented as newly collected.

The original Term 2 SPSS tables are retained as the sole source of inferential statistics. Reconciliation with the archived raw response file identified a scoring inconsistency affecting perceived stigma and an inconsistency in exported consent labels. These are reported explicitly and constrain the claims made in this report.

Abstract

Mental-health communication on social media is highly visible, yet visibility is not equivalent to professional help-seeking. This study critically tests an early Strategic Marketing for Mental Health framework among UK-resident Generation Z adults aged 18–29. It reuses, with explicit disclosure, primary evidence obtained in Term 2: 126 complete online survey responses and the associated IBM SPSS Statistics output. The cross-sectional pilot measured social-media exposure, mental-health awareness, perceived stigma, influencer credibility, message authenticity and help-seeking intention. Reliability analysis, Pearson correlations and two multiple regressions were interpreted within a critical-realist ontology and post-positivist epistemology. Exposure and authenticity predicted awareness, $F(3,122) = 35.44$, $p < .001$, $R^2 = .466$; exposure was the stronger predictor ($\beta = .590$), while influencer credibility was non-significant ($\beta = -.014$). Awareness predicted intention in the archived model ($\beta = .389$, $p < .001$), but the stigma path cannot be interpreted. A raw-file reconciliation showed that the stigma regression used a legacy unreversed composite although the methodology specified reverse-coding; the scale was also unreliable ($\alpha = .205$). Further construct contamination limits inference: awareness included an item attributing change to social media, and the intention scale mixed professional and general support. The evidence therefore supports refinement, not validation. A future measurement-first study should separate exposure from message quality, replace the stigma and professional-intention measures, use mandatory consent gates and a more diverse quota sample, and validate the measurement model before structural equation modelling. For practice, authentic, educational and clearly signposted content warrants-controlled testing, but campaign engagement must not be presented as behavioural impact.

Keywords: *Generation Z; social marketing; mental health literacy; help-seeking intention; message authenticity; SPSS*

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1. Introduction

1.1 Context and research problem

Young adulthood is a consequential period for the emergence, recognition and management of mental-health difficulties. Recent UK evidence indicates continuing mental-health need among young adults, while service contact and self-reported symptoms do not move in a simple or uniform pattern across groups (Dykxhoorn et al., 2025; Kelly and Fitzsimons, 2026). For adults who have grown up with networked media, social platforms are an everyday source of stories, explanations, peer norms and service information. This creates a strategic opportunity for charities, universities, employers, public bodies and responsible creators. It also creates risk: inaccurate simplification, performative disclosure, algorithmic repetition and engagement-led design may amplify attention without enabling informed professional support-seeking (Chhabra et al., 2025; Fassi et al., 2025). The managerial question is therefore not whether mental health appears online, but which controllable communication features are associated with outcomes that matter.

Existing campaign research often privileges reach, impressions, likes, shares, knowledge or attitudes. These are useful process indicators but weak substitutes for professional help-seeking intention or behaviour. Reviews report heterogeneous interventions, measures and follow-up periods, with behavioural effects less consistent than awareness effects (Tam et al., 2024; Draganidis et al., 2024; Plackett et al., 2025; Bora et al., 2026). This creates a mechanism gap between strategic marketing choices—message, source, narrative and platform—and psychological processes such as literacy, stigma, perceived norms and control. Without specifying that middle layer, positive engagement can be misread as social impact. The proposed Strategic Marketing for Mental Health (SMMH) programme addresses this gap by treating exposure as communication dose, message and source evaluations as potentially modifiable inputs, and professional help-seeking intention as a bounded proximal outcome rather than proof of service use (Caliendo-Chan, 2026b, 2026d).

1.2 Empirical provenance and purpose of the QRM study

This report uses empirical evidence obtained in Term 2 for the Critical Research Project: an anonymous Google Forms survey and archived SPSS output from 126 UK-resident adults aged 18–29 (Caliendo-Chan, 2026c). The reuse is deliberate and transparent. The task here is

not to present the pilot as new, nor to reproduce its prose. It is to restate the study in an independently written QRM report, interrogate the statistical evidence more rigorously, reconcile it with the raw file, and decide what can and cannot support the refined doctoral framework. That distinction is important because numerical reproducibility does not by itself establish construct validity, ethical adequacy or causal meaning. An exceptional quantitative account must preserve useful signals while treating unreliable measures, coding anomalies and sampling boundaries as evidence about research design.

1.3 Aim, research questions and objectives

The study aims to evaluate whether social-media exposure, influencer credibility and message authenticity are associated with mental-health awareness, and whether awareness and perceived stigma are associated with help-seeking intention among UK Generation Z adults, while determining how measurement and data-quality limitations should reshape the SMMH framework.

Table 1. Research questions and analytical purpose

Research question	Analytical purpose
RQ1. How are exposure, influencer credibility and message authenticity associated with mental-health awareness?	Tests the communication-to-awareness component of the pilot model.
RQ2. How are awareness and perceived stigma associated with help-seeking intention?	Tests the proposed psychological pathway while applying measurement-quality gates.
RQ3. Which statistical findings remain defensible after reliability, scoring and provenance checks?	Separates reproducible estimates from interpretable constructs.
RQ4. How should the evidence refine an ethical, testable SMMH framework?	Translates supported, null and indeterminate findings into research and practice decisions.

Source: author, informed by the pilot and later research-planning portfolio (Caliendo-Chan, 2026c, 2026d).

The corresponding objectives are to critically integrate help-seeking, literacy, stigma and strategic-communication literature; justify a coherent quantitative design and philosophy; evaluate the quality and provenance of the archived data; interpret descriptive, reliability, correlational and regression evidence from SPSS; and derive proportionate recommendations

for a measurement-first doctoral study and ethical campaign testing. The original pilot hypotheses are retained as an audit trail: H1 exposure is positively associated with awareness; H2 influencer credibility is positively associated with awareness; H3 authenticity is positively associated with awareness; H4 credibility is negatively associated with stigma; H5 authenticity is negatively associated with stigma; H6 awareness is positively associated with intention; and H7 stigma is negatively associated with intention. Hypothesis status is conditional on measurement adequacy rather than p-values alone.

1.4 Significance, scope and claim boundary

The paper contributes at three levels. Substantively, it tests an early bridge between strategic communication and professional-support outcomes. Methodologically, it demonstrates why high alpha, model fit or statistical significance cannot compensate for poor construct specification, and why a failed scale is a design result rather than an inconvenience. Practically, it gives decision-makers an evidence hierarchy: authentic and educational communication is promising enough to test, whereas influencer status, stigma reduction and behavioural impact remain unproven. The scope is a small, student-heavy, cross-sectional pilot. It cannot estimate population prevalence, establish temporal sequence, validate a latent model, distinguish platform effects, or demonstrate professional service use. Conclusions are consequently framed as associations and design implications, not causal effects.

2. Critical Literature Review

2.1 Help-seeking as a staged and socially situated process

Help-seeking is not a single binary action. A young adult may recognise distress, search privately, disclose to a peer, evaluate available services, form an intention and only later contact a professional. The barriers identified across youth research include limited symptom recognition, uncertainty about where to go, anticipated judgement, confidentiality concerns, self-reliance, low trust and perceived inaccessibility (Gulliver, Griffiths and Christensen, 2010). This staged view matters for measurement. A positive answer to seeking online information is not equivalent to willingness to contact a GP, NHS psychological service or qualified practitioner; intention is itself distinct from observed behaviour. Recent intervention synthesis reinforces this distinction: studies frequently collapse attitudes, intentions and behaviour even though they occupy different positions in a change pathway (Bora et al.,

2026). A defensible SMMH framework must therefore name the support route and avoid presenting intermediate outcomes as the endpoint.

The Theory of Planned Behaviour (TPB) offers a useful but incomplete organising logic. Intention is shaped by attitudes, subjective norms and perceived behavioural control, so communication could influence whether professional help appears valuable, socially acceptable and feasible (Ajzen, 1991). Yet TPB does not determine which message, or source characteristics create those beliefs, and cross-sectional correlations cannot establish the proposed sequence. Social Cognitive Theory adds observational learning and efficacy: relatable modelling may change perceived norms and capability, while unrealistic influencer narratives may instead create distance or mistrust (Bandura, 1986). These theories support mechanism testing, but neither licenses the assumption that exposure alone produces action.

2.2 Mental-health literacy and stigma: necessary mechanisms, insufficient proxies

Mental-health literacy includes recognition, knowledge of causes and treatments, beliefs that support recognition, and knowledge of how to obtain help (Kutcher, Wei and Coniglio, 2016). Digital interventions can improve literacy and some help-seeking outcomes, but effect sizes and measures vary, and knowledge gains do not reliably become professional contact (Nazari et al., 2023; Yeo et al., 2024). Awareness should therefore be modelled as a mechanism, not success itself. It must also be measured without circularity. If a scale combines general understanding with an item stating that social media increased awareness, regressing it on social-media exposure partly tests shared wording and retrospective attribution rather than an independent literacy construct. Reliability can be acceptable while criterion contamination remains.

Stigma is equally resistant to simplistic operationalisation. Link and Phelan (2001) conceptualise it as an interacting social process of labelling, stereotyping, separation, status loss and discrimination under unequal power. Public stigma, perceived public stigma, self-stigma and anticipated judgement are related but not interchangeable. A three-item score that combines belief that stigma exists, fear of personal judgement and the proposition that social-media discussions reduce stigma lacks a coherent direction unless the intervention item is correctly reverse-scored and the dimensions are theoretically justified. DeVellis (2017) and Churchill (1979) emphasise that internal consistency follows construct definition and item generation; it cannot rescue a concept assembled from heterogeneous statements. In this

study, stigma's theoretical importance makes its measurement failure more consequential, not less.

2.3 Social media: communication environment, exposure and risk

Social media is simultaneously a channel, social setting and algorithmically curated exposure system. Time spent, frequency of seeing mental-health content and reliance on social media for information capture different phenomena. High exposure may increase opportunities to encounter service information, but it may also reflect distress-driven searching, pre-existing interest or platform habits. Adolescent evidence shows that associations between use and mental health differ across people with and without existing conditions, warning against average-effect narratives (Fassi et al., 2025). Policy reviews further emphasise platform design, recommendation systems, safety and content governance rather than locating responsibility solely in individual users (Chhabra et al., 2025). For strategic research, exposure should be treated as dose or context and separated from judgements about message quality.

Campaign evidence shows why that separation is necessary. Systematic and scoping reviews find that social-media campaigns can improve knowledge, awareness or attitudes, while evidence for sustained help-seeking is more limited, heterogeneous and sensitive to outcome definition (Tam et al., 2024; Draganidis et al., 2024; Plackett et al., 2025). Bora et al. (2026) extend this criticism across recent interventions: mechanisms are insufficiently examined and measures are not consistently comparable. These findings do not show that digital communication is ineffective. They show that reach and proximal cognition require explicit links to meaningful outcomes, adequate follow-up and credible counterfactuals. The pilot is accordingly a feasibility and model-refinement exercise, not an impact evaluation.

2.4 Authenticity, source credibility, narrative and platform fit

The Elaboration Likelihood Model differentiates more effortful evaluation of arguments from peripheral cues such as source attractiveness or familiarity (Petty and Cacioppo, 1986). Mental-health communication may engage both routes. Clear explanations, service details and coping information support substantive processing; authenticity, lived experience and source identity shape attention and trust. Authenticity is not merely an informal tone. In this context it concerns perceived honesty, transparency, congruence and non-performative disclosure. It may make information more believable, but emotionally compelling storytelling

can also oversimplify recovery, normalise unqualified advice or expose creators and audiences to harm. Ethical authenticity therefore requires accuracy, boundaries and signposting, not simply intimacy.

Influencer evidence is similarly conditional. Reviews suggest that influencers can affect health attitudes and behaviours, yet credibility depends on expertise, trustworthiness, relatability, commercial disclosure, audience identification and message context (Powell and Pring, 2024; Kaňková, Binder and Matthes, 2025). A composite that mixes trust, ease of understanding and attention may conceal these dimensions. Once authenticity is controlled, a generic influencer coefficient could become non-significant because source status adds little, because predictors overlap, or because the measure is imprecise. None of those explanations justifies concluding that sources do not matter. The appropriate response is constructing refinement: distinguish professional expertise, lived-experience credibility and parasocial relatability, then test their incremental value.

Narrative framing and platform-message fit were not directly measured in the pilot but emerge from the literature and the Term 3 research-planning portfolio as missing controllable inputs (Caliendo-Chan, 2026d). A personal recovery story, an educational carousel and an urgent service-signposting video invite different cognitive and emotional responses. Their effects may depend on format, disclosure, moderation and platform norms. Treating all content as a single exposure variable erases this strategic variation. The final SMMH model should therefore place exposure outside the quality block and examine authenticity, source credibility, narrative framing and platform-message alignment as distinct predictors.

2.5 Social marketing and an integrated mechanism model

Social marketing provides the normative foundation because the purpose is voluntary behaviour that benefits individuals and society, not commercial conversion (Kotler and Zaltman, 1971; Grier and Bryant, 2005). Its exchange perspective asks what benefits and costs the audience experiences: reassurance, knowledge and access may be exchanged against time, vulnerability, fear of judgement and anticipated service barriers. This lens prevents a communication-only solution from ignoring service capacity. Encouraging demand without accessible routes, safeguarding or crisis escalation can be unethical. Campaign design must therefore align truthful messaging, credible sources and clear action pathways with the availability of support.

Table 2. Theoretical integration and pilot operationalisation

Theoretical lens	Mechanism relevant to SMMH	Pilot implication and limitation
Social marketing	Value exchange, audience orientation and social benefit	Frames professional support-seeking as the desired outcome, but service access was not measured.
Elaboration Likelihood Model	Argument quality and source cues shape persuasion	Supports authenticity and credibility; pilot items did not separate expertise, trust and attention.
Social Cognitive Theory	Modelling, norms and self-efficacy	Explains lived-experience content, but norms and control were absent from the pilot.
Theory of Planned Behaviour	Attitudes, norms and control inform intention	Justifies intention as proximal outcome; the scale mixed professional and general support.
Mental-health literacy and stigma	Recognition, navigation and social barriers	Awareness was promising but contaminated; stigma failed reliability and scoring gates.

Source: author synthesis from Ajzen (1991), Bandura (1986), Kotler and Zaltman (1971), Petty and Cacioppo (1986), Kutcher, Wei and Coniglio (2016) and Link and Phelan (2001).

2.6 Research gap and pilot model

The literature gap is not a lack of studies showing that young people see mental-health content. It is the limited UK Generation Z-specific evidence connecting modifiable communication characteristics to clearly defined professional-intention outcomes through validated mechanisms. The pilot addressed a reduced version of that problem: exposure, influencer credibility and authenticity predicted awareness; awareness and stigma predicted a broad help-seeking-intention score. Its value is diagnostic. It can reveal whether item's function, whether associations are present and which assumptions fail. It cannot validate the final SMMH framework because narrative framing, platform fit, norms and control were absent, the sample was non-probability, and key constructs were inadequately specified. The current report therefore treats pilot results as provisional evidence feeding a revised model rather than forcing the mature theory to fit the initial questionnaire.

2.7 Quality of the evidence base and unresolved tensions

The prior Critical Literature Review used a PRISMA-informed process to make searching and selection traceable, while the present chapter critically updates and reinterprets that evidence rather than claiming a new systematic review (Page et al., 2021; Caliendo-Chan, 2026b). Its strongest sources are systematic or scoping reviews, established theories and peer-reviewed measurement guidance. Even this hierarchy has limits. Campaign reviews inherit the weak outcome definitions, short follow-up and intervention heterogeneity of their primary studies; influencer reviews span products, populations and platforms that are not equivalent to UK professional mental-health help-seeking; and adolescent findings cannot be transferred uncritically to adults aged 18–29. Convergence across reviews strengthens the conclusion that knowledge outcomes are easier to move than behaviour, but it does not identify one universally effective message strategy.

Three tensions remain open. First, personal stories may increase relatability and normalise disclosure while also encouraging social comparison, oversimplification or unqualified advice. Second, source expertise may improve accuracy but feel less relatable than lived experience; a single credibility score cannot decide that trade-off. Third, increasing intention may expose a service-capacity constraint: successful communication without accessible care can produce frustration or harm. These tensions justify interaction and boundary-condition hypotheses in the final programme, but not exploratory data-mining in this pilot. They also strengthen the practical requirement to evaluate message, source and service pathway together rather than treating communication as an isolated intervention.

3. Methodology

3.1 Research design and evidence reuse

The empirical design was deductive, quantitative and cross-sectional. A self-administered online questionnaire captured exposure, perceptions and intentions at one point in time, enabling reliability assessment, bivariate association and multivariable prediction. This design is proportionate for a pilot because it tests feasibility and early construct behaviour economically, but it offers weak temporal and causal identification. The report reuses the exact dataset and original SPSS output obtained in Term 2 (Caliendo-Chan, 2026c). No new data were generated. All inferential values reproduced below are taken from the archived IBM SPSS Statistics tables; the software version was not preserved in the prior report, which

is itself a reproducibility limitation. The present work adds an independently written methodological account, a raw-file provenance reconciliation and a more conservative interpretation.

3.2 Ontology, epistemology and axiology

The ontological position is critical realist. Communication encounters, mental-health knowledge, stigma and help-seeking processes are treated as real, while the mechanisms connecting them are partly unobservable, context-dependent and mediated by social structures. Survey items are fallible indicators, not the constructs themselves. This stance is visible in the refusal to equate an internally consistent score with a valid social reality. It also explains why the same message may operate differently by prior experience, identity, platform or service access (Saunders, Lewis and Thornhill, 2023; Caliendo-Chan, 2026a).

The epistemology is post-positivist and fallibilist. Theory generates testable expectations, and quantitative estimates can challenge them, but findings remain probabilistic, measurement-error prone and bounded by design. A p-value is evidence against a statistical null under model assumptions; it is not proof of a mechanism or practical importance. This supports deductive regression while requiring uncertainty, null findings and anomalies to be reported rather than rationalised after the fact. Axiologically, the work prioritises youth wellbeing, non-stigmatising language, minimal disclosure and truthful communication. Marketing effectiveness is subordinate to avoiding harm and ensuring that calls to action connect to appropriate support. The researcher's interest in a workable SMMH framework is acknowledged as a potential source of confirmation bias; pre-specified hypotheses and explicit decision gates are used to counter it.

3.3 Population, recruitment and sample

The target population was UK-resident Generation Z adults aged 18–29. Adults were selected to keep the digital-native focus while avoiding the additional consent and safeguarding requirements of research with minors. Participants were recruited online through convenience and purposive dissemination across the researcher's accessible networks. Eligibility required the stated age range and current UK residence. The resulting 126 cases are adequate for identifying gross instrument and analysis problems in a pilot, but not for representative prevalence estimates or a complex latent-variable model. Pilot sample size should be justified by the decisions it supports rather than mistaken for a reduced confirmatory trial (Ying et al.,

2025). The absence of a probability frame and the dominance of students limit external validity.

3.4 Instrument and construct operationalisation

The questionnaire contained demographic screening, 18 five-point Likert items (1 = strongly disagree; 5 = strongly agree) and one optional open-text question. Three items were averaged for each construct. Q13 was intended to be reverse-coded as 6 – Q13 so that higher stigma scores indicated more stigma. Scale development principles require theoretical breadth, clear direction, item review and evidence of dimensionality before composite use (Churchill, 1979; DeVellis, 2017). The pilot relied on short researcher-developed measures, so Cronbach's alpha was treated as an initial consistency check rather than proof of content, convergent or discriminant validity.

Table 3. Pilot constructs, items and pre-analysis risks

Construct	Items	Meaning intended	Primary validity risk
Social-media exposure	Q5–Q7	Daily use, mental-health-content frequency and information reliance	Combines general use, topic exposure and reliance.
Mental-health awareness	Q8–Q10	Issue understanding, support knowledge and perceived social-media contribution	Q10 overlaps with the exposure predictor and may inflate association.
Perceived stigma	Q11–Q13	Public stigma, anticipated judgement and stigma reduction	Mixed dimensions; Q13 direction and composite scoring inconsistent.
Influencer credibility	Q14–Q16	Trust, clarity and attention	Conflates credibility with message comprehension and attention.
Message authenticity	Q17–Q19	Genuineness, believability and trust	Includes preference for personal stories; not independently validated.
Help-seeking intention	Q20–Q22	Professional help, encouragement and openness to support	Only Q20 specifies professional help; outcome mixes routes.

Source: author audit of the Term 2 survey instrument (Caliendo-Chan, 2026c).

3.5 Data collection, ethics and governance

Google Forms was used for anonymous data collection. The participant information stated that participation was voluntary, respondents could stop at any time, no personal or clinical information would be collected, and data would be used only for academic research. The form limited eligibility to adults aged 18–29 living in the UK. These choices reduced disclosure and re-identification risk, consistent with proportionate internet-based mental-health research (Murray et al., 2016; Smith, Thew and Graham, 2018). Because no direct identifiers were collected, withdrawal after anonymous submission could not reliably be implemented; this limitation should be stated before participation. Future surveys should add non-intrusive distress language, NHS and crisis signposting, retention periods and a data-controller contact.

The provenance audit found three consent-label combinations in the export: 112 records contained both agreement and eligibility confirmation, seven recorded agreements only, and seven recorded eligibility confirmation only. Every case separately answered that they lived in the UK and selected an eligible age band, and the opening information stated that continuing indicated agreement. The original Term 2 SPSS analysis retained all 126 records. Nevertheless, the checkbox design did not produce a uniform, auditable consent record. This report therefore does not conceal the issue or reinterpret it as ideal practice. The final study must use separate mandatory yes/no gates for informed consent and eligibility, route any negative response out of the form, time-stamp the approved information version and exclude records without explicit agreement before analysis.

3.6 SPSS analysis strategy

The Term 2 analysis used IBM SPSS Statistics to calculate frequencies, means, standard deviations, Cronbach's alpha, Pearson correlations and ordinary least-squares multiple regressions. Model 1 regressed help-seeking intention on awareness and the legacy stigma composite. Model 2 regressed awareness on exposure, influencer credibility and authenticity. Tests were two-tailed with $\alpha = .05$. Effect interpretation considered direction, standardised coefficients, R^2 and theoretical coherence rather than statistical significance alone. The archived coefficient tables included tolerance and variance-inflation factors: Model 1 VIFs were 1.241; Model 2 VIFs ranged from 1.171 to 1.505. These values do not suggest problematic linear collinearity, although they cannot establish discriminant validity between latent constructs.

The archive did not preserve residual histograms, P–P plots, influence diagnostics, Durbin–Watson statistics, confidence intervals or a written missing-data protocol. Consequently, homoscedasticity, residual normality, independence and influential-case assumptions cannot be claimed as demonstrated. Pearson and regression results are reported as provisional. No mediation, moderation, group comparison, factor analysis or causal modelling was attempted; the sample and instrument did not warrant them. For a publishable confirmatory study, data screening and assumptions must be pre-specified and archived, estimates should include confidence intervals, and the measurement model must be acceptable before structural paths are interpreted (Anderson and Gerbing, 1988; Kline, 2016).

3.7 Reliability, validity, bias and decision rules

Alpha near or above .70 was treated as an initial reliability signal, but item number, redundancy and construct breadth were considered. Convergent and discriminant validity were not tested, so apparently reliable composites remain provisional. The design is exposed to selection bias, non-response bias, social-desirability bias, recall error and common-method variance because predictor and outcome self-reports were collected in one survey at one time (Podsakoff et al., 2003). Procedural separation, reverse wording, source variation or marker-variable strategies were absent. The hypothesis decision rule was therefore hierarchical: first verify scoring and provenance; second require minimally coherent measurement; third interpret effect size and uncertainty; only then assign support. A statistically significant coefficient attached to a contaminated outcome was not allowed to override a failed measurement gate.

Reconciliation exposed the study’s most consequential anomaly. The SPSS reliability result of $\alpha = .205$ corresponds to the intended reverse-coded stigma items, but the reported stigma mean (3.33), correlation pattern and Model 1 coefficient reproduce the raw, unreversed Q13 composite. Thus, the archive contains a disconnect between reliability scoring and inferential scoring. Both versions are conceptually weak, and the inferential version does not follow the stated coding rule. All stigma correlations, its regression coefficient and hypotheses H4, H5 and H7 are therefore classified as non-interpretable. This is not a cosmetic correction: it changes the conclusion from “stigma was not significant” to “the study did not validly test the stigma pathway.”

3.8 Analytical alternatives and proportionality

The brief permits techniques such as t-tests and ANOVA, but method choice should follow the question rather than maximise the number of procedures. The primary hypotheses concerned relationships among continuous composite scores, so Pearson correlation and multiple regression were more direct than testing arbitrary demographic mean differences. Adding underpowered subgroup comparisons would increase researcher degrees of freedom and familywise error without answering the model’s central questions. Equally, mediation or structural equation modelling would be disproportionate: three-item researcher-developed scales, a failed stigma measure and $n = 126$ do not support confident latent-path interpretation. The two regressions therefore represent a deliberately limited analysis, while the absence of archived residual diagnostics reduces their evidential grade. In the final study, analysis should be specified before data inspection, distinguish primary from exploratory tests, report confidence intervals and sensitivity analyses, and document how missingness, influential cases and non-normality are handled. Statistical complexity should be earned by measurement quality and design, not used to disguise their absence.

4. Data Analysis and Findings

4.1 Data screening and participant profile

The archived raw file contained 126 response rows. All respondents selected UK residence and an eligible age band. The 18 Likert items were complete, the optional Q23 produced 82 non-blank answers, and no exact duplicate response pattern was identified when timestamps were ignored. SPSS reliability tables showed 126 valid cases and two excluded blank/import rows from a 128-row working file; the analytical N was consistently 126. The absence of item missingness simplifies composite calculation but may reflect required-response settings rather than respondent engagement. No response-time or attention-check data were available.

Table 4. Sample characteristics (n = 126)

Characteristic	Category	n	%
Age	18–20	14	11.1
	21–23	72	57.1
	24–26	21	16.7
	27–29	19	15.1

Characteristic	Category	n	%
Gender	Female	82	65.1
	Male	40	31.7
	Non-binary	2	1.6
	Prefer not to say	1	0.8
	Missing	1	0.8
Current situation	University/college student	85	67.5
	Working full-time	22	17.5
	Working part-time	11	8.7
	Other	8	6.3

Source: archived Term 2 Google Forms dataset; percentages may not total 100 because of rounding.

The profile is concentrated rather than balanced: 57.1% were aged 21–23, 65.1% identified as female and 67.5% were students. These distributions are analytically relevant because campus networks, mental-health literacy, service awareness and platform practices may differ from those of employed or older members of the target population. The regressions estimate within-sample associations; they should not be described as representative of UK Gen Z.

4.2 Descriptive statistics and reliability

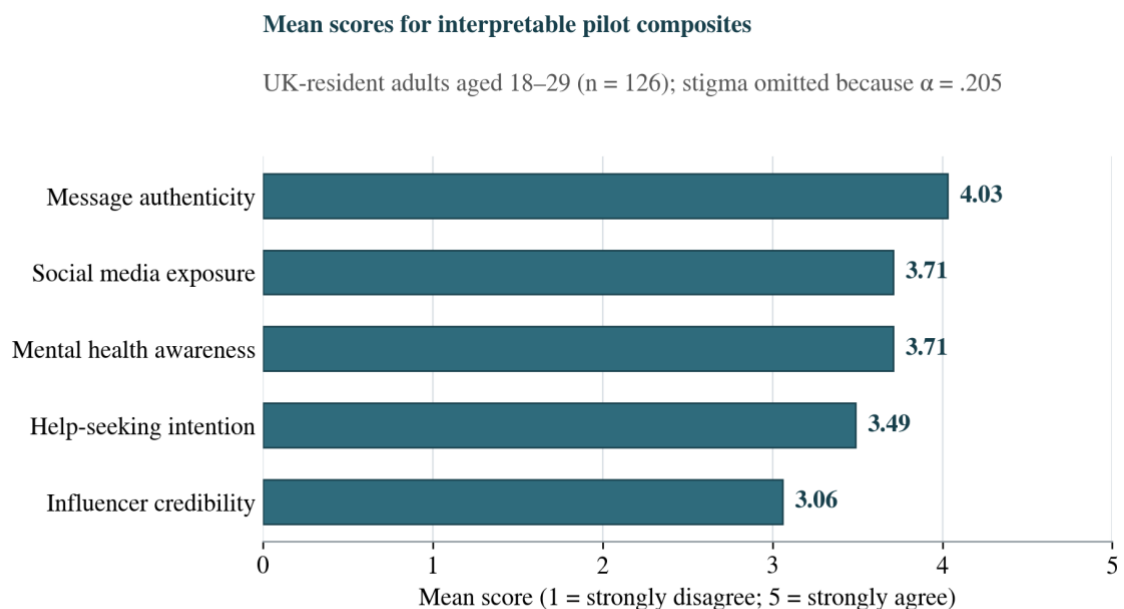
Table 5. Composite descriptives and internal consistency

Composite	Mean	SD	Cronbach's α	Decision
Social-media exposure	3.71	0.97	.724	Retain provisionally
Mental-health awareness	3.71	1.04	.791	Reliable but construct-contaminated
Perceived stigma	3.33	0.80	.205	Reject for inference
Influencer credibility	3.06	0.89	.804	Reliable but multidimensional wording
Message authenticity	4.03	0.92	.843	Retain provisionally
Help-seeking intention	3.49	1.07	.846	Reliable but outcome route mixed

Source: archived Term 2 SPSS output (Caliendo-Chan, 2026c). Legacy stigma descriptive based on the unreversed composite and not substantively interpretable.

Authenticity had the highest interpretable mean ($M = 4.03$), suggesting broad endorsement of genuine, honest or personal communication. Exposure and awareness both averaged 3.71, while intention averaged 3.49 and influencer credibility 3.06. These are response tendencies, not effect estimates. The figure omits stigma because a bar would lend visual legitimacy to an invalid composite. Five scales met the preliminary alpha criterion, but their wording still limits content validity. In particular, a high alpha for help-seeking intention does not show that professional, peer-influenced and general support intentions form the same theoretically precise outcome.

Figure 1. Mean scores for interpretable pilot composites



Source: archived Term 2 SPSS descriptive output (Caliendo-Chan, 2026c).

4.3 Correlation analysis

The SPSS matrix showed that all reported correlations using the legacy stigma composite were positive and statistically significant at $p < .01$. Among interpretable pairs, exposure and awareness were strongly associated ($r = .658$), authenticity and intention showed the largest bivariate relationship ($r = .600$), and influencer credibility correlated with authenticity ($r = .540$) and intention ($r = .493$). Awareness and intention were moderately related ($r = .464$). These coefficients show covariance, not sequence. The exposure–awareness association is

especially vulnerable to shared referent wording because Q10 states that social media increased awareness.

Table 6. Pearson correlation matrix from archived SPSS output

Variable	1	2	3	4	5	6
1 Exposure	1					
2 Awareness	.658	1				
3 Legacy stigma	.467	.441	1			
4 Influencer credibility	.300	.271	.277	1		
5 Authenticity	.361	.406	.449	.540	1	
6 Help-seeking intention	.375	.464	.342	.493	.600	1

Source: archived Term 2 SPSS output. $N = 126$; $p < .01$ (two-tailed). Legacy stigma used unreversed Q13 and is not interpretable.

The large authenticity–intention correlation is strategically interesting but was not tested as a direct effect in the archived regressions. It may reflect genuine persuasion, shared positive response style, conceptual overlap or a third variable. Similarly, credibility’s positive zero-order relationships do not contradict its null coefficient for awareness: the regression asks whether credibility explains incremental variance after exposure and authenticity are controlled. This distinction between association and unique prediction is essential to avoid cherry-picking the strongest bivariate result.

4.4 Regression models

Model 2 is the cleaner test of the communication-to-awareness hypotheses. The three predictors explained 46.6% of awareness variance, $F(3,122) = 35.435$, $p < .001$, adjusted $R^2 = .452$. Exposure made the largest unique contribution ($B = .636$, $\beta = .590$, $p < .001$) and authenticity made a smaller positive contribution ($B = .227$, $\beta = .200$, $p = .015$). Influencer credibility added no unique explanatory value ($B = -.016$, $\beta = -.014$, $p = .864$). VIFs of 1.171–1.505 reduce concern about severe linear multicollinearity, but they do not resolve construct overlap or common-method bias.

Table 7. SPSS multiple regression predicting mental-health awareness

Predictor	B	SE	β	t	p	VIF
Constant	.483	.358	—	1.347	.180	—

Predictor	B	SE	β	t	p	VIF
Social-media exposure	.636	.077	.590	8.235	< .001	1.171
Influencer credibility	-.016	.093	-.014	-.172	.864	1.438
Message authenticity	.227	.092	.200	2.466	.015	1.505

Dependent variable: mental-health awareness. N = 126; R² = .466; adjusted R² = .452; F(3,122) = 35.435, p < .001. Source: archived Term 2 SPSS output.

The archived Model 1 explained 23.9% of intention variance, F(2,123) = 19.302, p < .001, adjusted R² = .227. Awareness was a positive predictor (B = .399, β = .389, p < .001). The legacy stigma coefficient was positive and narrowly missed the conventional threshold (B = .231, β = .171, p = .053), contrary to H7. That coefficient is not evidence for or against stigma because the composite used in the regression did not implement the declared reversal and the intended scale had α = .205. Awareness's coefficient is reproduced for transparency but remains conditional on a model containing an invalid covariate and on the contaminated awareness and intention measures.

Table 8. Historical SPSS multiple regression predicting help-seeking intention

Predictor	B	SE	β	t	p	VIF	Interpretation
Constant	1.235	.398	—	3.108	.002	—	Intercept only
Mental-health awareness	.399	.090	.389	4.435	< .001	1.241	Provisional positive association
Legacy stigma composite	.231	.118	.171	1.953	.053	1.241	Non-interpretable

Dependent variable: help-seeking intention. N = 126; R² = .239; adjusted R² = .227; F(2,123) = 19.302, p < .001. Scoring inconsistency and α = .205 invalidate stigma inference. Source: archived Term 2 SPSS output.

4.5 Open-text contextual evidence

Eighty-two participants answered the optional question about helpful mental-health content. The Term 2 descriptive coding grouped responses into personal or lived-experience stories, educational explanations, practical coping strategies, authentic or relatable delivery, service signposting or expert guidance, motivational content, and unclear or sceptical responses (Caliendo-Chan, 2026c). These comments are not a formally sampled qualitative study, and

no inter-coder reliability was established. They are used only to contextualise the quantitative pattern. Their emphasis on genuine stories, understandable information, practical tools and routes to support is consistent with authenticity and literacy mechanisms, while the sceptical responses caution against assuming universal receptivity.

4.6 Hypothesis decisions

Table 9. Measurement-gated hypothesis outcomes

Hypothesis	Statistical evidence	Decision	Reasoned claim
H1 Exposure → awareness (+)	$\beta = .590, p < .001$	Provisionally supported	Strong association, but Q10 shared the social-media referent.
H2 Credibility → awareness (+)	$\beta = -.014, p = .864$	Not supported	No incremental prediction; measurement may be too broad.
H3 Authenticity → awareness (+)	$\beta = .200, p = .015$	Provisionally supported	Smaller unique association; causal direction untested.
H4 Credibility → stigma (-)	No valid model	Indeterminate	Stigma failed reliability and scoring gates.
H5 Authenticity → stigma (-)	No valid model	Indeterminate	Stigma failed reliability and scoring gates.
H6 Awareness → intention (+)	$\beta = .389, p < .001$	Provisionally supported	Positive association; both composites require refinement.
H7 Stigma → intention (-)	Legacy $\beta = .171, p = .053$	Not validly tested	Direction, reliability and scoring were inconsistent.

Source: author interpretation of archived Term 2 SPSS output after measurement and scoring audit.

5. Discussion

5.1 Answers to the research questions

RQ1 is answered with qualified evidence: exposure and authenticity were associated with awareness, whereas influencer credibility supplied no incremental prediction. RQ2 is only partly answerable. Awareness was positively associated with the broad intention composite, but stigma was not validly tested. RQ3 changes the evidential status of several results: five scales were internally consistent, yet shared wording and mixed outcome routes constrain

validity; the stigma pathway fails both reliability and scoring checks. RQ4 therefore yields a refinement decision rather than a validated framework. Exposure remains contextual dose; authenticity remains a candidate message-quality predictor; source credibility should be decomposed; mental-health literacy should replace vague awareness; and professional intention needs route-specific measurement.

5.2 Exposure and authenticity: promising signals with different meanings

Exposure's standardised coefficient was almost three times authenticities in Model 2. A superficial reading would prioritise media frequency. That conclusion would be premature. The awareness outcome included "social media has increased my awareness," so predictor and criterion share the channel referent. Exposure also combines daily social use, frequency of mental-health content and reliance on social media for information. The coefficient may represent opportunity to learn, prior interest, common wording or self-perceived media influence. Recent reviews similarly warn that generic social-media use obscures platform and content differences (Chhabra et al., 2025; Fassi et al., 2025). The final model should measure mental-health-content dose separately and use a channel-neutral literacy scale.

Authenticity is more actionable as a message feature. Its positive unique association with awareness and its strong bivariate relationship with intention align with participants' preference for honest lived experience and with persuasion theory. Yet the result does not establish a direct or mediated effect: authenticity was not entered in the intention regression, temporal order is unknown, and positive evaluations may share response style. Ethical translation should focus on testable design principles—transparent authorship, accurate personal narratives, clear limits and professional signposting—rather than the claim that "authentic posts cause help-seeking." This is consistent with campaign reviews that find awareness effects more robust than behavioural effects (Draganidis et al., 2024; Plackett et al., 2025).

5.3 Why the credibility null should refine, not erase, the source construct

Influencer credibility correlated with intention and authenticity but became negligible when predicting awareness with the other communication variables. This is a meaningful null finding. It indicates that the pilot's generic credibility score did not explain unique awareness variance, so influencer status should not receive investment merely because it attracts attention. However, the items conflate trust, comprehension and attention, and the sample

may evaluate clinicians, lived-experience creators and commercial influencers differently. Reviews treat expertise, trustworthiness, relatability and disclosure as conditional dimensions (Powell and Pring, 2024; Kaňková, Binder and Matthes, 2025). The final study should compare source types and test incremental validity; it should not remove credibility before measuring it coherently.

5.4 Awareness, literacy and the intention boundary

The positive awareness–intention coefficient is consistent with literacy as an enabling mechanism: recognising difficulties and knowing where support exists can make action more thinkable (Kutcher, Wei and Coniglio, 2016; Nazari et al., 2023). It is not sufficient evidence of mediation, because the pilot did not estimate an indirect effect and all variables were simultaneous. Moreover, “awareness” combines issue understanding, service knowledge and retrospective media influence. The future construct should be mental-health literacy with validated subdimensions, while perceived norms and behavioural control should be considered because knowledge can coexist with fear, cost, waiting times or low confidence.

The dependent variable also needs repair. Q20 is explicitly professional, whereas Q21 refers to being encouraged to seek help and Q22 to openness to getting support. High alpha may reflect a general positive orientation rather than a unidimensional professional-intention construct. Online peer support may complement professional care, but it is a different route with different benefits, safeguards and evidence (Yuan et al., 2026). The final study should define professional intention as willingness to contact a GP, NHS psychological service or qualified practitioner when support is needed, measure informal and peer routes separately, and avoid describing stated intention as observed uptake.

5.5 Stigma as a productive failure

The stigma anomaly is the pilot’s most valuable methodological finding. Theoretical importance tempted the original interpretation towards a “near-significant” $p = .053$ result. A measurement-first reading rejects that temptation. The intended reverse-coded scale had $\alpha = .205$, and the inferential composite did not follow the declared reversal. The positive legacy correlations therefore have no stable substantive meaning. Label, stereotype, judgement and campaign appraisal were compressed into three items from different levels of analysis. The correct conclusion is not that stigma lacks influence, nor that it almost predicts intention. It is that this instrument cannot adjudicate the hypothesis. A validated and dimension-specific

measure, expert review and cognitive interviews are required before stigma re-enters the structural model (Link and Phelan, 2001; DeVellis, 2017).

5.6 Theoretical and practical implications

Theoretically, the pilot supports a mechanism model more than an exposure-effects model. Social marketing defines the ethical outcome and exchange; the Elaboration Likelihood Model separates substantive information from source cues; Social Cognitive Theory explains modelling and perceived capability; TPB positions literacy, norms and control upstream of intention. The evidence suggests a revised architecture in which exposure is contextual dose; authenticity, source credibility, narrative framing and platform fit are communication inputs; literacy and stigma are primary mechanisms; norms and control are pre-specified candidates; and professional intention is the outcome. This is an evolutionary integration, not a new paradigm, and it remains open to disconfirmation (Caliendo-Chan, 2026a, 2026d).

For practitioners, the evidence justifies small, controlled tests of authentic, educational and practical content with explicit service signposting. Evaluation should follow a chain from reach to comprehension, literacy, intention and verified service-navigation actions where ethically and operationally feasible. Likes and shares belong near the beginning, not the end, of that chain. Influencer partnerships should be selected against expertise, trust, disclosure and audience fit rather than follower count. All creative work should avoid diagnosis, sensational recovery narratives and unqualified advice, and it should align calls to action with actual service capacity. These recommendations are proportionate because they translate promising associations without claiming an effect that the design cannot establish.

5.7 Limitations and strength of inference

Internal validity is limited by simultaneous self-report measurement, common method, unarchived regression diagnostics and construct contamination. External validity is limited by convenience recruitment, a female and student-heavy sample, unknown response rate and lack of regional or ethnic profile. Statistical conclusion validity is constrained by short measures, multiple unadjusted tests and absent confidence intervals. Construct validity is the dominant problem: the stigma score failed, awareness shared predictor wording, credibility mixed dimensions and intention mixed support routes. Ethical auditability is weakened by the non-uniform consent export. Conversely, transparent reuse, complete Likert data, preserved

SPSS tables, exact reporting of nulls and reconciliation with the raw file are strengths. The appropriate inference grade is “promising but provisional,” not “validated.”

5.8 Rival explanations and tests that could discriminate between them

Several rival explanations fit the observed pattern. People already interested in mental health may seek more content, rate it as authentic and report higher awareness, reversing the proposed direction. A general tendency to agree could elevate authenticity, awareness and intention together. Student recruitment may create shared service knowledge and campaign exposure, while prior mental-health experience—unmeasured here—could influence every construct. Algorithmic personalisation may also make exposure a consequence of earlier searches rather than an exogenous dose. A stronger cross-sectional study can reduce, but not eliminate, these ambiguities by measuring prior experience, platform context, social desirability and theoretically justified covariates, and by using temporally neutral outcome wording. Experimental comparison of message and source formats could estimate immediate communication effects; longitudinal follow-up could test whether literacy precedes intention; and ethically governed service-navigation data could assess whether intention translates into action. Triangulating these designs would be stronger than treating one larger survey as definitive.

6. Conclusions and Recommendations

6.1 Conclusion

This QRM study has re-examined, in fully rewritten form, empirical evidence obtained during Term 2. The archived SPSS analysis indicates that social-media exposure and message authenticity predicted mental-health awareness, influencer credibility did not, and awareness was positively associated with a broad help-seeking-intention score. The most defensible contribution is not a claim that social media causes professional help-seeking. It is a disciplined set of model decisions. Authenticity and exposure warrant retention in different roles; credibility requires sharper definition; literacy should replace generic awareness; professional intention must be route-specific; and stigma was not validly tested. The scoring and consent anomalies demonstrate why quantitative rigour includes provenance, construct meaning and ethical records, not only calculations.

6.2 Recommendations for the final DBA study

First, rebuild the instrument before enlarging the sample. Use established multi-item measures, expert review and cognitive interviews; separate exposure, source, authenticity, narrative and platform fit; define literacy and stigma dimensions; and distinguish professional, informal and peer-support intentions. Second, implement separate mandatory consent and eligibility gates, signposting, retention information and an auditable version history. Third, recruit a multi-channel non-probability quota sample across gender, ethnicity, region and student/employment status, transparently report deviations, and determine the required 400–600 working range through a priori power and model-complexity analysis (Wolf et al., 2013). Fourth, apply a two-step measurement-first strategy: data screening and item analysis, confirmatory factor analysis, convergent and discriminant validity, then structural and indirect-effect testing only if the measurement model passes (Anderson and Gerbing, 1988; Fornell and Larcker, 1981; Henseler, Ringle and Sarstedt, 2015; Kline, 2016).

6.3 Recommendations for ethical practice

Organisations should pilot authentic, comprehensible and practical content with clear professional signposting, compare source types and narrative formats, and predefine outcomes beyond engagement. Report reach, literacy and intention separately; where service data can be linked lawfully and safely, evaluate navigation or contact rather than assuming behaviour. Do not use the current stigma or influencer findings to justify removal or investment decisions. Finally, maintain an ethical stop rule: communication that increases demand without safe, accessible support or that relies on distressing disclosure should not be scaled merely because it performs well on a platform. The pilot's role is to improve the next test; its limitations are part of that evidence.

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Appendix A. Pilot survey instrument

Title: Social Media Communication and Mental Health Awareness among UK Young Adults (18–29)

Participant information and consent

You are invited to take part in a short academic survey exploring how social media and digital communication influence mental-health awareness among young adults in the UK. Participation is voluntary and anonymous. You may stop at any time. No personal or clinical information will be collected. Data will be used for academic research purposes only.

Eligibility: aged 18–29 and currently living in the UK. By continuing, participants were told that they understood the information and agreed to participate.

Consent checkboxes: I agree to participate; I confirm that I am aged 18–29 and currently live in the UK.

Screening and demographics

Q1 Age group: 18–20; 21–23; 24–26; 27–29.

Q2 Current UK residence: Yes/No.

Q3 Gender (optional): Male; Female; Non-binary; Prefer not to say.

Q4 Situation: University/college student; Working full-time; Working part-time; Other.

Likert sections

Response scale for Q5–Q22:

1 Strongly disagree; 2 Disagree; 3 Neutral; 4 Agree; 5 Strongly agree.

Q5 I use social media daily.

Q6 I frequently see mental-health content on social media.

Q7 Social media is one of my main sources of information.

Q8 I understand common mental-health issues (for example, anxiety and depression).

Q9 I know where to find mental-health support services.

Q10 Social media has increased my awareness of mental health.

Q11 There is still stigma around mental-health problems.

Q12 I would feel judged if I told others I was struggling mentally.

Q13 Social media discussions are helping reduce mental-health stigma.

Q13 was intended to be reverse-coded.

Q14 I trust influencers who talk about mental health.

Q15 Influencers make mental-health topics easier to understand.

Q16, I pay attention to mental-health messages shared by people I follow.

Q17 Personal stories feel more genuine than formal campaigns.

Q18 Authentic content makes mental-health information more believable.

Q19 Honest and open communication increases my trust in mental-health content.

Q20 I would seek professional help if I experienced mental-health difficulties.

Q21 Seeing others share their experiences encourages me to seek help.

Q22 Online information makes me more open to getting support.

Q23 (optional): What type of mental-health content do you find most helpful on social media?

Appendix B. Data provenance and integrity log

Check	Archived evidence	Treatment in this report
Empirical origin	Term 2 Google Forms data and SPSS output	Disclosed; no claim of new collection.
Raw response rows	126	Retained to reproduce the historical SPSS analysis.
Likert missingness	0 across Q5–Q22	Complete-case composites.
Exact duplicates	None when timestamps excluded	No duplicate removal.
Consent labels	112 both; 7 agreements only; 7 eligibilities only	Reported as an audit limitation; mandatory dual gates required next time.
Stigma reliability	$\alpha = .205$ after intended reversal	Scale rejected for inference.
Stigma inferential composite	Archived mean/correlations/regression match unreversed Q13	Legacy outputs reproduced but classified as non-interpretable.
SPSS version	Not preserved	Declared reproducibility limitation.

Source: author reconciliation of the attached Term 2 dataset, questionnaire and SPSS output.

Appendix C. Selected archived Term 2 SPSS output

The following pages 36–41 reproduce the selected SPSS tables embedded in the Term 2 report. The original appendix labels and page numbers are retained as evidence provenance; the current report's Tables 5–8 provide the accessible transcription and revised interpretation.

Appendix D: Selected SPSS Output

Selected SPSS output is provided in Appendix D as supporting evidence for the statistical analyses reported in Section 5.

D1 Reliability analysis

D1.1 Social Media Exposure

Reliability

➔ Scale: Social Media Exposure

Case Processing Summary

		N	%
Cases	Valid	126	98.4
	Excluded ^a	2	1.6
	Total	128	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.724	3

D1.2 Mental Health Awareness

Reliability

Scale: Mental Health Awareness

Case Processing Summary

		N	%
Cases	Valid	126	98.4
	Excluded ^a	2	1.6
	Total	128	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.791	3

D1.3 Perceived Stigma

Reliability

Scale: Perceived Stigma

Case Processing Summary

		N	%
Cases	Valid	126	98.4
	Excluded ^a	2	1.6
	Total	128	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.205	3

D1.4 Influencer Credibly

Reliability

Scale: Influencer Credibility

Case Processing Summary

		N	%
Cases	Valid	126	98.4
	Excluded ^a	2	1.6
	Total	128	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.804	3

D1.5 Message Authenticity

Reliability

Scale: Message Authenticity

Case Processing Summary

		N	%
Cases	Valid	126	98.4
	Excluded ^a	2	1.6
	Total	128	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.843	3

D1.6 Help-Seeking Intention

Reliability

Scale: Help-Seeking Intention

Case Processing Summary

		N	%
Cases	Valid	126	98.4
	Excluded ^a	2	1.6
	Total	128	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.846	3

D2 Correlation matrix (SPSS output)

Correlations

		Correlations					
		Composite score: Social Media Exposure	Composite score: Mental_Health_Awareness	Composite score: Perceived_Stigma	Composite score: Influencer_Credibility	Composite score: Message_Authenticity	Composite score: Help_Seeking_Intention
Composite score: Social Media Exposure	Pearson Correlation	1	.658**	.467**	.300**	.361**	.375**
	Sig. (2-tailed)		<.001	<.001	<.001	<.001	<.001
	N	126	126	126	126	126	126
Composite score: Mental_Health_Awareness	Pearson Correlation	.658**	1	.441**	.271**	.406**	.464**
	Sig. (2-tailed)	<.001		<.001	.002	<.001	<.001
	N	126	126	126	126	126	126
Composite score: Perceived_Stigma	Pearson Correlation	.467**	.441**	1	.277**	.449**	.342**
	Sig. (2-tailed)	<.001	<.001		.002	<.001	<.001
	N	126	126	126	126	126	126
Composite score: Influencer_Credibility	Pearson Correlation	.300**	.271**	.277**	1	.540**	.493**
	Sig. (2-tailed)	<.001	.002	.002		<.001	<.001
	N	126	126	126	126	126	126
Composite score: Message_Authenticity	Pearson Correlation	.361**	.406**	.449**	.540**	1	.600**
	Sig. (2-tailed)	<.001	<.001	<.001	<.001		<.001
	N	126	126	126	126	126	126
Composite score: Help_Seeking_Intention	Pearson Correlation	.375**	.464**	.342**	.493**	.600**	1
	Sig. (2-tailed)	<.001	<.001	<.001	<.001	<.001	
	N	126	126	126	126	126	126

**. Correlation is significant at the 0.01 level (2-tailed).

D3 Regression output: Model 1 predicting Help-Seeking Intention

D3.1 Model Summary

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.489 ^a	.239	.227	.94444

a. Predictors: (Constant), Composite score: Perceived_Stigma, Composite score: Mental_Health_Awareness

D3.2 ANOVA

ANOVA^a

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	34.433	2	17.217	19.302	<.001 ^b
	Residual	109.711	123	.892		
	Total	144.145	125			

a. Dependent Variable: Composite score: Help_Seeking_Intention

b. Predictors: (Constant), Composite score: Perceived_Stigma, Composite score: Mental_Health_Awareness

D3 Regression output: Model 1 predicting Help-Seeking Intention (Cont.)

D3.3 Coefficients

Coefficients ^a										
Model	Unstandardized Coefficients		Standardized Coefficients Beta	t	Sig.	Correlations			Collinearity Statistics	
	B	Std. Error				Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	1.235	.398	3.108	.002					
	Composite score: Mental_Health_Awareness	.399	.090	.389	4.435	<.001	.464	.371	.349	.806
	Composite score: Perceived_Sigma	.231	.118	.171	1.953	.053	.342	.173	.154	.806

a. Dependent Variable: Composite score: Help_Seeking_Intention

D4 Regression output: Model 2 predicting Mental Health Awareness

D4.1 Model Summary

Model Summary				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.682 ^a	.466	.452	.77306

a. Predictors: (Constant), Composite score: Message_Authenticity, Composite score: Social Media Exposure, Composite score: Influencer_Credibility

D4.2 ANOVA

ANOVA ^a					
Model		Sum of Squares	df	Mean Square	F
1	Regression	63.531	3	21.177	35.435
	Residual	72.910	122	.598	
	Total	136.441	125		

a. Dependent Variable: Composite score: Mental_Health_Awareness

b. Predictors: (Constant), Composite score: Message_Authenticity, Composite score: Social Media Exposure, Composite score: Influencer_Credibility

D4 Regression output: Model 2 predicting Mental Health Awareness (Cont.)

D4.3 Coefficients

		Coefficients ^a									
Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Correlations			Collinearity Statistics	
		B	Std. Error	Beta			Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	.483	.358		1.347	.180					
	Composite score: Social Media Exposure	.636	.077	.590	8.235	<.001	.658	.598	.545	.854	1.171
	Composite score: Influencer Credibility	-.016	.093	-.014	-.172	.864	.271	-.016	-.011	.696	1.438
	Composite score: Message Authenticity	.227	.092	.200	2.466	.015	.406	.218	.163	.665	1.505

a. Dependent Variable: Composite score: Mental_Health_Awareness

Appendix D. Contextual coding of Q23 responses

Theme	Description	Illustrative response
Personal stories / lived experience	Recovery narratives and first-hand coping accounts	“Hearing others’ experiences and how they managed to overcome difficulties.”
Educational / awareness	Symptoms, conditions, stigma and treatment explanations	“In-depth explanations of the topic, the treatments and the stigma surrounding it.”
Practical coping	Stress-management tools and exercises	“Practical tips for managing stress and anxiety.”
Authentic / relatable	Honest, transparent and non-performative delivery	“Honest personal stories.”
Signposting / expert guidance	Links to services or qualified guidance	“Links to support services and information about coping strategies.”
Motivational / positive	Hope, encouragement and resilience	“Motivational content.”
Other / unclear / sceptical	Vague, off-topic or resistant responses	“None.” / “Not sure.”

Source: contextual coding reported in the Term 2 pilot (Caliendo-Chan, 2026c). Quotation punctuation lightly standardised.