The impact of Mental Health Campaigns on Attitudes and Help-Seeking Behaviours in New Zealand Rugby Union Players

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Abstract

This research aimed to investigate the impact of mental health campaign messages on rugby union players’ attitudes and behavioural intentions. This thesis used the context of New Zealand rugby players to explore whether affective, cognitive or combined types of campaign messaging registered any form of influence on rugby players’ attitudes and behavioural intentions. An experimental method with between-subjects design was used. This project conducted a survey on current rugby union players from the Canterbury region who were over the age of 18 years old. 139 rugby players in total completed the survey. Participants saw one of four different campaign messages that were used to investigate the impact of mental health campaigns on rugby players’ attitudes towards the campaign message and behavioural intentions towards seeking help. Overall, the findings presented very few differences in attitudes and behavioural intentions as a function of the campaign messages. However, contrary to expectations, the results indicated that as participant’s age increases, their likelihood to seek help for a mental health related challenge decreases. This suggested that as a participants’ age increased, they were more likely to have experienced longer periods of exposure to the hegemonic masculinity within the sport. It was speculated that this culture had embedded suppressive behaviours among older players that the younger demographic may not have experienced. The findings from this research suggest that a different type of intervention is required to develop or change help seeking behaviours and attitudes among rugby players. These findings are discussed in terms of their implications, and further suggestions are made for future research.
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1 Introduction

1.1 Preface

This research investigates what types of campaign messages influence rugby players’ attitudes towards mental health and behavioural intentions towards seeking help. This chapter will discuss the purpose of this study and the different types of campaign messages that have been depicted and analysed for this research. The importance of understanding what specific types of campaign messages rugby players’ are influenced by, and the implications this can have on general mental health in organisations, specifically in the sporting community will also be discussed. This chapter will conclude with a brief preview of the thesis structure. This thesis canvassed a wide variety of relevant literature pertinent to this topic, ranging from management to marketing to psychology.

1.2 Research Background

The value and importance of mental health within the workplace has been well documented in recent literature (Rüsch, Angermeyer, & Corrigan, 2005; Sartorius, 2007). In a world that has gradually progressed to placing profits over people, mental health within the workforce has deteriorated significantly (World Health Organization, 2003). Statements from the World Health Organisation report,

“The impact of mental health problems in the workplace has serious consequences not only for the individual but also for the productivity of the enterprise. Employee performance, rates of illness, absenteeism, accidents and staff turnover are all affected by employees’ mental health status. In the United Kingdom, for example, 80 million days are lost every year due to mental illnesses, costing employers £1-2 billion each year” (World Health Organization, 2003a, p. 1)

Organisations are constantly under pressure from the external environment (including; market competition, technological advancements and market growth) and are forced to exhaust their resources, consequently demoting the priority of employee wellbeing (Gabriel & Liimatainen, 2000; Greene-Shortridge, Britt, & Castro, 2007; Heijnders & Van Der Meij, 2006; Jorm, 2015; World Health Organization, 2003). These organisational procedures and routines
have led to a rise in health conditions such as depression, anxiety and other mental health related issues (Gabriel & Liimatainen, 2000).

For many years, physical activity has played an important role in mental health interventions (Paluska & Schwenk, 2000). Physical activity is considered an important strategy in the effort towards minimising the stigma surrounding mental health problems, including anxiety, post-traumatic stress disorder and depression (Paluska & Schwenk, 2000). Literature also suggests that there are many mental health benefits linked to exercise and outdoor activities (Hughes & Leavey, 2012; Paluska & Schwenk, 2000; Rice, Purcell, Silva, Mawren, McGorry, & Parker, 2016). However, sporting individuals and the sporting industry itself are currently faced with one of their greatest battles to date with the state of mental health in rugby union (Hughes & Leavey, 2012; Paluska & Schwenk, 2000; Rice et al., 2016). Discriminatory behaviour towards individuals suffering from a mental illness, the stigma surrounding help seeking interventions and behaviours, combined with extensive media attention on mental health, has had varying influence on mental health in the sporting industry (Hughes & Leavey, 2012; Paluska & Schwenk, 2000; Rice et al., 2016). Although improving through the work of John Kirwan and the ministry of health (as an example), negative and entrenched attitudes towards mental health continue to be prominent within the sport.

Literature suggests that one of the key places to begin changing the stigma towards individuals suffering from, and the interventions associated with, mental health is within organisations (Cross, Heijnders, Dalal, Sermrittirong, & Mak, 2011; Heijnders & Van Der Meij, 2006; Szeto & Dobson, 2010). Creating safe, non discriminatory environments within the organisations, will influence behaviours on how individuals act outside of the workplace (Cross, Heijnders, Dalal, Sermrittirong, & Mak, 2011). Also further assisting in the attempt to reduce the stigma surrounding mental health (Cross et al., 2011). With the potential to develop and improve health promotion in the industry, sports organisations can play a fundamental role in reducing stigma towards mental health challenges (Mitchell & Popham, 2008).

One of the most highlighted issues surrounding mental health within the current literature are sporting organisations and their respective cultures (Bauman, 2016). The organisational culture within the sporting industry is often portrayed as a product of negative societal factors, dominated by stereotypically masculine behaviours and attitudes, which consequently influences individuals to not seek help for mental health-related challenges (Bauman, 2016;
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Gulliver, et al., 2012). Therefore, mental health challenges within this industry and other sporting organisations is too often left unaddressed, undiscussed or disregarded due to these entrenched attitudes associated with, and discriminatory behaviours towards, individuals who seek mental health treatment (Bauman, 2016). Literature suggests these attitudes and behaviours are a consequence of individuals acting outside of social norms, seeking help for illnesses that the public find challenging to accept (Bauman, 2016). With such harmful symptoms including persistent periods of sadness, stress or hopelessness, being concealed by individuals, it is no surprise that the literature suggests one of the most prominent forms of mental illness in this industry is depression (Bauman, 2016; Gulliver et al., 2012; Hughes et al., 2012; Schwenk, 2000).

The culture within the sport of rugby has long revolved around the accentuation of masculine behaviours, further embodying the stereotypical ‘hard man’ attitude that the sport's historic reputation is notorious for (Nauright & Chandler, 1996). This ‘kiwi bloke’, ‘only girls cry’ (Phillips, 1996) attitude that has been embedded within New Zealand rugby (both organisations and the sport itself) has potentially prolonged the ongoing force of these behaviours against those with a mental illness (Phillips, 1996; Pringle & Markula, 2005; Nauright, 1999; Tagg, 2008). This emphasises the sports traditional use as a means of social distinction and masculine expression (Phillips, 1996; Pringle & Markula, 2005; Nauright, 1999; Tagg, 2008). This culture remains a reinforcement of the traditional notions of masculinity in rugby (Anderson & McGuire, 2010). Several studies identify the increasing risks the culture of rugby is facing because of rapidly changing cultural and social conditions (Anderson & McGuire, 2010; Light & Kirk, 2010). The ideals and culture within rugby have developed from hegemonic masculinity as a result of the sports traditional background, this has left a significant influence on the modern rugby culture (Anderson & McGuire, 2010). Connell (1995) described hegemonic masculinity as,

“The configuration of gender practices which embodies the currently accepted answer to the problem of the legitimacy of patriarchy, which guarantees (or is taken to guarantee) the dominant position of men and the subordination of women”. (Connell, 1995, p. 77).

Connell (1995) elaborates on this point stating that the modern forms of hegemonic masculinity connect illustrious ideology surrounding manliness with undeniable competitiveness and toughness. Further emphasising that the modern example of hegemonic
masculinity are male participants of prevalent winter sports, most noticeably, rugby union (Connell, 1995; Pringle & Markula, 2005). Hegemonic masculinity arose as a very traditional term that represented the ideal-typical, form of masculinity (Adinkrah, 2012; Connell & Messerschmidt, 2005). This was personified by the stereotypically physical males of society and one in which the majority of males in that society imitate to varying levels (Adinkrah, 2012; Connell & Messerschmidt, 2005). These stereotypically masculine behaviours inevitably impact individuals outside of just their respective sporting environments, such as help seeking behaviours or attitude towards mental illness. This dominant masculinity seems to be prominent throughout multiple competitive and contact sports, with statements similar to the following emerging from the traditional background of American football.

“football’s historical prominence in sports media and folk culture has sustained a hegemonic model of masculinity that prioritises competitiveness, athleticism, success (winning), aggression, violence, superiority to women, and respect for the compliance with male authority” (Sabo & Panepinto, 1990, p. 115)

Statements like these are common throughout the literature and can be applied to rugby union football in New Zealand because of the cultural and behavioural similarities such as, masculinity, aggression, and competitiveness. Unfortunately, this masculine environment the game has been shrouded in continues to delay improvements in the stigma associated with mental health issues that occur in modern rugby union. Thus, action needs to be taken by the organisations who hold influential and commanding roles within those sporting communities through the creation of stigma reduction interventions and strategies (Barney, Griffiths, Jorm, & Christensen, 2006; Corrigan, 2004; Komiti, Judd, & Jackson, 2006; Szeto & Dobby, 2010).

One demographic the literature suggests face continuous challenges with help seeking behaviours and mental health stigma are males (Addis & Mahalik, 2003; Good & Wood, 1995; Mahalik, Good, & Englar-Carlson, 2003; Rochlen, 2005; Rochlen, Blazina, & Raghunathan, 2002; Rochlen, McKelley, & Pituch, 2006). Many studies have indicated significant gender differences in mental health issues and the likelihood of an individual seeking help (Hammer & Vogel, 2010; Seidler, Dawes, Rice, Oliffe, & Dhillon, 2016). The research suggests that males hide and conceal their mental health related symptoms, unlike females who tend to be more willing to express their emotions (Anderson & McGuire, 2010; Seidler et al., 2016). Highlighting the significant issues males have when dealing or coping with mental health related challenges, with societal influences heavily influencing an individuals’ decision to
express or suppress their mental health related symptoms (Anderson & McGuire, 2010; Seidler, et al., 2016; World Health Organization, 2003).

The purpose of this research is to further understand what types of mental health campaign messages influence rugby players' attitudes and behavioural intentions. The results that may arise from this research could reveal a new understanding to the attitudes held by New Zealand rugby players toward mental health. This has the potential to provide researchers with a deeper knowledge on the types of campaign messaging that can influence rugby players’ attitudes and intentions to seek help. The results of this research have potential to give sporting institutions a better understanding of the current perceptions on the player’s mental health held within their sporting regions. This will allow them to adapt to the messages discussed later in this thesis. Thus further providing contributions to the New Zealand rugby community through the analysis of cognitive, affective, combined and original mental health campaign messaging and their influence on rugby players’ attitudes and help seeking behaviours. Therefore, improving awareness of mental health related issues within New Zealand rugby and their respective institutions.

1.3 Research Objectives

This study aims to identify whether cognitive or affective mental health campaign messaging is more influential in improving rugby players’ behavioural intentions towards seeking help for mental health related challenges and attitudes towards the campaign messages. The objective is to identify if cognitive or affective messaging is more influential when addressing the attitudes and behavioural intentions surrounding mental health within the sport. The research objectives are:

- To determine what type of mental health campaign messages have the greatest influence on a players’ behavioural intention towards seeking help for mental health issues.
- To determine which type of mental health campaign messages have the greatest influence on a players’ attitudes towards the campaign message.
- To determine what type of mental health campaign messages have the greatest influence on a players’ perceived barriers towards seeking help for mental health issues.
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1.4 Thesis Structure

This thesis is comprised of five chapters which aim to fill the research gap discussed in Chapter 2 and explain the importance of understanding what specific types of campaign messages rugby players’ are influenced by. Chapter one has discussed and explained the importance of this research, and briefly touched on the potential contributions to both the academic and practical communities.

Chapter two, Literature Review, provides a greater, more in-depth discussion on current academic literature. This will include and emphasise: Relevant findings on mental health within organisations, mental health in sports in general, and the relationship between mental health campaigns and attitudes towards mental health.

Chapter three, Methodology, will outline the method adopted for this research study, and test the relevant hypotheses presented in chapter two. Detailed explanations of the research design, participants and data collection will be given to provide greater context to the processes that took place as part of this thesis.

Chapter four, Results, will analyse and present the results of the research hypotheses, significant findings, relationships and differences between the variables.

Chapter five, Discussion, summarises the results section of the thesis, discussing key findings highlighted in chapter four. A brief overview of the limitations to this research is discussed. Lastly, recommendations and directions for future research are provided, ending with a conclusion of the thesis.
2 Literature Review

2.1 Introduction

The following chapter reviews and discusses the literature of key areas that build the basic foundations of this research. The main topics that will be discussed below are: mental health in organisations, mental health in sports, mental health campaigns, and the relationship between these variables. The purpose of this literature review is to provide the reader with an a greater understanding of the relevant literature regarding the relationships between mental health, organisations, mental health campaigns and sport. This literature review is structured in a way that builds and develops themes suggested by the literature towards a justification for each of the hypotheses. Finally, this literature review will end with a summarised discussion of the research gap and hypotheses that form the purpose of this research.

2.2 Mental Health in Organisations

For the purpose of this literature review, statistics were gathered from sources that were publicly available and as recent as possible, this includes the 2003 statistics provided by the World Health Organization report. The World Health Organization’s 2003 analyses are the most recent and comprehensive global mental health statistics that are publicly available. Nevertheless, a small number of their more recent publications and reports offer some updated statistics which will be used throughout this thesis where applicable.

In order to understand the concept of mental health, it is essential to note the difference between mental health and mental illness. This distinction is important as the focus of this research is primarily on mental health, however both mental health and mental illness will be discussed. Keyes (2002), defines mental health as,

“An emergent condition based on the concept of a syndrome. A state of health, like illness, is indicated when a set of symptoms at a specific level are present for a specified duration and this constellation of symptoms coincides with distinctive cognitive and social functioning” (Keyes, 2002, p. 208).
As opposed to the term Mental illness which will also be used throughout this research. Mental illness categorises an individual as someone who “impairs the execution of social roles and it is associated with emotional suffering” (Keyes, 2002, p. 209).

“In order to reduce the increasing burden of mental disorders and avoid years lived with disability or death, priority should be given to prevention and promotion in the field of mental health” (World Health Organization, 2003a, p. 26).

In recent years, studies suggest that the number of individuals who suffer from a mental illness has continued to and will continue to rise if actions are not taken (World Health Organization, 2003a; World Health Organisation, 2014). With the topic of mental health becoming more noticeable among communities, researchers have highlighted the significant gap between the burden of mental health disorders and resources (World Health Organization, 2003a). Even though developed nations are highlighted for having the best technologies, the most resources and the best living conditions, between 44% and 70% of patients seeking help for mental disorders such as, depression, alcohol-use, and child mental illnesses, did not receive treatment (World Health Organization, 2003a). In developing countries this number is closer to 90% (World Health Organization, 2003a). More than 40% of all countries worldwide having no mental health policy and a further 30% having no mental health programmes (World Health Organization, 2003a). This statistical evidence has been suggested to lead to as many as 450 million individuals suffering from a mental or behavioural disorder and a further 800,00 people committing suicide per year (World Health Organisation, 2014; World Health Organisation, 2018). This statistic makes suicide the second leading cause of death in 15-29 year olds, with further suggestions indicating that for every single adult who died as a result of suicide, it was estimated that there were 20 others attempting suicide (World Health Organisation, 2014). It was also estimated that males are 75% more likely than females to die as a result of suicide (World Health Organisation, 2018).

Because of the knowledge and technology that exists, interventions are able to be implemented immediately and widely, with the potential benefits of reduced disability, stigma and prevention of premature death being enormous (World Health Organization, 2003a). Although there are many ways in which countries can further the efforts regarding mental illness, the workplace is a very applicable environment in which organisations can raise the awareness of mental health problems and also educate individuals on mental health (World Health Organization, 2003b). Through the promotion of good mental health practices,
establishing links with local mental health services, and providing their employees with tools for recognition and early identification of mental health problems, organisations will create environments where employees with mental health problems are not stigmatised or discriminated against (World Health Organization, 2003b).

Giving employees these abilities and resources will not only improve their overall mental health but also their wellbeing. In recent years, many researchers have attempted to define wellbeing, suggesting that there is yet to be a solidified proposal for the definition of the topic (Dodge, Daly, Huyton, & Sanders, 2012; Kloep, Hendry, & Saunders, 2009). Kloep, Hendry and Saunders (2009) state that wellbeing can be described as, “Each time an individual meets a challenge, the system of challenges and resources comes into a state of imbalance, as the individual is forced to adapt his or her resources to meet this particular challenge” (Kloep et al., 2009, p. 337).

Further studies elaborate on the proposed definition stating that, “Stable wellbeing is when individuals have the psychological, social and physical resources they need to meet a particular psychological, social and/or physical challenge. When individuals have more challenges than resources, the see-saw dips along with their wellbeing, and vice-versa” (Dodge et al., 2012, p. 230).

Employee mental health and wellbeing when recognised and supported, can be critical to the overall success of an organisation (Cross, Heijnders, Dalal, Sermrittirong, & Mak, 2011). Many studies emphasise the suggestion that negative perceptions of mental health and illness are further suppressing individuals’ emotive behaviours (Keyes, 2007; Tugade, Fredrickson, & Feldman Barrett, 2004). These perceptions produce significant disadvantages to the creation or development of a positive environment within an organisation (Keyes, 2007; Tugade et al., 2004). One study even suggests that mental health problems arise (this time, specifically in Europe) from within the workplace/organisations (Gabriel & Liimatainen, 2000). The suggestion originates from the idea that organisations operating in the modern marketplace are being pushed by increasing market pressure to exhaust their resources to the point of maximum efficiency to provide them with a competitive edge in the market (Gabriel & Liimatainen, 2000). As a result, the study’s authors found that there was an increase in the number of reported chronic conditions such as depression, causing a significant increase in the number of those deemed ‘disabled’ in organisations (Gabriel & Liimatainen, 2000). These studies further reiterate the growing concern and importance surrounding employee wellbeing, including both
mental and physical health, in the modern workplace (Greene-Shortridge et al., 2007; Heijnders & Van Der Meij, 2006; Jorm, 2015; World Health Organization, 2003).

Therefore, it is important for organisations to implement the correct processes and procedures to reduce and, where possible, stop workplace discrimination and the stigma surrounding mental health (Byrne, 2000; Schulze, 2007). Researchers indicate that these processes must be accessible and maintainable for organisations to successfully reduce stigma and discrimination (Byrne, 2000; Schulze, 2007). Several studies also suggest that the main reason reinforcing the increasing number of mental health problems within organisations is because of an individual’s lack of access to the mental health services they require when they need them (Byrne, 2000; Greene-Shortridge et al., 2007). Organisational leaders and their respective owners understand that without their workforce operating efficiently, productivity and profitability begin to fall (Harnois & Gabriel, 2000; Newman, Howells, & Fletcher, 2016; Szeto & Dobson, 2010). Much like employees’ attitudes and mental health, successful organisations require clarity surrounding the communication of information, interaction with those who have experienced similar positions of adversity and detailed planning to minimise negative outcomes (Rüssch et al., 2005).

At an organisational level, there is a greater chance of influencing individuals through building on readily accessible pre-existing knowledge that is, applicable, and can be adapted to, different contexts, rather than attempting to completely reinvent their processes (World Health Organization, 2003a). Researchers have conducted numerous studies surrounding the significance that programmes can have in the fight against minimising organisational stigma (Heijnders & Van Der Meij, 2006; Szeto & Dobson, 2010). Therefore, organisations must stress and emphasise the importance these have on improving an individual’s mental health (Heijnders & Van Der Meij, 2006). With the correct plans in place, consistently adaptation and growth of these plans, organisations collectively can become much stronger and more resilient with greater relationships throughout their workforce (Heijnders & Van Der Meij, 2006). However, if these plans are avoided this could lead to substantial impacts not only on an individual level but also on an organisations level through higher absenteeism rates, and decreases in both efficiency and job satisfaction (World Health Organization, 2003a). The responsibility of the organisation needs to turn towards providing employees who are faced with mental health related challenges the ability to seek the professional help they require without barriers such as, fear of stereotyping or discrimination (Barney et al., 2006; Corrigan, 2004; Komiti et al., 2006; Szeto & Dobson, 2010). Institutions must begin planning for the
allowance of substantial implementation of interventions throughout their framework that target the reduction of the expectations regarding negative responses from co-workers and negative self-responses towards seeking help (Barney et al., 2006). Interventions that reduce this problem do not need to be comprehensive, with literature suggesting basic forms of intervention including interaction and discussions with people who have personally experienced a mental illness (Couture & Penn, 2003; Schomerus, Schwahn, Holzinger, Corrigan, & Grabe, 2012). This contact has been suggested to be one of the most effective anti-stigma strategies recognised to date (Couture & Penn, 2003; Schomerus et al., 2012). These proactive actions and conversations further the movements taken to reduce workplace discrimination and allows individuals to change their attitudes and perceptions of mental health issues for the better (Couture & Penn, 2003; Dalky, 2012; Schomerus et al., 2012).

Recent literature suggests that for real attitude change to take place across all levels of society, organisations will play a critical role in effectively reducing stigmatic and discriminatory behaviours within societies (Cross, Heijnders, Dalal, Sermrittirong, & Mak, 2011; Szeto & Dobson, 2010). The existing literature highlights the pressing need for mental health care of employees to become a more prioritised concern for organisations (World Health Organization, 2003a).

2.3 Mental Health in Sports

One industry currently experiencing a surge in the number of reported mental illnesses is the sporting industry (Newman, et al., 2016; Schwenk, 2000). This includes semi-professional and professional rugby organisations who are responsible for both professional players and organisations, and players aspiring to be professionals. The literature suggests that physical activity has been one of the most influential forms of mental health interventions for a long period of time (Paluska & Schwenk, 2000). Seen as a key strategy towards reducing mental health related challenges, physical activity has led to a decrease in a number of mental health problems such as anxiety, post-traumatic stress disorder and depression (Paluska & Schwenk, 2000). Unfortunately, many mental health services struggle to implement physical activity as a long term intervention, with consistent drop off percentages of individuals of 30% within six months, growing to 50% after six months (Stathopoulou, Powers, Otto, Berry, & Smits, 2006). Therefore, it is suggested that when a mental health care professional prescribes any type of physical health, the ‘patient’ has a likelihood of 70% to follow professional advice
for up to 6 months, decreasing to 50% after this period (Stathopoulou, Powers, Otto, Berry, & Smits, 2006). This indicates that this form of intervention remains very short term orientated (Stathopoulou et al., 2006). Thus, it is important that sporting organisations recognise these issues and implement strategies that will mark this form of intervention as more appealing to those affected. This will allow physical activity to develop into a significant, long-term focused strategy in future.

Contrary to several recent studies highlighting the numerous mental health benefits that have been linked to exercise and outdoor activities, the professional sporting industry itself is currently faced with one of its greatest battles yet in the form of rising mental health issues (Hughes & Leavey, 2012; Paluska & Schwenk, 2000; Rice, Purcell, Silva, Mawren, McGorry, & Parker, 2016). Significant barriers and extensive media attention have engulfed the topic of mental health in the sporting sector, leaving a persistent and relentlessly negative perception of mental health in sports (Hughes & Leavey, 2012). A recent study conducted in the United States on mental health in semi-professional and professional athletes revealed that, in 2012, 20% of the United States adult population suffered from or experienced at least one form of mental health issue per year (Bauman, 2016). Numerically this equates to one in five adults or 62.8 million individuals (Bauman, 2016). However, to add to these pressures, this figure rises to 30% when analysing individual’s aged 18-25 year olds (Bauman, 2016). This demographic also registered a significantly lower help seeking rate of less than one-third of the total 18-25 year old sampled population (Bauman, 2016). The sporting culture has been slow in response to athletes who seek or require psychological treatment, with mental toughness and mental health seen as two contradicting terms in the sporting world (Bauman, 2016). In sporting institutions, studies suggest that it is this type of evidence that needs to be promoted for organisations to understand the growing severity of mental health problems (Bauman, 2016; Gulliver, et al., 2012). Through the use of public figures, sporting organisations can set exemplary behaviour for the public and in effect, inspire a number of people simply by reducing the perceived emasculating attitudes associated with help seeking behaviours (for example) (Bauman, 2016; Gulliver et al., 2012).

Nevertheless, with the potential to host a growing and accepting environment for health promotion, sports organisations will be looked to in the near future to assist in leading the way forward as societies improve their efforts to increase the use of help seeking interventions and reduce the stigma surrounding mental health (Mitchell & Popham, 2008). Thus, it is crucial that these organisations address the mental health problems that continue to riddle their industry
(Nauright & Chandler, 1996; Newman et al., 2016; Rice, et al., 2016) Furthermore, literature indicates the considerably high vulnerability of not only professional athletes but semi-professional athletes as well (Anderson & McGuire, 2010; Newman et al., 2016). Various studies conclude by stating that the overall competitive nature, constant pressure for success, emotional cost of failure and the need for high levels of commitment, creates a substantial risk to the well-being and mental health of athletes (Newman et al., 2016; Rice et al., 2016; Schwenk, 2000).

One of the most highlighted problems within sporting organisations identified by literature is the perceived cultural norms and the culture itself surrounding mental health (Bauman, 2016; Gulliver et al., 2012). Literature describes the culture as being dominated by stereotypical masculine behaviour and attitudes, consequently harming efforts to improve help seeking behaviours (Anderson & McGuire, 2010; Pringle & Markula, 2005). Therefore, mental health in these types of organisations is often either ignored, hidden or overlooked due to the negative perceptions associated with mental health treatment (Bauman, 2016). With such strong feelings being harboured by individuals coupled with the cultural norms for males to suppress their emotions, it is no surprise that the leading form of mental illness specific to sporting institutions is depression (Bauman, 2016; Gulliver et al., 2012; Hughes et al., 2012; Schwenk, 2000). One study conducted in the United Kingdom highlighted the potential risk athletes were facing in regards to serious mental health problems, with athletes being more susceptible to these challenges whilst under injury (Walker , Thatcher, & Lavellee, 2007). The study indicated that although a number of injured players felt a sense of relief from the pressures of coaches, teammates and personal expectations, 10-20% of injured athletes experienced a severe response to injury, most noticeably depressive symptoms (Walker , Thatcher, & Lavellee, 2007). These figures suggest the need for the implementation of serious player wellbeing interventions as many of these athletes were referred to professional health care for concern of suicidal tendencies (Walker et al., 2007).

2.4 Mental Health in Rugby

With the ideas outlined above, it is no wonder that cultural values play a significant role in the impact sport has on its players, rugby in particular is a good example of this (Nauright & Chandler, 1996; Phillips, 1996). Though rugby is recognized globally as a brutal contact sport played largely by males, it is famously regarded as the national sport of New Zealand
(Harris & Clayton, 2007; Laidlaw, 1999; Richards, 1999). Whether New Zealanders celebrate, repel, or remain disinterested in rugby union’s influential position, the sport still holds an influential presence in their nation’s communities (Pringle & Markula, 2005). It is this attachment between rugby and the nation’s culture which influences the concealment of mental health issues among individuals (Pringle & Markula, 2005). The rugby culture has for years been heavily male orientated, with masculinity being a key driver for the sports reputation (Nauright & Chandler, 1996). The traditional culture that forms the foundations of rugby union itself have created this hegemonic form of masculinity that prioritises athleticism, competitiveness, success, and aggression (Harris & Clayton, 2007). It is this underpinning, traditional culture that has damaged the link between rugby players’ and help seeking behaviours for mental health issues (Rochlen et al., 2006). Masculine behaviour in the sport of rugby union has been described by literature as a promotion for the avoidance of emotional expression (Addis & Mahalik, 2003; Good & Wood, 1995; Mahalik et al., 2003; Rochlen, 2005; Rochlen et al., 2006). The need to solve problems without the help of others, coupled with the inability to express signs of vulnerability or weakness, all cause a significant influence and hindrance towards male help seeking behaviours (Addis & Mahalik, 2003; Good & Wood, 1995; Mahalik et al., 2003; Rochlen, 2005; Rochlen et al., 2006).

One area that offers insight into the mental health issues that arise in rugby is the impact of contact sports on mental health (Newman et al., 2016; Rice, et al., 2016). With a rise in the awareness of physical injuries, the mental pressures that players can experience are substantial (Cresswell & Eklund, 2005; McCrory et al., 2012; Tew, Ramon, Slade, Bird, Melton, & Le Boutillier, 2012). Studies show that the mental stress professional athlete’s encounter throughout their careers, remain a primary factor in the influence of their mental state (Cresswell & Eklund, 2005; Nicholls et al.2006). The relevant literature highlights a number of coping strategies players are most likely to use when faced with adversity or both mental and physical challenges. The most worrying statement depicted from the studies was that players who are suffering from intense levels of negative emotions are more likely to use the coping mechanism of ‘blocking’, which is when the individual actively makes an effort to disengage from a stressful situation, only intensifying the potential outcome of their struggles by ignoring the issue (Cresswell & Eklund, 2005; Nicholls, Holt, Polman, & Bloomfield, 2006). It is from this literature we can conclude that injuries, specifically concussions, play a significant role in the mental capabilities of rugby union players (Newman et al., 2016; Rice, et al., 2016; Tew et al., 2012).
Rugby has always been a very masculine sport, where people played through serious injuries, with disregard for their own bodies (Malcolm & Sheard, 2002; Nauright & Chandler, 1996). This further emphasises the ideals reinforcing the notion of a ‘real man’ in earlier New Zealand times. An example that illustrates just how much pain players would go through in the New Zealand All Blacks (New Zealand’s national men’s rugby team) to prove their masculinity can be taken from Phillips (1996),

Fergie McCormick and Colin Meads were ‘hard’ men noted not only for their strength, but also for their complete insensitivity to pain. McCormick was known as a man who never left the paddock and... (Who refused) to concede to his body... Colin Meads played in South Africa with a broken arm. Pluck and refusal to admit to pain has always been part of the All Blacks’ image. (Phillips, 1996, p.121-122).

Examples such as these emphasise the game’s traditional use as a means of masculine expression (Nauright, 1999). Even though the medical care of players has improved, there is still a strong reluctance among team members to accept pain or injuries (Malcolm & Sheard, 2002). This idealistic ‘hard man’ character remains prominent in modern rugby culture with the likes of Richie McCaw (former All Black captain) playing in the 2011 rugby world cup final with a broken foot. With the improvement in player analysis and safety precautions in place, players’ ability to perform under these health risks should be slim (Malcolm & Sheard, 2002). However, the masculinity that traditionally underpinned the sport, although outdated, still plays a significant role in the sports culture, including player safety (Anderson & McGuire, 2010). Several studies identify the threat that the modern rugby culture is under because of fast changing social and cultural conditions (Light & Kirk, 2010). It is this masculine nature the game has developed that continues to increase the mental health issues that arise in the sport (Anderson & McGuire, 2010; Newman et al., 2016; Rice, et al., 2016). Rugby union in New Zealand, has traditionally been dominated by masculinity and used as a form of masculine expression, providing a strong environment for investigating the different ways in which men use rugby union to establish their understandings of masculinities (Nauright & Chandler, 1996; Pringle & Markula, 2005). It is this prominence and presence that gives rugby union and its associated institutions the foundations to become leaders in the movement towards stigma reduction of mental illness (Good & Wood, 1995; Rochlen et al., 2006). Furthering efforts to target the players who conform to these masculine gender roles, and reduce the likelihood of players’ expression of entrenched help-seeking attitudes (Good & Wood, 1995; Rochlen et al., 2006).
Through playing rugby union, both traditional and modern day rugby players embody (whether it is intentional or not) and develop the stereotypical definition of a ‘real man’ (Pringle & Markula, 2005). Through categorising what it means to be a ‘real man’ in terms of which player can withstand the most pain, who is the strongest, and who can distance themselves from all characteristics of feminine behaviour, the sport of rugby union has enveloped these traits as part of a long standing, traditional culture (Pringle & Markula, 2005). Rugby has become a traditional means of masculine expression, increasing the stigma and discrimination towards men who may express characteristics that stereotypically are associated with feminine behaviour, further damage the impact of help seeking behaviours among males (Pringle & Markula, 2005). These consequences are suggested to be influential to a players’ help seeking behaviours and overall wellbeing, which leads to the first two hypotheses:

Hypothesis 1a/b: There will be a positive relationship between rugby player’s help seeking behaviours and general wellbeing (1a) and mental wellbeing (1b).

The above section emphasises the significance of early recognition of mental illness symptoms which assists in the reduction of current, and prevention of future, mental illnesses in sport/sports organisations (Newman et al., 2016).

2.5 Social Marketing and Mental Health Campaigns

Literature suggests that one way to improve awareness and consequently individual’s wellbeing is through the use of mental health campaigns (Rochlen et al., 2005; Seidler et al., 2016). An example of a large-scale awareness campaign that has produced substantial improvements in the awareness of, and recognition for mental illness and wellbeing is the ‘Real Men, Real Depression’ campaign in the United States (Rochlen, 2005; Seidler et al., 2016). However, even with the success that this campaign has experienced through the improvement of awareness of mental illness, the literature still indicates that a gap remains in help seeking behaviours for men (Rochlen, 2005; Seidler et al., 2016).

Studies indicate that one of the keys to bridging this barrier to engagement with an audience is through the use of social marketing (Dao Truong, 2014). Social marketing is defined by literature as,

“Social marketing is the adaptation of commercial marketing technologies to programs designed to influence the voluntary behaviour of target audiences to improve their
personal welfare and that of society of which they are a part” (Andreason, 1994, p. 110).

Social marketing began as an approach to social advertising, but with the help of modern literature has been adapted and reinvented into one of the main approaches in social communications and promotion (Dao Truong, 2014). Progressing from a traditional approach of marketing, used for the purpose of advertising goods and services, to a form of marketing used to promote information and raise awareness of relevant societal activity (Dao Truong, 2014). The following section will focus on the relevant social marketing theories that will be further discussed in chapter five as part of the discussion. Social marketing theories were used to assist in the development of the theoretical grounding for this research. With a number of relevant models and theories considered in the creation of the hypotheses stated later in this literature review, and the creation of campaign messaging.

Many studies suggest that social marketing consists of three main theories that assist in the promotion of information, these are: The transtheoretical model, social cognitive theory, and health belief model (Armitage & Conner, 2000; Dao Truong, 2014; Thackeray & Neiger, 2000). Social cognitive theory explains human behaviour and analyses behaviour change through the use of a three way dynamic model where personal factors, environmental influences, and behaviour interact (Armitage & Conner, 2000). This theory recognises that individuals learn from not only their own experiences but also through the observation of others actions and the results of those actions (Armitage & Conner, 2000). The health belief model hypothesises people’s beliefs about whether they are susceptible to a disease or health problem, and their perceptions towards the benefits associated with taking action to avoid such problems, are the main influence on their readiness to take action (Armitage & Conner, 2000). This theory mainly consists of perceived susceptibility, severity, benefits, barriers and cues to action that in turn will influence the individuals’ behaviours (Armitage & Conner, 2000). The final core theory of social marketing is the transtheoretical model which suggests that individuals can be at any one of five different stages in terms of readiness to adopt health behaviours (Armitage & Conner, 2000). This model has been very useful in explaining a number of behaviours associated with health promotion, which the researcher will further discuss in chapter five (Armitage & Conner, 2000).

With the preconceptions traditionally entrenched in the subject of mental health, there is a substantial reliance from the public for the media to provide factual information (Sieff,
This is why there are a number of substantial barriers towards people suffering from mental health issues as they are led to believe the misrepresentations the media broadcast (Corrigan, 1998; Klin et al., 2008; Vaughan et al., 2004). This increases stigma and discrimination making it significantly harder for those dealing with a mental health issue to live their lives without experiencing discrimination in their society (Corrigan, 1998; Klin et al., 2008; Vaughan et al., 2004). This form of information is one of the main sources that change and shape our perceptions and attitudes towards relevant topics in the media (Corrigan, 1998; Klin et al., 2008; Sieff, 2003). A number of studies illustrate the side effects such information sources can have on discrimination, further labelling and judging those who seek help from mental health interventions, creating distrust and preconceived misrepresentations of mental health illnesses throughout communities, further belittling those who are in need of help (Corrigan et al., 1995; Cross et al., 2011). This results in multiple consequences towards campaigns that target the reduction of stigma surrounding mental health.

Attitudes towards mental health campaigns remain generally neutral in modern society, however, many people continue to worry about how they will be perceived by society if they are caught acting outside of social norms (Schomerus et al., 2012; Rüscher et al., 2005). This generates more stigma and discrimination that only adds to the problems surrounding mental health (Schomerus et al., 2012; Rüscher et al., 2005). This makes it increasingly difficult for campaigns to become engaging and long term orientated as opposed to informative and short term focused (Sartorius, 2007; Stathopoulou et al., 2006). Reinforcing the above success factors of campaigns, contact and education were found to be most significant when shaping people’s perceptions on mental health and were the leading factors behind adjusting the attitudes and perceptions of individuals (Corrigan et al., 2000; Couture et al., 2003; Dalky, 2012).

2.5.1 Mental Health Campaigns

A number of mental health campaigns in previous years have been scolded, rejected or simply ignored by individuals due to their lack of engagement or inability to relate to individuals within their targeted demographic (Rüscher et al., 2005; Sartorius, 2007; Schomerus et al.,2012). Therefore, this section provides a brief overview of the key factors that have led to an increase in individuals’ help seeking behaviours and reductions in the perception of barriers to help seeking as a function of mental health campaigns in prior years.
Many mental health related programmes that have not reached their desired outcomes in the past, such as reduced barriers and increased behaviours towards help seeking, were due to their inability to be long term orientated and adaptable (Sartorius, 2007). Instead, many organisations have previously implemented campaigns that are short term focused, resulting in short term ‘wins’, which only deteriorates the long term consequences by prolonging the ability to make substantial and lasting changes to behaviours and attitudes (Sartorius, 2007). In several of these cases, the campaigns themselves lacked the identification of a specific target audience and instead targeted a much broader group of people (Rüsch et al., 2005; Sartorius, 2007; Schomerus et al., 2012). This may have somewhat increased people's knowledge on the topic but did not achieve the desired change in attitudes towards mental health (Rüsch et al., 2005; Sartorius, 2007; Schomerus et al., 2012). Another factor that these particular set of campaigns failed to address was the reinforcement of the campaign aim (Rüsch et al., 2005). Studies show that this simple step, although repetitive, has an overwhelming influence on the potential of mental health campaigns that is often unrecognised (Mehta, 2015; Sartorius, 2007).

The ability to have a successful mental health campaign will not only benefit the target audience but is likely to also result in positive externalities for the wider community/public in the form of changed attitudes and improved knowledge/awareness of mental health (Mehta, 2015; Rüsch et al., 2005; Sartorius, 2007). However, campaigns must first enhance the media’s knowledge and understanding of mental health as modern forms of media have influenced people into believing inaccurate information on mental health (Corrigan, 1998; Klin & Lemish, 2008; Vaughan & Hansen, 2004). The literature goes on to identify three main concepts that the stigma associated with mental health consists of, these are: Stereotypes, prejudice and discrimination (Cross, et al., 2011; Lauber, 2008; Rüsch, et al., 2005; Thornicroft, Brohan, Kassam, & Lewis-Holmes, 2008). Literature defines this terminology as, stereotypes are associations and attributions of specific characteristics to a group, prejudice is an attitude reflecting an overall evaluation of a group, and discrimination is biased behaviour towards, and sometimes even treatment of, a group or its members (Dovidio, Hewstone, Glick, & Esses, 2010). These negative connotations further promote discrimination towards those labelled as ‘mentally ill’ (Corrigan, 1998). Consequently, this causes a resounding change in the attitudes of the general public towards those suffering from mental illness (Corrigan et al., 1995). Individuals are labelled as ‘dangerous’ or ‘different’, resulting in fear from the public towards the targeted individual (Corrigan et al., 1995). Thus, segregating them as outcasts of modern communities, this leaves the general public avoiding those that are already experiencing times
of adversity (Corrigan et al., 1995). This leads to those who have experienced mental illness feeling emotions that are overwhelming, and out of fear of discrimination they become lost, with an inability to confidently seek help without the effects of social scorn (Corrigan, 1998; Kim et al., 2011; Seidler et al., 2016). It is because of this inability that many individuals who have previously or are currently dealing with a mental health issue begin to diminish their own self-esteem (Corrigan, Watson, & Barr, 2006). This is when self-stigma plays a significant role in one’s ability to understand their current situation, which only results in increasing the severity of the risk the person is at (Corrigan et al., 2006; Dalky, 2012; Barney et al., 2006).

A number of successful campaigns from the past have discovered that factors such as: consumer contact and educational information were found to combat these concepts of stigma, which could also be used to improve the media’s perceptions on mental health (Corrigan et al., 2000; Rüsch et al., 2005; Vogt, 2011). The literature suggests that campaigns largely consist of three strategies used in an attempt to reduce stigma, these are: education, contact and protest (Couture et al., 2003; Rüsch et al., 2005). Education attempts to debunk preconceived myths surrounding mental health and illness with accurate conceptions and information (Corrigan, et al., 2001; Couture et al., 2003; Rüsch et al., 2005). Contact strategies challenge the public’s attitudes about mental illness and health through direct interactions with people who have faced these challenges (Corrigan, et al., 2001; Couture et al., 2003; Rüsch et al., 2005). Finally, protest strategies aim to suppress stigmatising attitudes and behaviours towards mental illness (Corrigan, et al., 2001; Couture et al., 2003; Rüsch et al., 2005). These studies emphasise the importance education and contact/interaction play in changing attitudes rather than merely increasing the level of knowledge on mental health (Couture & Penn, 2003; Dalky, 2012). Also mentioning that although a valid strategy, protests result in negative associations coupled with less reputable results (Couture & Penn, 2003; Dalky, 2012). Education is highlighted as an ideal way to spread awareness of mental health issues (Couture & Penn, 2003; Dalky, 2012). It is the form of campaign that allows the target audience to improve their current knowledge through the questioning of their own thought processes on stigma (Corrigan et al., 2000; Rüsch et al., 2005). This becomes beneficial when campaigns need to get a substantial amount of information rapidly spread across a broad target audience (Corrigan et al., 2000; Rüsch et al., 2005). Yet the concept of consumer contact was suggested by the majority of the literature to be the most persuasive theme depicted from the campaigns (Couture & Penn, 2003; Dalky, 2012; Rüsch et al., 2005). Several studies identify contact as the most engaging and positive form of anti-stigma strategy used in mental health campaigns (Couture & Penn, 2003; Dalky,
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2012; Rüsch et al., 2005). The ability to physically engage in conversation and discussion with individuals who understand the challenges others may be facing is the key influencer behind changing the attitudes and behaviours of the general public (Couture & Penn, 2003; Corrigan et al., 2000; Dalky, 2012; Jorm, 2015; Thronicroft et al., 2008). These key interactions between those who have experienced the challenges of mental illness and the general public allow for a more interactive and lasting form of campaigning (Couture & Penn, 2003; Corrigan et al., 2000; Dalky, 2012; Jorm, 2015; Thronicroft, Mehta, Clement, Evans-Lacko, & Doherty, 2012). The literature suggests that contact with the public and people who have experienced mental health related challenges often result in the public becoming more aware of stigmatic and discriminatory behaviours (Corrigan et al., 2000; Sartorius, 2007). Therefore, the public would feel inclined to improve their efforts to reduce this discrimination (Corrigan et al., 2000; Sartorius, 2007). Campaigns that implemented educational information and strategies before contact strategies with individuals who have experienced mental health related challenges, reported better results in the reduction of stigma behaviours than campaigns that applied contact based strategies first, followed by educational information (Cross et al., 2011). Literature also indicated that the two strategies implemented together provided a greater influence and were more effective than when contact was used as an approach on its own (Couture et al., 2003; Cross et al., 2011; Sartorius, 2007; Schomerus et al., 2012).

Nevertheless, campaigns that resolve the three main concepts of stigma (discrimination, prejudice and stereotyping) were also found to be very informative (Cross et al., 2011; Rüsch et al., 2005; Schomerus et al., 2012). This allowed for contact between the public and those who had experience with a mental health issue who were open to sharing these experiences, inevitably underpinned the campaigns success (Cross et al., 2011; Rüsch et al., 2005; Schomerus et al., 2012). These campaigns that merge contact and education strategies, when successfully implemented acted as catalysts that drove the campaign from short term interventions to long term attitude changing strategies (Cross et al., 2011; Rüsch et al., 2005; Schomerus et al., 2012). This development will be further discussed in the sections below on the relationship between campaigns and the attitudes towards them, and also the role of social marketing in campaigns. By using the three forms of campaign strategy identified above, beneficial relations were identified between the stage at which many individuals were recognised as requiring help with their mental health related challenges and the level of illness they were experiencing (Newman et al., 2016). This allowed the process to become less of an exception among societal norms (Newman et al., 2016). This also meant the act of seeking help
for mental illnesses became more of an accepted action from a societal perception through various campaigns (Corrigan, Isaarkowitz, & Watson, 2004). Further studies also found that help seeking behaviours and participation in mental health services were supported, resulting in a higher use of mental health care services (Corrigan, 2004). It is suggested that these campaigns were able to succeed through their ability to effectively inform the general public with factual evidence that was unable to be manipulated by media (Corrigan, 1998; Vaughan & Hanson, 2004). This led to less distortion and misrepresentation of facts surrounding mental health in the media, which helped to significantly reduce stigmatizing behaviour (Corrigan, 1998; Vaughan & Hanson, 2004).

2.6 Relationship between Campaigns and Attitudes towards Mental Health

The literature suggests that the relationship between campaigns and attitudes towards mental health form the foundation from which engagement can develop (Sartorius, 2007). Recent literature portrays attitudes towards mental health as a very fluctuating and adverse aspect that over time creates the potential to change through various strategies and campaigns that become part of social norms (Rüsch et al., 2005; Lauber, 2008). Yet, in general, societies persist in the refusal to associate with mental health, casting negative attitudes and discrimination towards those labelled mentally ill (Lauber, 2008). Attitudes stand to affect the contact the public are willing to have with mental illness sufferers, stating that it is uncomfortable due to the unpredictable nature of the symptoms of mental illness (Lauber, 2008; Rüsch et al., 2005). Therefore, the relationship between mental health campaigns and attitudes towards mental health is critical to the success of the campaign in achieving their goals to reduce stigma (Corrigan, 1998; Klin et al., 2008; Lauber, 2008; Rüsch et al., 2005; Sartorius, 2007; Stathopoulou et al., 2006; Vaughan et al., 2004). Campaigns need to inform first, then connect to change the behavioural intentions of the general public (Corrigan et al., 2000; Rüsch et al., 2005; Vogt, 2011). This will inevitably see stronger links between campaigns and change in the general public’s perceptions and attitudes towards mental health, leading to an increase in mental health service use (Corrigan, 2004; Vogt, 2011). The literature often suggests the campaign advertisements have the ability to encourage help seeking behaviour, causing more people to talk about mental health (Cross et al., 2011; Rüsch et al., 2005; Schomerus et al., 2012). This engagement acts as a platform for further campaigning to take place where individuals can have contact/interactions with other individual’s who have
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experienced the challenges of mental illness (Cross et al., 2011; Rüsch et al., 2005; Schomerus et al., 2012; Thornicroft et al., 2012). Once changes can be made to the perceptions and attitudes held by the public through the use of media and campaigning, it will become more accepted in societies that those experiencing mental health issues seek help from mental health services (Kim et al., 2011; Corrigan et al., 2004).

Literature also shows that because of this acceptance, the interventions associated with seeking help have an effect on the negative attitudes and connotations associated with help seeking treatment, therefore reducing the discrimination and societal scorn patients suffer when seeking help (Brown & Loretta, 2002; Klin et al., 2008; Thornicroft et al., 2012). Consequently causing an effect that leads to an increase in the number of patients who are recognised early as mentally ill, these individuals become less of a target for behaviours of discrimination and stigma (Corrigan et al., 2004; Newman et al., 2016). Thus changing the attitudes surrounding the subject and the success the campaigns have specifically on the mentally ill (Corrigan et al., 2004; Newman et al., 2016). Overall, the literature describes the relationship between mental health campaigns and the attitudes towards mental health as fearful and often avoided, but with the correct strategies in place within a campaign, these have the potential to be changed and become drivers towards the push for societal acceptance towards treatment and the phenomenon that is mental health (Corrigan et al., 2004; Kim et al., 2011; Sartorius, 2007).

To engage with audiences, literature suggests that messaging (used in campaigns) can be influential in changing an audience’s behaviour and attitudes, further reiterating that the way in which a message is framed can have a significant impact on an individual (Gifford & Comeau, 2011; Gallagher & Updegraff, 2012; Maheswaran & Meyers-Levy, 1990; Salovey & Williams-Piehota, 2004). The promotion of public health campaigns is often framed to highlight either the benefits of engaging in a specific behaviour or action, this is referred to as ‘gain-frame’, or the consequences of not partaking or engaging in a particular set of behaviours or actions, this is referred to as ‘loss-frame’ (Gallagher & Updegraff, 2012; Maheswaran & Meyers-Levy, 1990; Salovey & Williams-Piehota, 2004). A number of studies suggest that gain-framed messages have a greater likelihood of encouraging prevention behaviours than loss-framed messages, especially when targeting health promotions such as, physical activity, smoking cessation and skin disease prevention (Gallagher & Updegraff, 2012; Salovey & Williams-Piehota, 2004). These studies further emphasised the suggestion that gain-framed messages were significantly more likely to promote prevention behaviours than loss-framed messages (Gallagher & Updegraff, 2012; Salovey & Williams-Piehota, 2004). Therefore, it is
suggested that when trying to promote preventative behaviour (in this context an example of preventative behaviour would be seeking professional help), campaigns should use a gain-frame message to engage with their targeted audience (Gallagher & Updegraff, 2012; Maheswaran & Meyers-Levy, 1990; Salovey & Williams-Piehota, 2004). Although the studies discussed above do suggest that gain-framed messaging is highly effective for the promotion of preventive behaviours, negatively framed messaging can be highly persuasive within certain contexts (Maheswaran & Meyers-Levy, 1990). To elaborate on this suggestion, if the individuals who receive the message is sufficiently involved with the issue then loss-framed messaging can be just as useful as gain-frame messaging (Maheswaran & Meyers-Levy, 1990).

Nevertheless, the above studies recognise the importance of message framing, a number of studies also suggest that there may be more to the framing of a campaigns message than a simple gain versus loss perception (Homer & Yoon, 1992; Maheswaran & Meyers-Levy, 1990; Shen & Dillard, 2007). The literature indicates that emotional (affective messaging) and cognition (cognitive messaging) based responses can have an influential role in the persuasion process of an individual (Shen & Dillard, 2007; Homer & Yoon, 1992).

Cognitive messaging strategies entail components that target the part of an individuals’ attitude that can be approached on a rational level with information and factual evidence used as means of persuasion (Broderick & Pickton, 2005). Cognitive messaging is based on the view that an important element of the campaign message should be to convey evidence and information (Broderick & Pickton, 2005). Both cognitive and affective messaging were used as one of the four advertising conditions throughout this thesis.

Affective strategies were used throughout this research as one of the four conditions used as part of the experimental design. Broderick and Pickton (2005) defined affective strategy as, “An affective or emotional strategy attempts to invoke involvement and emotion. Not usually associated with a strong ‘selling’ emphasis, the message can nevertheless be extremely powerful. The Lynx (respect for animals) poster campaign, which featured a fur coat being dragged along the floor leaving behind a trail of blood, was an extremely emotive plea to stop animals being bred and slaughtered for their furs” (Broderick & Pickton, 2005, p. 428).

The affective messaging allows campaigns to target an individuals attitudes and behavioural intentions through the use of emotive language, attempting to generate an emotional response or engagement with the advertisement, while cognitive messaging is very information and evidence based, provoking the audience to think about the information
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conveyed (Shen & Dillard, 2007). Of the two types of messaging, it has been suggested that affective messaging can cause a greater engagement with an audiences’ attitudes towards the campaign message and also attitudes towards a particular brand, rather than cognitive messaging (Homer & Yoon, 1992). However, the literature also highlights that the relationship between affective messaging and action/attitudes is very context dependent (Shen & Dillard, 2007). Therefore it is crucial that when researching the impact or difference between message framing to remain aware of various factors in the environment that could impact the audiences responses (Shen & Dillard, 2007). Although it has been suggested that affective messaging has a greater influence than cognitive messaging, studies indicate that they both have the potential to impact an audiences responses, but affective is suggested to be the more influential of the two (Homer & Yoon, 1992; Shen & Dillard, 2007).

Experimental research has widely examined these factors that lead to greater success and engagement for campaigns, specifically those used for public health promotion (Corrigan, 1998; Klin et al., 2008; Lauber, 2008; Rüsch et al., 2005; Sartorius, 2007; Statthopolou et al., 2006; Vaughan et al., 2004). Further analysing the influence a campaign’s message can have in changing an audience’s behaviours and attitudes (Gifford & Comeau, 2011; Gallagher & Updegraff, 2012; Maheswaran & Meyers-Levy, 1990; Salovey & Williams-Piehota, 2004). Gain verse loss frames of campaign messaging can be influential in attempting to reach audiences through conveying the benefits of, or consequences of not, partaking in a particular set of behaviours (Bauman, 2016; Rüsch et al., 2005; Lauber, 2008). Although they often incur negative associations due to the existing stigma surrounding the topic, such as mental health/illness, leading to preconceived ideas and assumptions made of those affected (Bauman, 2016; Rüsch et al., 2005; Lauber, 2008). However, a number of studies indicate that there is more than a simple gain frame versus loss frame approach to campaign messaging (Homer & Yoon, 1992; Maheswaran & Meyers-Levy, 1990; Shen & Dillard, 2007). Two key forms of campaign messaging that emerged from the literature were, affective campaign messages and cognitive campaign messages (Homer & Yoon, 1992; Maheswaran & Meyers-Levy, 1990; Shen & Dillard, 2007). Through the use of affective and cognitive campaign messaging, an audience can be targeted using rational to change an individual’s behavioural processes or emotive language to generate further engagement with a campaign (Broderick & Pickton, 2005). Therefore through the analysis of the influence of affective and cognitive campaign messages, research can further develop the understanding of which of these campaign messages has the potential to be more influential on individuals’ behavioural intentions and attitudes.
towards the campaign. As a result, analyses may suggest similar findings previously indicated in the literature, that affective messaging is more influential than cognitive campaign messaging on behaviours and attitudes. Based on these statements made above from previous literature regarding the relationship between attitudes and campaign messaging, it is further hypothesised that –

**Hypothesis 2**: There will be a significant difference in attitudes towards the campaign message as a function of condition, such that the participants in the affective message condition are expected to report more positive attitudes as compared with the other conditions.

With the above suggestions made by previous literature on the relationship between campaign messaging and the behavioural intentions and preventative behaviours of individuals, it is hypothesised that behavioural intentions will be different as a function of campaign messaging.

**Hypothesis 3**: There will be a significant difference in help seeking behaviours as a function of condition, such that the participants in the affective message condition are expected to report higher likelihood of help seeking as compared with the other conditions.

**Hypothesis 4**: There will be a significant difference in perceived barriers to seek help as a function of condition, such that the participants in the affective message condition are expected to report lower levels of perceived barriers to seek help as compared with the other conditions.

The literature also suggests that there is a significant relationship between individual’s age and help seeking behaviours (Mackenzie, Gekoski, & Knox, 2006; Mackenzie, Scott, Mather, & Sareen, 2008; Rickwood, Deane, Wilson, & Ciarrochi, 2005; Robb, Haley, Becker, Polivka, & Chwa, 2003; Sirey, et al., 2001). Although, conflicting suggestions remain prominent throughout the literature regarding this relationship, many studies suggest that as an individuals age increases, their help seeking behaviours also increase (Mackenzie et al., 2006; Mackenzie et al., 2008; Rickwood et al., 2005; Robb et al., 2003; Sirey, et al., 2001). Therefore in the context of this research it is plausible that age will also influence an individuals’ help seeking behaviours (Mackenzie et al., 2006; Mackenzie et al., 2008; Rickwood et al., 2005; Robb et al., 2003; Sirey, et al., 2001).

**Hypothesis 5**: There will be a positive relationship between participants’ help seeking behaviours and their age.
The current literature focuses on mental health within the organisation, mental health in sports in general, and mental health campaigns and their link with attitudes towards mental health. However, the contribution to the literature lies within the analysis of campaign messaging strategies and their influence on rugby players’ attitudes and behavioural intentions. The current literature significantly lacks explorative studies that analyse the effects of campaign messaging and its influence on rugby players’ (specifically) attitude towards the campaign messages, and wellbeing, especially in New Zealand. Therefore, the assumption was made that a gap exists in the literature regarding the influence of mental health campaign messages and the associated influence on rugby players in New Zealand.
3. Methods

3.1 Introduction

This chapter will discuss and review the research methodology applied to this project, including explanations on the research design, participants and data collection. A study’s methodology should not be perceived solely as a set of practices, rather a comprehensive way of approaching and developing the topic of the research piece (Kazdin, 2016). The objective behind research has always been to draw valid conclusions for future exploration, and the methodology provides the resources to achieving this (Kazdin, 2016). For this study, a quantitative and experimental approach has been used. Quantitative research is the process of explaining phenomena through the collection of numerical data that is further analysed using mathematically based methods (Mujis, 2004). Quantitative research methods are used when a researcher begins with a theory (or hypothesis) and tests for confirmation or disconfirmation of that hypothesis (Newman & Ridenour, 1998).

In Chapter 2, the researcher discussed the various factors and themes that relevant literature has highlighted as key drivers and barriers towards mental health for employees. Through the process of analysing relevant literature, a number of these barriers and drivers were emphasised with direct links to their influence on rugby players’ wellbeing. This research project aims to further question the influence of these drivers and barriers through an experimental design study. The findings from this research will allow the reader to gain a greater insight towards understanding what aspects of mental health campaigns affect rugby players’ attitudes and behavioural intentions towards seeking help. This chapter will begin by defining and explaining the research design used for this study.

3.2 Design

An experimental method with between-subjects design was used for this research. The project consisted of a survey that was used to measure participant responses towards mental health campaign messaging, including the impact they have on a rugby players’ attitudes towards mental health, behavioural intentions towards seeking help, and wellbeing (both general and mental wellbeing). The experiment ran for a period of 14 days, beginning on the 23rd of March 2018 and finishing on the 6th of April 2018. Participants received one of four mental health campaign advertisements (affective, cognitive, combined and original campaign...
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message). Participants who received the image with the original campaign message (which was created using an existing campaign message to raise the awareness of rugby players’ mental health challenges in New Zealand) formed the original campaign message group. This group was used as the foundation for comparisons against the experimental group. The study had a between subject design with four conditions (Condition: affect, cognition, combined vs. original campaign message).

3.3 Participants

This research was conducted with 191 total participants. Participants were recruited from the Canterbury Rugby Football Union’s (CRFU) database with the help of the community rugby manager. Rugby union players currently playing in the Canterbury rugby region and over the age of 18 years who were registered in this database were invited to take part in this research project. A total of 3,666 rugby union players were invited to participate in this research. Overall, 139 participants completed the survey (4% response rate). Total surveys submitted comprised of 118 male participants, and 21 female participants (with 5 registering as unlisted or did not select a gender).

Out of the 139 participants who completed the survey, 36 participants received the original campaign message (which used the same message as an existing national advertisement for mental health in rugby) this group formed the control advert for the experiment. The remaining 103 participants were distributed evenly across the three different experimental conditions (34 affective campaign message, 36 cognitive campaign message, 33 combined campaign message). All participants were randomly assigned to one of the four conditions. Of the participants who were invited, those who submitted a completed survey were offered the opportunity to enter a prize draw to win one of 10 NZD$50 shopping vouchers. Please refer to Figure 1 below for the participant numbers.
The demographic characteristics in the sample were analysed and the results are presented in the Appendices (see Appendix 7.5.1). The demographics table indicates that 139 participants took part in this study. Overall, 118 (84.9%) of participants were male, with ages ranging from 18 years to 54 years ($M=28.17$, $SD=8.95$); and 21 (15.1%) of participants were female, with ages ranging from 18 years to 39 years ($M=26.25$, $SD=5.57$). The age distribution shows that ages ranged from 18 to 45 and over, with the majority of the participant sample aged between 18-24 years old (41.1%). Participants aged between 25-34 years old were the
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second highest demographic in terms of sample representation with 38.9%. The remaining 20% was distributed across the 35-44 age range (13.7%), and the 45 and older age range (6.3%). Furthermore, the majority of the participants reported a tenure level in the sport of 16 years or more (49.6%). Therefore, it is safe to assume that with the majority age of participants identified above, many of the participants began playing rugby union at a young age in New Zealand. The largest reported ethnicity was New Zealand European with 74.8%, followed by Māori (including those who identified as ‘European-Māori’) and Pacific peoples at 9.3% and 8.6%, respectively. As shown in the Appendices (see Appendix 7.5.1), the majority of rugby union players that participated in this experiment played at a competitive club level (62.6%), with the most popular sub union being the Metropolitan sub union with 57.6% of participants stating they play their rugby here.

3.4 Materials

Participants were presented with a survey, which was created for this study using the survey creation website, Qualtrics (https://www.qualtrics.com). This research survey included the following measures: Attitudes towards the campaign messages, behavioural intentions towards seeking help for mental health related challenges, general and mental wellbeing, and demographics. Demographics measured in this study included: Age (measured in years), gender (listed as male, female, transgender male, transgender female, gender variant/non-conforming, or other), and ethnicity. Other demographic information included: Current rugby playing level (Measured in social club level, competitive club level, semi-professional level), playing region (Ellesmere Rugby sub union, North Canterbury sub union, or Metropolitan rugby sub union), and tenure at the participants chosen club.

3.4.1 Experimental Conditions

The surveys information page identified and explained the need for an increase the awareness of rugby union players’ mental health and wellbeing within Canterbury rugby union clubs. The research was therefore being conducted to analyse Canterbury rugby players’ general wellbeing and behavioural intentions towards seeking help. However, participants were unaware prior to beginning the study that the survey was part of an experiment in which there would be one control group (this will be referred to as the ‘original’ campaign message) who received the original campaign message and three distinctly different experimental groups.
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Rather than analysing broadly the ability to achieve behavioural change across the general public, the researcher designed four campaign messages on mental health with the intention to influence the voluntary behaviour of the target audience (rugby union players) (Wood, 2008). As this study is looking at public health campaigns rather than campaigns that sell physical goods, the main focus of these campaign messages was to create voluntary behavioural change among participants. By using the tools of standard marketing procedures to encourage voluntary behaviour change in target audiences for combined wellbeing, social marketing is able to demonstrate its potential in a number of sectors (Dao Truong, 2014). Each condition was created to target the demographic through different forms of behavioural responses (i.e. cognitive vs affective). Because of the suggestions made by literature, both affective and cognitive campaign messages were created, as well as the inclusion of a combined message that consisted of both campaign messages. Very little research had investigated the influence of a combined message, therefore this was included to provide further comparisons between campaign message effects on participants’ attitudes and behavioural intentions. An original (pre-existing) campaign message was also used to compare how the manipulated campaign messages performed against pre-existing mental health campaign materials.

The image used for the study remained the same across all four of the conditions (see Appendix 7.1), with only the text changing between campaign messages depending on the manipulation condition. The stock image used in the adverts was identified using Google’s advanced search, for images that were free to use, share or modify, to ensure no copyright infringements were made. The image for the advertisements was then modified to resemble a current mental health campaign for rugby players in New Zealand (see Appendix 7.1). These were created through a free to use image editing website called, Canva (https://www.canva.com). However, it should be noted that all campaigns had the same imagery, and only the campaign message changed (see Appendix 7.1). The experimental campaign messages structure was based on the original message to allow for comparisons to be made (see Appendix 7.1). This included a heading for the message, followed by a body of writing relevant to the manipulation (i.e. statistics on mental health in New Zealand for cognitive, and emotive wording for affective), concluding with a summary sentence intended to prompt behavioural action amongst participants (see Appendix 7.1).
3.4.2 Attitude towards the Campaign Message

For all survey scale items, a higher score indicated a greater (positive) response to the item, except for the perceived barriers to help seeking scale, where a higher score indicated a negative response. Attitudes towards the campaign message were measured using two separate scales, and behavioural intentions were measured using three separate scales.

Attitudes towards the campaign message were first measured using the attitudes towards the campaign message (novelty) scale (AN) (Koslow, Sasser, & Riordan, 2003; Sheinin, Varkl, & Ashley, 2011). This scale was developed to measure how interesting and original a person believes a campaign message to be (Koslow et al., 2003; Sheinin et al., 2011). The attitude (novelty) scale, was comprised of six items, which use a seven point response scale from 1 = “Strongly Disagree” to 7 = “Strongly Agree”. An example item is “This adverts message is interesting” (see Appendix 7.2.3) (Koslow et al., 2003; Sheinin et al., 2011). The internal reliability for the scale was acceptable (α = .87).

The attitudes towards the campaign message (informative) scale (AI) was also used to measure the attitudes towards the campaigns message (Haws, Dholakia, & Bearden, 2010; Pham, & Avnet, 2004). These items aim to be thought provoking and informative for participants (Haws et al., 2010; Pham, & Avnet, 2004). This scale used a seven point Likert scale to measure participant responses, from 1 = “Strongly Disagree” to 7 = “Strongly Agree”. An example from these items is “This ad has provided me with relevant information on the topic of mental health awareness” (see Appendix 7.2.3) (Haws et al., 2010; Pham, & Avnet, 2004). The internal reliability for the scale was acceptable (α = .86).

3.4.3 Behavioural Intention Measures

Two distinct measures were used to analyse participants’ behavioural intentions throughout this experiment, these included: Perceived barriers to help seeking scale, and the likelihood of seeking help scale. Behavioural intentions was first measured by the likelihood of seeking help scale (referred to in this thesis as a participants’ ‘help seeking behaviours’ for ease of differentiation between behavioural intention measures). Due to the lack of specific resources, a scale was created for the purpose of identifying a rugby union players’ likelihood of seeking help for a mental health challenge. This scale consisted of a single item that was created by the researcher for the purpose of this study. The item read, “The likelihood of me
seeking help for a mental health-related challenge is”, with participant responses measured on a seven point Likert scale where 1 = “Extremely Unlikely” to 7 = “Extremely Likely”.

The perceived barriers to help seeking scale (PBHS) was also used to measure participants’ behavioural intentions (Mansfield, Addis, & Courtenay, 2005). This scale consisted of five items on a seven point Likert scale from 1 = “Strongly Disagree” to 7 “Strongly Agree”. The perceived barriers to help seeking scale was intentionally left worded in a manner where a higher response (i.e. 7 = ‘Strongly Agree’) represented a less positive answer. This was used to prevent participants from answering the survey carelessly, and to assist in minimising any potential biases in their responses (Mansfield et al., 2005). An example of this item from this scale is “I would not want to seek help from others out of fear of appearing weak to my mates/peers” (see Appendix 7.2.3) (Mansfield et al., 2005). The internal reliability for the scale was acceptable (α = .82).

3.4.4 Wellbeing Measures

Wellbeing was measured with two items; general wellbeing and mental wellbeing. The first item was, “I would describe my general wellbeing at the present time as”, which was reworded from the Idler, Kasl, and Lemke (1990) scale, “How would you rate your health at the present time”. Participants were asked to record their responses on a seven point Likert scale from 1 = “Very Poor” to 7 = “Very Good”.

The second item read, “I would describe my mental wellbeing at the present time as”. This was altered from the same original scale item above, provided by Idler, Kasl, and Lemke (1990). Participants were instructed to record their responses on a seven point Likert scale 1 = “Very Poor” to 7 = “Very Good”.

3.5 Procedure

The scale items used to analyse the main hypotheses under investigation in this research was assembled in Qualtrics. Qualtrics as mentioned earlier, is an online survey tool suggested by the University of Canterbury that allows researchers free access to its survey services. Once the online survey was developed, 20 copies were distributed to local rugby players as a pilot study, to analyse whether the questions and the format were user friendly, allowing participants to have complete understanding. Following this step, once the feedback received from
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respondents was amended in the survey (question placement and some minor wording changes), the survey questions were finalised (see Appendix 7.2). A number of campaign messages representing different manipulations (affective, cognitive, and combined) were then created based on previous literature and examples. The researcher then deliberated over which messages would have the greatest influence on rugby players’ attitudes and behaviours. The experimental campaigns were then distributed along with six questions depicted from the survey, to a total of 20 respondents as part of the pilot study. This pilot test resulted in unsatisfactory responses and therefore was repeated with different campaign messages. As a function of the feedback from the initial pilot testing the detail within the messages were adjusted and distributed to a further 20 different respondents that formed the second pilot test. These advertisements had far better results suggesting that the campaign messages used for the second pilot test prompted differences between attitudes and behavioural intentions among respondents. Therefore, these campaign messages were finalised for the survey (see Appendix 7.2). This study was reviewed and approved by the University of Canterbury’s Human Ethics Committee on the 19th of February, 2018 (See Appendix 7.3).

The researcher then approached Canterbury Rugby Union who controlled the registry for all Canterbury rugby union football players within the Canterbury region. This organisation held the registry for players within the Canterbury region and was able to reach 3,666 individuals who met the criteria outlined in the participants section of this chapter. This allowed the researcher to gather data directly from players within the Canterbury rugby union. This factor, tied with the respected reputation the organisation has throughout the Canterbury region made them a very desirable organisation to have assist in the recruitment of participants. The researcher met with this organisation and discussed a criteria that participants would have to meet in order to take part in this research study. Due to the nature of this research, it was agreed between the researcher and community rugby manager that the appropriate age to participate in this experiment would be 18 or over. After this briefing, the organisation identified a section from their database that contained 3,666 potential participants (as outlined earlier) that would meet this criteria.

Recruitment of participants was then managed by the organisation's Community Manager who was able to access the organisations database after gaining required approval from the organisations CEO. With the assistance of the organisations content and media Manager, and information management Coordinator, the survey was able to be distributed across the chosen section of the database applicable to this study. Firstly, all potential
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participants (3,666 individuals) received an email from the organisation on behalf of the researcher introducing the research project and explaining the purpose and process of the survey involved with the study (see Appendix 7.4). Within this email was an invitation and link to the survey on Qualtrics, an online survey tool that was used in this study (see Appendix 7.4). The introduction for the survey explained the purpose of the study was to investigate rugby union players’ wellbeing, attitudes towards mental health campaign messages and behavioural intentions towards seeking help. Participants were informed that they hold the ability to withdraw their responses at any stage of the survey until they choose the ‘submit my responses’ answer in the final section of the survey. Participants were reassured that their identities will remain anonymous and all data collected remains confidential. For any further questions or comments on the study, the contact details of the projects researcher and supervisors were provided.

Along with responses to questions regarding the research measures outlined earlier, participants were also asked to provide demographic information (both general and context specific), an email address and informed consent. The participants gave their consent upon reading the information sheet that was presented to them at the beginning of the survey experiment. This consent was again required at the end of the experiment following a debrief sheet that informed participants of the deception involved in the study (i.e. the inclusion of multiple conditions/campaign messages) (see Appendix 7.2.6). All respondents verified themselves as meeting the experiment criteria of, currently playing rugby union and over the age of 18, and were therefore granted access to the online questionnaire. Participant email addresses were collected in a separate link that could not be traced back to the survey responses given (see Appendix 7.2.8). This email address was given by participants if they wished to register for the prize draw. Participant email addresses were later replaced by a four digit ID number once the collection of data had ended.

The survey also included a campaign message for mental health in rugby (see Appendix 7.2.2). There were four different conditions in total (affective, cognitive, combined and original campaign message) (see Appendix 7.1). The survey was open for a total of 14 days to give participants sufficient time to submit their responses.

In order to keep participant identity anonymous, email addresses were collected for the sole purpose of contacting prize draw winners and was a voluntary decision made solely by the participant. This was conducted using a separate survey link to ensure responses and email
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addresses could not be linked. Finally, all participants who completed the survey, had the
opportunity to enter the prize draw for their chance at winning one of 10 $50 Westfield
vouchers. This incentive was only offered to those participants who completed the survey. This
was performed in a separate link attached at the end of the survey that could not tie the
responses given in the survey to the individuals email address.
4. Results

4.1 Introduction

The aim of this chapter is to present the statistical analyses that were carried out to test the hypotheses outlined in Chapter 2. The first section of this chapter will provide an overview of the data screening, including the sample size and composition. The following section will discuss the factor analyses results for the relevant dependent variables. Next, the tests for the assumptions associated with Analysis of Covariance (ANCOVA) will be reported. Finally, the last section of this chapter will provide the findings from the hypotheses testing.

4.2 Data Screening

Prior to beginning the analyses, the participants’ responses were screened for incomplete data to ensure participant responses were complete and consent for data collection was given. Out of the 191 responses, 52 were removed as the information was either incomplete ($n = 51$) or no submission of final consent was given ($n = 1$).

To confirm that the requirements and criteria of the sampled population were met, the survey contained two ‘qualifying’ questions. These questions asked participants whether they were over the age of 18, and if they were current rugby players within the Canterbury region. When answered, participants were either forwarded to the end of the survey as they did not meet the criteria or were granted access to the survey/submission of their survey responses.

The final sample included 139 participants, of which 103 responses formed the experimental groups (34 affective message, 33 combined message and 36 cognitive message) and 36 participants formed the original campaign message group.

4.3 Factor Analysis

IBM SPSS Statistics Version 24 was used for all analyses in this research project.

After the removal of all non-submitted survey responses, a ‘missing completely at random’ (MCAR) test was run, to indicate that the probability of missing data on the dependent variable had no relation to other independent variables or the dependent variable itself. The data was expected to have a non-significant result, meaning the data was missing at random. The results were not statistically significant. Therefore, the data is most likely missing at
random, and pairwise deletion was the appropriate method to deal with missing data (Field, 2013).

To investigate the factor structure of the measures used in this study, both within and between-measure factor analyses, using principal axis factoring and oblique rotation (direct oblimin) were run on the outcome variables of this study (Field, 2013). By using factor analysis, the researcher was able to observe whether items loaded onto the factors they were supposed to (Field, 2013). For all scales, the resulting Kaiser-Meyer-Olkin (KMO) and Bartlett’s test of sphericity produced significant values across all scale analyses (> .7, \( p < 0.01 \)) (Field, 2013; Hutcheson & Sofroniou, 1999). Values are deemed acceptable when values exceed .7, and any values greater than .8 are preferred in accordance with Field (2013, pp. 706). Although the effectiveness of the Bartlett’s test is often questioned as the significance depends on sample sizes, and in factor analysis the majority of sample sizes are large, all analyses produced significant results. Therefore, with the recommendations made by Field (2013), it was deemed appropriate to proceed with factor analyses.

The following section will discuss the within-measures factor analyses. This will be followed by a further discussion of the between-measures factor analyses of the attitudinal intention measures, concluding with additional data analysis and hypotheses testing.

4.3.1 Overview

Kaiser’s criterion (Kaiser, 1960) was used to extract any factors that produced eigenvalues greater than 1, with no cross loadings greater than .3 and all factor loadings greater than .4 (DeVellis, 2012; Field, 2013; Schultz & Whitney, 2005).

Scree plots were unable to be used as extraction criteria as Stevens (2002) states that in order to use the scree plot as a reliable form of factor extraction, the sample size should ideally be equal to or greater than the value of 200 participants. Therefore, as this study only had 139 participants, this type of criteria was only able to be used to reinforce the identification of factors from the analyses.
4.3.2 Attitudes towards the Campaign Messages

Attitude measure: Novelty - The initial factor analysis produced just one factor for the attitudes towards the campaign message (Novelty) scale (Koslow et al., 2003; Sheinin et al., 2011). After taking the scree plot’s point of inflexion (Shultz & Whiney, 2005), the percentage of variance explained by factor 1 (47.2%), and the fact that the high eigenvalue of factor 2 still fell short of Kaiser’s criterion, the decision to extract only one factor was made. A composite score was therefore calculated for these items (entitled "Novelty”).

Attitude measure: Informative – For the second ‘attitudes towards the campaign message (informative)’ scale, factor analyses suggested two factors that produced eigenvalues greater than 1, and together explained 68.26% of the total variance. The scree plot was clear, showing inflexions that would validate the extraction of two factors. However, before proceeding with calculating the composites for these attitude measures (one for Novelty, two for Informative), the researcher conducted a between measure factor analysis which included all three of the attitudinal factors to see if there was an overlap between attitude scales. This was conducted given the potential conceptual similarity between the items within the measures. The analysis resulted in two factors (see Appendix 7.5.3). In addition, factor loadings suggested that three items originally in the Informative measure (AI06, AI07, and AI08) were now loading with the Novelty factor (see Appendix 7.5.3). Conceptually, the items loading onto this factor suggest that the Novelty dimension (factor 1), measures the visual appeal of the campaign advertisements (attitude – Novelty). Compared with factor 2 (Informative) in which items measured how descriptive and helpful the campaign advertisements were (attitude – Informative).

One exclusion was made, as item 2 (Novelty: “This ad is different from my expectations of a print advertisement) loaded poorly to both factors (.24) (see Appendix 7.5.3). This item showed low communality (.10 – Initial, .07 – Extraction). When conceptually analysing this scale item, it was obvious that this item was not measuring the same as the other items in the scale, using both outdated references and terminology referring to printed advertisements. The five other items within this scale (Novelty) all measured the uniqueness and engagement within the advertisement rather than the comparison of expectations between advertising platforms. These factors made it a simple decision to remove the item from the composite (see Appendix 7.5.3).
In conclusion, two composites were created; one for Novelty and another for Informative (see Appendix 7.5.3). Both the factor analyses and internal reliabilities were deemed acceptable for these composites (Novelty composite, $\alpha = .87$, Informative composite, $\alpha = .86$).

4.3.3 Behavioural Intentions

Only the perceived barriers to help seeking scale required factor analyses from the behavioural intentions variables. The second behavioural intentions scale (help seeking behaviours scale) was a single item scale, therefore did not require factor analyses. Two factors from the perceived barriers to help seeking scale reported eigenvalues greater than Keiser’s criterion of 1, and explained a total of 78.73% of the variance. The scree plot produced somewhat ambiguous results, with inflexions that would suggest the retention of 1 (possibly 2) factors, with the second barely meeting Kaiser’s criterion. With the sample size taken into consideration, the Keiser’s criterion would ideally be comfortably higher than the value of 1 for the second factor. If two factors were extracted then this had a significant impact on the internal reliability of one of the factors (falling from .82 to .71), as opposed to when there was only one factor extracted, the reliability of the factor was stronger as a whole. After looking at Kaiser’s criterion, Bartlett’s test for sphericity, scree plot produced and the impact on the internal reliability of the scale with one factor extracted as opposed to two, the decision was made to extract only one factor (see Appendix 7.5.4). A composite score for perceived barriers towards seeking help was created ($\alpha = .82$).

4.4 Assumptions of ANOVA/ANCOVA

Analysis of Variance (ANOVA) is a linear model, therefore it has multiple assumptions to ensure biases are accounted for or excluded (Field, 2013). The same assumptions used in ANOVA testing are also required for Analysis of Covariance (ANCOVA) with only one additional assumption, the assumption of homogeneity of regression slopes (Field, 2013).

ANOVA requires there to be two or more categories for the independent variable and a continuous dependent variable (Field, 2013). These were met using four separate campaign messages (independent variable), and a seven point Likert scale for dependent variable
responses. The independence of observations assumption was met as each participant was randomly assigned to one condition only.

A Levene’s test was conducted to examine the assumption of homogeneity of variance. All scales reported significance values $p < .05$, and therefore this assumption was met.

The assumption of normality was tested using the Shapiro-Wilk test, and the exploration of the data file in SPSS (Field, 2013). These tests indicated that the assumption of normality for the majority of measures was not met for the majority of the measures. Although the Shapiro Wilks test was violated ($p < .05$), the researcher was able to run a number of further tests for normality to see whether the distributions became more or less dispersed across a histogram when the population size decreased/increased (Field, 2013). These analyses were carried out to ensure the researcher did not breach or violate the central limit theorem (Field, 2013), providing evidence for a lack of severe violation. The results supported that the population size made a dramatic difference on the normality of the distribution, changing the skewness of the histograms, and therefore, confirming the central limit theorem that, “Parameter estimates of that population will have a normal distribution provided the samples are big enough” (Field, 2013, p. 170). With the graphical results produced, the assumption of normality requirements stated in Field (2013), and the robust nature of ANOVA testing (even when data is not normally distributed), parametric ANOVA tests were used for the analysis of this study, and data normality was assumed (Field, 2013).

Analysis of Variance testing assumes that there are no outliers within the dataset (Field, 2013). A number of boxplots were created to indicate any outliers existing in the data, with only eight outliers identified among the dataset. To test if these outliers required extraction from the dataset the analyses were run again without the identified outliers. These results reported no differences to the first analyses and therefore, no outliers were removed.

Because ANCOVA was used as part of these analyses, one additional assumption was required, the assumption of homogeneity of regression slopes (Field, 2013). This tests the relationship between the dependent variable and the covariate. In this study, both mental and general wellbeing were used as covariates for three of the five hypotheses tests. Therefore scatterplots were used as well as regression lines to analyse the type of relationship shared between dependent variables and wellbeing as a covariate. The results showed that there was a positive relationship across all analyses, and thus the assumption of the homogeneity of regression slopes was met (Field, 2013).
Results

Dependent variable means, standard deviations, coefficient alphas and correlations between variables are presented below in Table 1.
### Results

**Table 1. Means, Standard Deviations, Coefficient Alphas (in Brackets on the Diagonal), and Correlation between Variables**

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>SD</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Help Seeking Behaviours</td>
<td>4.40</td>
<td>1.76</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Perceived Barriers to Help Seeking</td>
<td>3.97</td>
<td>1.28</td>
<td>-.24**</td>
<td>(.82)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Attitude – Novelty</td>
<td>4.84</td>
<td>.98</td>
<td>.31**</td>
<td>.04</td>
<td>(.87)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Attitude – Informative</td>
<td>4.61</td>
<td>1.15</td>
<td>.13</td>
<td>.13</td>
<td>.50**</td>
<td>(.86)</td>
<td></td>
</tr>
<tr>
<td>5. General Wellbeing</td>
<td>5.35</td>
<td>1.21</td>
<td>.31</td>
<td>-.23**</td>
<td>-.04</td>
<td>-.02</td>
<td>-</td>
</tr>
<tr>
<td>6. Mental Wellbeing</td>
<td>5.06</td>
<td>1.41</td>
<td>.06</td>
<td>-.27**</td>
<td>-.11</td>
<td>-.06</td>
<td>.79**</td>
</tr>
</tbody>
</table>

*Note. n=139, p < .01 level (2-tailed); p < .05 level (2-tailed); All scales ranged from 1-7; For the Perceived barriers to help seeking scale a higher number represents a lower likelihood of seeking help.*
4.5 Hypothesis Testing

In order to test the hypothesised differences several Analysis of Covariance (ANCOVA), and correlation analyses were run.

4.5.1 Relationship between Help Seeking Behaviours and Participant Wellbeing

Hypotheses 1a/b proposed that there would be a positive relationship between participants’ help seeking behaviours and their general (1a) and mental (1b) wellbeing. For these hypotheses, the relationship between the two variables were measured using Pearson product-moment correlation coefficient. For general wellbeing, there was a non-significant relationship between the two variables \( r = .09, p = .31 \) and therefore hypotheses 1a was not supported. Similarly, for mental wellbeing, there was a non-significant relationship between the two variables \( r = .06, p = .52 \) and therefore hypotheses 1b was not supported.

4.5.2 Differences between Attitudes towards the Campaign Message as a Function of Condition.

Hypothesis 2 suggested that there will be a significant difference between attitudes towards the campaign message (Novelty & Informative), as a function of the conditions, while controlling for wellbeing. Two separate Analysis of Covariance (ANCOVA) tests were conducted. The first ANCOVA was conducted with the conditions as the independent variable, the attitudes towards the campaign message (Novelty) as the dependent variable, and both general and mental wellbeing as the covariates. The same ANCOVA test was run with attitudes towards the campaign message (Informative) as the dependent variable and wellbeing as the covariate. The results indicated no statistically significant differences between attitudes towards the campaign message as a function of the conditions, with \( F (3,133) = 2.22, p = 0.09 \) (Novelty); \( F (3,133) = 2.00, p = 0.12 \) (Informative). The results showed that the mean scores for each group were not significantly different from one another, thus Hypotheses 2 was not supported.

4.5.3 Participants’ Help Seeking Behaviours as a Function of Conditions

Hypotheses 3 stated whether a participants’ help seeking behaviours will be different as a function of the conditions, while controlling for wellbeing. The literature discussed in Chapter 2 suggests that affective campaign messaging will have more influence on help seeking
behaviours than cognitive (Homer & Yoon, 1992). Therefore, this hypotheses was created and analysed with the intention that affective campaign messaging will have the greatest influence on participants’ help seeking behaviours. To analyse this, the researcher ran an ANCOVA with the conditions as the factors, help seeking behaviours as the dependent variable, and both general and mental wellbeing as the covariates. No statistically significant differences were found in the participants’ help seeking behaviours as a function of the conditions, with $F(3,133) = .40, p = 0.75$. Thus, Hypotheses 3 was not supported.

4.5.4 Differences in Participants’ Perceived Barriers to Seeking Help as a Function of Conditions

Hypotheses 4 stated there will be a significant difference on participants’ perceived barriers to help seeking as a function of the conditions. As stated in the above hypotheses, it is expected that affective campaign messaging will have more influence on a participants perceived barriers to seeking help, than cognitive messaging because of suggestions made by previous studies within the literature (Homer & Yoon, 1992). In order to analyse this, an ANCOVA was conducted with the conditions as the factors, and participants’ perceived barriers to seeking help as the dependent variable, and both general and mental wellbeing as the covariates. Results indicated no statistically significant differences between participants’ perceived barriers to seeking help as a function of the conditions, with $F(3,133) = .995, p = 0.40$. Thus, Hypotheses 4 was not supported.

4.5.5 Relationship between Participants’ Help Seeking Behaviours and Their Age

Hypotheses 5 stated that there will be a positive relationship between participants’ help seeking behaviours and their age. To test the relationship between the variables a Pearson product-moment correlation coefficient was run. The analysis found that there was a small, negative relationship between the two variables, $r = -.23, p = .03$, suggesting that as the participants’ age increases, their likelihood to seek help for a mental health challenge decreased. Thus, Hypotheses 5 was not supported.
5. Discussion

This chapter begins with a brief discussion of the research purpose and objectives. Next, a discussion of the main findings from the research will be presented, outlining the findings from each of the hypotheses of this thesis. The researcher will then explain both the practical and theoretical contributions of this study. This will be followed by a discussion of the limitations and suggestions for future research.

5.1 Research Purpose

For many organisations the modern working environment has shed light on the value a mentally healthy workplace can offer to organisational success (Rüsch et al., 2005; Sartorius, 2007). For sporting organisations, this has become an important objective in recent times (Bauman, 2016). Studies suggest that when organisations can reduce the negative associations tied to mental health treatment, people are more likely to seek help rather than suppress their emotions out of fear of being judged or discriminated against (Gulliver et al., 2012; Kim et al., 2011). Therefore, the literature has suggested that the current culture (both societal and organisational) must be adapted to a more accepting and non-judgemental state (Bauman, 2016; Casey, Payne, & Eime, 2012; Rochlen et al., 2006). This way a new social norm can be established where athletes feel welcomed to seek mental health treatment without confronting any negative consequences or stigmatization as part of the process (Bauman, 2016).

Therefore, this research aimed to investigate campaign messages to further understand players’ attitudes and likelihood of help seeking behaviours. Specifically, the objective was to identify whether cognitive, affective or combined campaign messaging would be more influential on rugby players’ behavioural intentions towards seeking help for mental health related concerns and attitudes towards the campaign messages. As the above overview indicates, it is vital that organisations understand how to engage with their affiliates (including members and employees), in order to implement lasting processes towards reducing the stigma surrounding mental health issues.
Discussion

5.2 Research Findings

The results indicated very few significant differences between the experimental campaign messages on participants’ attitudes and behavioural intentions. The below section will discuss the potential reasons behind why hypotheses in this research were not supported.

Hypotheses 1a and 1b examined the relationship between rugby players’ help seeking behaviours and their general (1a) and mental wellbeing (1b). These hypotheses were developed based on previous literature that examined the impact of masculinity in rugby union on rugby union players’ behaviours, consequently influencing individuals’ wellbeing (Good & Wood, 1995; Pringle & Markula, 2005; Rochlen et al., 2006).

Contrary to suggestions made by the literature (Good & Wood, 1995; Pringle & Markula, 2005; Rochlen et al., 2006), the results indicated no statistically significant relationships between players’ help seeking behaviours and both general and mental wellbeing. Players’ who had higher levels of general or mental wellbeing, did not indicate higher levels of a players’ likelihood to seek help for mental health related challenges. Conceptually, this makes sense and when compared to literature it is not surprising that an individual who is experiencing higher levels of wellbeing would not be more likely to seek help as they are less likely to require professional help (Good & Wood, 1995; Pringle & Markula, 2005; Rochlen et al., 2006). Thus, neither players’ mental or general wellbeing share an association with players’ help seeking behaviours. With the suggested significant influence of masculinity, and the stigma that has traditionally been prominent throughout rugby union’s culture, research indicated that there would be significant relationships between help seeking behaviours and both mental and general wellbeing (Good & Wood, 1995; Pringle & Markula, 2005; Rochlen et al., 2006). Further suggesting that the culture and environment within rugby union often reduces a players’ wellbeing, consequently decreasing their likelihood to seek help for mental health related challenges because of the stigma associated with help seeking behaviours (Good & Wood, 1995; Pringle & Markula, 2005; Rochlen et al., 2006). However, the findings produced did not support hypotheses 1a or 1b. Nevertheless, the potential reasons for this lack of relationship are still intriguing. The lack of relationship suggests that even if a player has a high level of mental or general wellbeing, their help seeking behaviours can remain low. Therefore, campaign messages must encompass information for individuals experiencing various levels of wellbeing.
Discussion

Hypotheses 2, 3 and 4 suggested that there would be a difference among rugby players’ attitudes towards the campaign message (H2) (Novelty & Informative), help seeking behaviours (H3), and perceived barriers to seeking help (H4) as a function of the conditions (affective, cognitive, combined, original), while controlling for wellbeing. These hypotheses were created based on previous literature that investigated the difference between various outcomes as a function of different campaign messages (Homer & Yoon, 1992; Maheswaran & Meyers-Levy, 1990; Shen & Dillard, 2007). Results from past literature indicating that emotional and cognitive responses play an influential role in persuading individuals (Homer & Yoon, 1992). Suggestions from past research indicate that of the campaign messages, affective content would be more influential in improving an individuals’ behavioural intentions to seeking help and attitudes towards campaign messages than cognitive content (Homer & Yoon, 1992; Maheswaran & Meyers-Levy, 1990; Shen & Dillard, 2007).

Similarly, the findings regarding Hypotheses 2, 3 and 4 differ from the findings highlighted in the literature that suggested the affective campaign message would have a greater effect on attitudes (H2), likelihood of help seeking behaviours (H3), and perceived barriers to help seeking (H4), than cognitive campaign messaging (Homer & Yoon, 1992; Maheswaran & Meyers-Levy, 1990; Shen & Dillard, 2007). Contrary to the literature, the results indicated that these hypotheses were unsupported. This meant that players’ behavioural intentions (H3), perceived barriers to help seeking (H4), and attitudes towards the campaign messages (H2) were not significantly different as a function of the conditions. One potential reason for the lack of differences between the conditions is that the participants who took part in the survey were exposed to campaign messages that were short and concise. These campaign messages were created with the intent to avoid unnecessary increases in the attrition rate of the survey by increasing the duration of time participants spent in the survey. For the help seeking behaviours (H3), perceived barriers to help seeking (H4) and attitudes towards the campaign messages (H2) to differ as a function of the campaign messages, significant engagement is required (Homer & Yoon, 1992; Maheswaran & Meyers-Levy, 1990; Shen & Dillard, 2007). Therefore, with the conciseness of these campaign messages, it is also plausible that participants did not have the desired engagement with the messages that the researcher had anticipated. One reason as to why this could be possible is because of the lack of controls over audience engagement. This means that there was no way to know whether the participants actually read the campaign messages.
Discussion

Although the campaign messages met the researcher’s expectations of gathering high mean scores across all dependent variables, the lack of difference between dependent variables as a function of the campaign messages was disappointing. This makes it conceivable that the campaign messages/manipulations have limitations themselves. Although the literature suggested that the affective would be more effective than the cognitive messaging (Homer & Yoon, 1992), there was very little significant differences among the data analyses. Therefore it is conceivable that the campaign messages used within the survey produced results contrary to the literature as they lacked the distinction between campaigns required for achieving or identifying similar results. Future research can look at creating campaign messages that provide more detail to establish differences among campaign messages. This would allow the campaign messages to cover a greater deal of detail and the targeted audience to give much more thorough responses.

Hypotheses 5 examined the relationship between participants’ help seeking behaviours and their age. This hypotheses was constructed from current literature that discussed the plausible relationship between an individual’s age and their help seeking behaviours (Mackenzie et al., 2006; Mackenzie et al., 2008; Rickwood et al., 2005). Further suggesting that as an individual’s age increases, they are more likely to seek help for mental health related challenges (Mackenzie et al., 2006; Mackenzie et al., 2008; Rickwood et al., 2005).

Suggestions made by the literature studying age differences and help seeking behaviours remain unclear. However, a number of studies indicate that there are significant relationships between a person’s age and their help seeking behaviours (Berger, Levant, McMillan, Kelleher, & Sellers, 2005; Robb et al., 2003; Sirey, et al., 2001; Mackenzie et al., 2006; Mackenzie et al., 2008; Rickwood et al., 2005). That is, much research has found that as age increases, the individuals’ help seeking behaviour also improves (Berger et al., 2005; Robb et al., 2003; Sirey, et al., 2001; Mackenzie et al., 2006; Mackenzie et al., 2008; Rickwood et al., 2005). A significant relationship was found between participant’s age and help seeking behaviours. However, contrary to expectations, rugby union players who were older, were less likely to seek help for a mental health challenge. Hypotheses 5 was therefore not supported. However, it can be speculated that with the relevant literature coupled with the age and tenure statistics from the sampled population, the culture of rugby union represents an environment that when individuals have been in it for longer, they get acculturated into the masculine culture. Therefore it is speculated that individuals with longer tenure in the sport are less likely to seek help for mental health related challenges.
The results discussed above are both interesting and surprising when compared to previous literature. Moreover, contrary to the conclusions made by the literature, these findings suggest that there is a negative relationship between participant age and help seeking behaviours (Mackenzie et al., 2006; Mackenzie et al., 2008; Rickwood et al., 2005). The direction of this relationship found was contrary to a number of previous studies (Mackenzie et al., 2006; Mackenzie et al., 2008; Rickwood et al., 2005). As the literature review in Chapter 2 discussed, the earlier years of rugby union was when hegemonic masculinity became prominent throughout the sports culture (Anderson & McGuire, 2010; Harris & Clayton, 2007; Nauright & Chandler, 1996; Phillips, 1996; Pringle & Markula, 2005). This suggests that as participants’ age increases, the individual has experienced greater exposure to the hegemonic masculinity within the sport. Consequently embedding suppressive behaviours among players that the younger demographic may not have been exposed to. Therefore, it is implied that a participants’ age can be influential in likelihood of seeking help for mental health related challenges.

5.3 Practical and Theoretical Implications

Though the findings may appear limited, this research study has been able to produce both practical and theoretical contributions. This research was created with the intention to provide a greater insight into the current lack of empirical studies looking at New Zealand mental health campaigns in the field of sports management, specifically rugby players’ wellbeing and employee mental health. This study provides mental health organisations, sporting organisations and organisations in general with some additional suggestions in the way individuals should be approached about their mental health through campaign messages. These implications can specifically benefit those organisations in the sporting industry in New Zealand.

5.3.1 Practical Implications

This research aimed to assist the New Zealand rugby community in the form of practical contributions towards raising the awareness of mental health in rugby. This thesis has implications for sporting organisations in regards to identifying the need for more responsibility for the mental health of players. As a result of the lack of difference between outcome variables as a function of the campaign messages, there may be other avenues that
hold potential to be more impactful in creating change. This potential opens opportunities for
the training of players’ immediate support network in mental health awareness (e.g. a player’s
coach being trained in identifying the early signs of mental health problems). Therefore,
improving the discussion of mental health within the sport as well as promoting mental health
awareness through the initiation of conversation.

Though the manipulations of the campaign messages used in this study did not cause any
significant differences to a participants’ outcome variables, it can be speculated that different
forms of messaging are required. This means that in future, marketers or researchers could look
at the difference of a gain versus loss frame approach to messaging, rather than the affective
and cognitive messages detailed throughout this thesis. Literature suggests that these
approaches to messaging can be very influential and could provide greater responses among
the targeted demographic (Gallagher & Updegraff, 2012; Maheswaran & Meyers-Levy, 1990;
Salovey & Williams-Piehota, 2004). Therefore as the manipulations from this research did not
prompt differences among outcome variables, researchers may look at the different forms of
campaign messaging outlined above to engage with rugby players as this study indicates that
more is needed to increase help seeking behaviours among this demographic.

In chapter two, the researcher discussed the main objective of campaigns and their
messaging. Literature suggests that campaigns that resolve the three main concepts of stigma
(discrimination, prejudice and stereotyping) were found to be very informative and allowed for
contact between the public and those who had experience with a mental health issues (Cross et
al., 2011; Rüscher et al., 2005; Schomerus et al., 2012). However, literature also suggests that if
this study had used contact as the primary initiative rather than providing participants with
information about the issue, it would likely intensify the stigma (Cross et al., 2011; Rüscher et
al., 2005; Schomerus et al., 2012). Given the strong, pre-existing cultural norms around
masculinity and mental toughness, the behaviours and attitudes surrounding stigma would
likely increase (Cross et al., 2011; Rüscher et al., 2005; Schomerus et al., 2012). Instead, this
study attempted to use advertisements (campaign messages) to encourage meaningful
conversations where more players discussed their experiences with mental health issues. It can
then be speculated that this research is the first stage in a potentially broader research project
that may assist in breaking down the cultural barriers to starting the process of cultural change.
Therefore, this study is potentially the first to attempt this form of engagement between rugby
players in New Zealand.
Discussion

5.3.2 Theoretical Implications

The current literature significantly lacks explorative studies that analyse the effects of campaign messaging and its influence on rugby players’ attitude towards the campaign messages, and help seeking behaviours, especially in New Zealand. Moreover, the literature focuses specifically on mental health within the organisation, mental health in sports in general, and mental health campaigns broadly.

The contribution of the current study to the literature lies within the analysis of campaign messaging strategies and their influence on rugby players’ attitudes and behavioural intentions. Thus, the assumption was made that a gap exists in the literature regarding the influence of mental health campaign messages and their influence on rugby players in New Zealand. This research has therefore provided a foundation for future research studies within the field of organisational mental health and player wellbeing to be developed. Through the use of experimental research, this study trialled one of many different avenues that researchers are able to take when investigating this topic. Even though there was a lack of findings from the hypotheses of this research, the emphasis on player wellbeing and the importance of this topic is highlighted, leaving substantial potential for future experimental research to investigate. Additionally, this thesis builds on the current lack of empirical studies looking at New Zealand mental health campaigns in the field of management, specifically rugby players’ wellbeing and mental health. Further adapting and developing management theory, with potential implications towards social psychology research also. These implications are specific to the topics of social perception and prejudice within social psychology literature. Moreover, these implications progress the direction of studies towards the different forms of influence or interaction rugby players require for behavioural or attitudinal changes to occur. One theoretical implication that is very intriguing is the relationship found between a participants’ age and likelihood of help seeking behaviours. Contrary to literature, this finding indicated a negative relationship between these two variables. This finding creates a new avenue for future researchers to investigate within the targeted demographic of this study. This thesis assists the minority yet, growing body of research implying that an individuals’ age and likelihood of seeking help share a negative relationship (Olfson, et al., 2002; Troller, Anderson, Sachdev, Brodaty, & Andrews, 2007). Further challenging the suggestions made by literature (Berger et al., 2005; Robb et al., 2003; Sirey, et al., 2001; Mackenzie et al., 2006; Mackenzie et al., 2008; Rickwood et al., 2005).
5.4 Research Limitations and Future Directions

As with all research, there are limitations to this study that need to be considered and future directions that need to be discussed. The discussion of findings presented earlier in this chapter indicates the need for future research to fully understand the influence of campaign messaging on rugby players’ attitudes and behavioural intentions, to improve the current research on rugby player wellbeing.

Although the sample mean was diverse and included a range of different ethnicities, 74.8% of the sample population identified as NZ European/Caucasian (see Appendix 7.5.1). Future research therefore should encompass a wide variety of ethnicities where possible. Although rugby in New Zealand has become more diverse throughout the years (regarding gender and ethnic diversity), the demographic sampled remains similar to the current overall rugby playing population of New Zealand, therefore, conclusions can be used within reason. To improve this research and minimise demographic limitations, future research could be conducted on a larger sample size. This would allow for greater diversity among gender, and ethnicities, with potential for a higher representations of minority populations. This would allow the research to make much broader generalisations and also provide greater insights to minority groups.

The sample also included a significantly uneven ratio of males (84.9%) to females (15.1%), (see Appendix 7.5.1). This higher response rate from males may be explained by the gender inequality the sport of rugby union currently consists of. Since the sport was established in the early 19th century, rugby union has been heavily dominated by the male gender, and only in recent years has the gender diversity become more prominent within the sport. The literature identifies this gender inequality and further highlights significant differences between genders when dealing or coping with mental health issues (Anderson & McGuire, 2010; Rickwood et al., 2005; Seidler, et al., 2016; World Health Organization, 2003). This suggest that males are more likely so suppress rather than express their mental health related symptoms (Anderson & McGuire, 2010; Rickwood et al., 2005; Seidler, et al., 2016; World Health Organization, 2003). Moreover, studies also indicate that the modern culture of rugby impacts individuals decision to supress their emotions because of the hegemonic masculinity that developed from the sports traditional background (Anderson & McGuire, 2010). Therefore future research could analyse
males specifically for this study, gathering more detailed responses to draw conclusions as to why males suppress these mentally challenging emotions, specifically in male rugby players.

This research did not include participants under the age of 18 as highlighted in the original agreement between the research party and human ethics committee. With specific regards to teenage or high school rugby in New Zealand, the exposure to the sports culture is occurring at a much younger age. Furthermore, this demographic has not only experienced the current culture of rugby, but also has the potential to guide future culture of the sport through present actions and behaviours. Therefore, it would be of significant value for future research to analyse this demographic (18 years or younger) as they continue to play an influential role in the direction of rugby culture for future years to come.

One methodological limitation needs to be acknowledged in this research project is the use of a cross-sectional survey. Even though the decision to use a cross-sectional design was reinforced by previous research designs, cross-sectional study does not allow the researcher to analyse incremental changes to a participants attitudes and behavioural changes. Therefore, future research should consider conducting a longitudinal study to assess rugby players’ incremental behavioural and attitudinal changes over a longer period of time. One consideration associated with this future research would be to use the transtheoretical model as a means of analysis of players’ incremental changes. As discussed in Chapter 2, the transtheoretical model is used to outline an individual’s readiness to adopt health behaviours, which is highly applicable to future research using a longitudinal design on this topic.

Another future direction for research would be for researchers to apply qualitative methods to this study to further the understanding of participants’ attitudes, perceived barriers to seeking help and help seeking behaviours. In order to gather data of a high quality, researchers must look to improve past research. One way in which this is achieved is by adapting methods and research designs to create a greater engagement between participants and the study. This approach could be of significant benefit to future research as it allows the researcher gather far more in-depth knowledge and information from participants. A qualitative approach could investigate the relationship between campaign messaging and the outcome variables of this study in more detail than a quantitative approach could. Future research could therefore conduct a qualitative study where interviews are used as the primary method of research, surveys to gain more in-depth information and understanding of the attitudes and behaviours held by rugby players.
5.5 Conclusion

The main aim of this study was to analyse the impact of different campaign messaging on rugby players’ likelihood of help seeking behaviours, barriers to help seeking behaviours and attitudes towards the campaigns. The research hypotheses analysed in this study indicated that there was not enough differentiation between campaign manipulations for there to be a significant influence on participants’ help seeking behaviours and attitudes. However, the results did provide further insights into the factors such as age, and their relationship with, and influence on, rugby players’ help seeking behaviours. Moreover, with the discussion of the findings alongside the limitations presented in this study, it is suggested that further research is required to investigate different avenues that could potentially influence individual’s attitudes and help seeking behaviours. Furthermore, the potential influence from future research could also consequently improve the culture of rugby union over time. Nevertheless, this study does identify the importance of mental health and the challenges of stigma reduction through a unique and intriguing study on a demographic that is highly respected among New Zealand societies.
6. References


References


References


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References


References


References


7. Appendices

7.1 Final Campaign Messages

7.1.1 Affective Campaign Message

You do not need to suffer alone

Rugby is a team effort, why should mental health be different? In life or on the pitch, the mental battle can be the toughest, but there is always someone that can help you. The hardest part is taking the first step.

Share more - Feel more - Think more - Do more

7.1.2 Cognitive Campaign Message

1 in 5 kiwis experience some form of stress, anxiety and depression

In 2016, 169,000 kiwis accessed mental health services, growing from 158,000 in 2014. 47% of New Zealanders experience a mental illness and/or an addiction at some point in their lives, with one in five people affected every year.

For more information on mental health please contact your local health care provider
7.1.3 Combined Campaign Message

1 in 5 kiwis experience some form of stress, anxiety and depression. You do not need to suffer alone.

In 2016, 169,000 kiwis accessed mental health services, growing from 158,000 in 2014. 47% of New Zealanders experience a mental illness and/or an addiction at some point in their lives, with one in five people affected every year. Rugby is a team effort, why should mental health be different? In life or on the pitch, the mental battle can be the toughest, but there is always someone that can help you. The hardest part is taking the first step.

For more information on mental health please contact your local health care provider.
Share more - Feel more - Think more - Do more

7.1.4 Original Campaign Message

FEEL A BIT OFF?
It’s more common than you think

1 in 5 kiwis experience some form of stress, anxiety and depression. Rugby and the sporting community are no different.

Be proactive. Let's talk about mental health.
Appendices

7.2 Final Survey

7.2.1 Section One: Information and Consent

Department of Management, Marketing and Entrepreneurship
Telephone: 0800 VARSITY
Researcher: Josh Loader
Email: josh.loader@pg.canterbury.ac.nz

Research Project: How mental health campaign messages and imagery influence rugby players’ wellbeing - An analysis of attitudes and behavioural intentions towards seeking help

Please read the following information prior to starting the questionnaire

My name is Josh Loader and I am a postgraduate student at the University of Canterbury studying a Masters of Commerce. I would like to warmly invite you to participate in this research project.

Firstly, I would like to take this opportunity to thank all those who have decided to participate in this research questionnaire, your responses are truly appreciated.

The following survey should take no longer than 10 minutes to complete. You will be asked a number of different questions, including age, gender, general well-being, attitudes towards mental health campaign advertisements and behavioural intentions towards seeking help. You will have exactly two weeks to complete this survey, meaning the survey will close on Friday 6th of April at 5 pm.

There will be an opportunity to participate in a prize draw of 10 x $50 Westfield vouchers at the end of the survey.

This project is being conducted as part of the requirements for a Masters of Commerce degree outlined by the University of Canterbury, under the supervision of Dr Sarah Wright and Dr Sanna Mainen. Both Sarah and Sanna would be pleased to discuss any questions you may have regarding this research and your involvement. They can be contacted at the following email addresses, sarah.wright@canterbury.ac.nz or sanna.mainen@canterbury.ac.nz.

All data gathered as part of this research will remain confidential and you can be assured your identity will remain anonymous. The results will be analysed, interpreted and examined by the researcher and can be published as part of his Masters of Commerce thesis. A thesis is a public document and will be available through the University of Canterbury’s ‘Research Repository’.

Participation is voluntary and your identity will remain anonymous throughout the process. You have the right to withdraw at any point until your questionnaire has been submitted. After the point of submission, it is impossible to retrieve your data as it will be anonymous.

As participants of this study, you have the right to know that the CRFU will be presented with the data from this research in summary form (i.e., participants individual data will not be shared). This is to give the CRFU a greater insight into the current mental health situation of the Canterbury rugby region and to improve efforts towards effectively supporting those with mental health issues.

This project has been reviewed and approved by the University of Canterbury Human Ethics Committee, and participants should address any complaints to The Chair, Human Ethics Committee, University of Canterbury, Private Bag 4890, Christchurch (human-ethics@canterbury.ac.nz).

By completing this questionnaire, it is understood that you have given your consent to participate in the project outlined above. Furthermore, you accept the data collected will be analysed and the results published, but with the understanding of complete participant anonymity.

© I agree to participate and have read the terms and conditions of this project
This study requires participants are aged 18 years or over and are currently playing the sport of Rugby Union. Do you meet this requirement?

- Yes
- No

7.2.2 Section Two: Experimental Campaign Messages

Please take a moment to view the ad campaign and message below as the remainder of the survey will ask questions regarding your perceptions of the advert (You will be able to advance to the next question after 15 seconds)

1 in 5 Kiwis experience some form of stress, anxiety and depression

In 2016, 169,000 Kiwis accessed mental health services, growing from 158,000 in 2014. 47% of New Zealanders experience a mental illness and/or an addiction at some point in their lives, with one in five people affected every year.

For more information on mental health please contact your local health care provider
### 7.2.3 Section Three: Dependent Measures

Please select the amount to which you agree or disagree with the following statements:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>This ad is original</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This ad is different from my expectations of a print advertisement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This ad is memorable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This ad is visually interesting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This advert message is interesting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This ad is different</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please select the amount to which you agree or disagree with the following statements:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>This ad has provided me with relevant information on the topic of mental health awareness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This ad does a good job of presenting the issues surrounding mental health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This ad provides me with practical information</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This ad provides me with additional information about mental health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This ad explained the link between mental health and rugby well</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This ad encourages my thoughts about mental health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This campaign ad was able to convey its message well</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The image used made the campaign ad more relatable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Please indicate the likelihood of you personally seeking help for mental health-related challenges

<table>
<thead>
<tr>
<th>Extremely unlikely</th>
<th>Moderately unlikely</th>
<th>Slightly unlikely</th>
<th>Neither likely nor unlikely</th>
<th>Slightly likely</th>
<th>Moderately likely</th>
<th>Extremely likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>The likelihood of me seeking help for a mental health-related challenge is</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Below is a list of people you might seek help or advice from if you were experiencing a mental health-related challenge. Please select the option that indicates how likely it is that you would seek help from each of these individuals.

<table>
<thead>
<tr>
<th>Extremely unlikely</th>
<th>Moderately unlikely</th>
<th>Slightly unlikely</th>
<th>Neither likely nor unlikely</th>
<th>Slightly likely</th>
<th>Moderately likely</th>
<th>Extremely likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teammates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>GP/Doctor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friend</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Please Specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please select the amount to which you agree or disagree with the following statements

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would not want to speak help from others out of fear of appealing weak to my mates/peers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I wouldn’t want to overreact to a problem that wasn’t serious</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would prefer to just ‘suck it up’ than dwell on my problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I wouldn’t know what sort of help was available</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I wouldn’t know where to find help for mental health challenges</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendices

Please select the level you believe best reflects your **general wellbeing** at the present time.

<table>
<thead>
<tr>
<th></th>
<th>Very Poor</th>
<th>Poor</th>
<th>Below Average</th>
<th>Acceptable</th>
<th>Above Average</th>
<th>Good</th>
<th>Very Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would describe my General Wellbeing at the present time as</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Please select the level you believe best reflects your **mental wellbeing** at the present time.

<table>
<thead>
<tr>
<th></th>
<th>Very Poor</th>
<th>Poor</th>
<th>Below Average</th>
<th>Acceptable</th>
<th>Above Average</th>
<th>Good</th>
<th>Very Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would describe my Mental Wellbeing at the present time as</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Appendices

7.2.4 Section Four: Demographics

Please state your age in years in the box below

Please select your gender
- Male
- Female
- Transgender Male
- Transgender Female
- Gender Variant/Non-Conforming
- Not Listed
- Prefer not to answer

Please specify your ethnicity
- NZ European/Caucasian
- Māori
- European-Māori
- Pacific Peoples
- Asian
- Middle Eastern/Latin American/African
- Other
Appendices

7.2.5 Section Five: Mental Health Care Services Information

Mental health challenges are common in New Zealand with 1 in 5 kiwis experiencing some form of mental illness each year. If the study has raised any concerns for you, we recommend contacting your local GP for advice on the issue. Similarly, if you or someone you know is in need of help do not hesitate to get in touch with one of the following professional mental health care services:

- Lifeline (open 24/7) – 0800 543 543
- Depression Helpline (open 24/7) – 0800 111 757
- Anxiety Line (open 24/7) – 0800 ANXIETY (0800 209 4389)
- The Lowdown – Contact trained counselors by free text (5626)
- Samaritans (open 24/7) – 0800 726 666
Appendices

7.2.6 Section Six: Debrief Sheet and Final Consent

If you wish to submit your responses, please scroll down to the options at the bottom of the page.

The following is a Debriefing sheet for participants of this research.

Thank you for participating in my study, your input is greatly appreciated. If you wish to submit your answers please scroll down to the options at the bottom of the page.

The main purpose of this research was to determine what types of campaign messages and imagery influence rugby players’ attitudes and behavioural intentions towards mental health.

In this survey, I gave participants one of four rugby-specific mental health campaign adverts. This was followed by a set of questions on well-being, attitudes towards the advert, and behavioural intentions towards seeking help. Each advert was altered slightly differently in regards to the framing of the mental-health-related messages. Without these differences being included, the results of this survey would not be comparable.

I did not inform participants of the different adverts as participants may have responded differently had they known of different versions.

Please note that participation remains voluntary and you have the right to withdraw without penalty up until you click “Yes, please submit my responses” below. As beyond this point, there is no way of identifying an individual’s response for the purpose of removal.

Lastly, if you have any further questions regarding this research feel free to contact Josh Loader, josh.loader@uc.canterbury.ac.nz, senior supervisor Dr. Sarah Wright, sarah.wright@canterbury.ac.nz, or associate supervisor Dr. Sanna Mailinen, sanna.mailinen@canterbury.ac.nz.

If you would like to withdraw the answers you have provided up until this point, please select the “No, I wish to withdraw my answers and participation from this study”; if you would like to submit your answers and go in the draw to win 1 of 10 x $50 Westfield vouchers, please select “Yes, please submit my responses”.

- YES, Please submit my responses
- NO, I wish to withdraw my answers and participation from this study

7.2.7 Section Seven: Finish

We thank you for your time spent taking this survey and your participation is greatly appreciated.

Finally, if you would like to go into the draw to win 1 of 10 $50 Westfield vouchers, then please click the link below and enter your email address in the text box. If you do not wish to go into the draw, simply exit the page.

http://canterbury.qualtrics.com/je/form/SV_1KSJy5zdsPMlcabr

Your response has now been recorded.
Hello, and thank you for participating in this important research.

If you would like to be in the draw to win 1 of 10 x $50 Westfield vouchers please enter your email address in the box below. (It should be noted that the answers you have given in the research surveys cannot be linked to this email address, ensuring the anonymity of participants throughout this project).
7.3 Human Ethics Committee Approval

HUMAN ETHICS COMMITTEE
Secretary, Rebecca Robinson
Telephone: +64 3 365 4598, Extn 94568
Email: human-ethics@canterbury.ac.nz

Ref: HEC 2017/136

19 February 2018

Joshua Loader
Management, Marketing and Entrepreneurship
UNIVERSITY OF CANTERBURY

Dear Joshua

The Human Ethics Committee advises that your research proposal “How Mental Health Campaign Messages and Imagery Influence Rugby Players' Wellbeing: An Analysis of Attitudes and Behavioural Intentions towards Seeking Help” has been considered and approved.

Please note that this approval is subject to the incorporation of the amendments you have provided in your emails of 26th December 2017 and 15th January and 7th February 2018.

Best wishes for your project.

Yours sincerely

[Signature]

Professor Jane Maidment
Chair
University of Canterbury Human Ethics Committee
Appendices

7.4 Participant Recruitment

Rugby players’ attitudes towards mental health campaigns

Canterbury Rugby and the University of Canterbury invite you to participate in a research survey on mental health awareness in New Zealand rugby.

As current rugby union players, you can give us valuable first-hand information on this important topic.

This survey will take a maximum of 10 minutes, and is multiple choice. You will be asked for your opinions about an advert relating to Mental Health. Your responses to the questions will be kept anonymous and confidential so your identities cannot be linked to any responses you give in the survey. Each individual’s survey responses will be given a code to ensure that personal identifiers are not revealed.

There will be an opportunity to participate in a prize draw of 10 x $50 Westfield vouchers at the end of the survey.

If you are willing to participate, please click here to complete the survey.
### 7.5 Factor Analyses Tables

#### 7.5.1 Demographic Information

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male</td>
<td>84.9%</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>15.1%</td>
</tr>
<tr>
<td>Age</td>
<td>18 years – 24 years</td>
<td>41.1%</td>
</tr>
<tr>
<td></td>
<td>25 years – 34 years</td>
<td>38.9%</td>
</tr>
<tr>
<td></td>
<td>35 years – 44 years</td>
<td>13.7%</td>
</tr>
<tr>
<td></td>
<td>44 years and older</td>
<td>6.3%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>NZ European/Caucasian</td>
<td>74.8%</td>
</tr>
<tr>
<td></td>
<td>Māori</td>
<td>4.3%</td>
</tr>
<tr>
<td></td>
<td>European-Māori</td>
<td>5.0%</td>
</tr>
<tr>
<td></td>
<td>Pacific Peoples</td>
<td>8.6%</td>
</tr>
<tr>
<td></td>
<td>Asian</td>
<td>1.4%</td>
</tr>
<tr>
<td></td>
<td>Middle Eastern/Latin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>American/African</td>
<td>0.7%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>5.0%</td>
</tr>
<tr>
<td>Rugby Level</td>
<td>Social Club Level</td>
<td>31.7%</td>
</tr>
<tr>
<td></td>
<td>Competitive Club Level</td>
<td>62.6%</td>
</tr>
<tr>
<td></td>
<td>Semi-Professional Level</td>
<td>5.8%</td>
</tr>
<tr>
<td>Rugby Region</td>
<td>Ellesmere Rugby Sub Union</td>
<td>20.9%</td>
</tr>
<tr>
<td></td>
<td>North Canterbury Sub Union</td>
<td>12.9%</td>
</tr>
<tr>
<td></td>
<td>Metropolitan Sub Union</td>
<td>57.6%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>8.6%</td>
</tr>
<tr>
<td>Tenure in Rugby Union</td>
<td>0 years – 5 years</td>
<td>12.9%</td>
</tr>
<tr>
<td></td>
<td>6 years – 10 years</td>
<td>15.1%</td>
</tr>
<tr>
<td></td>
<td>11 years – 15 years</td>
<td>22.3%</td>
</tr>
<tr>
<td></td>
<td>16 years or older</td>
<td>49.6%</td>
</tr>
</tbody>
</table>
### 7.5.2 Attitude (Informative)

*Factor Loadings for the Items Measuring Attitudes towards the Campaign Messages (Informative)*

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor 1</th>
<th>Factor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>AI03</td>
<td>.872</td>
<td>-.121</td>
</tr>
<tr>
<td>AI04</td>
<td>.791</td>
<td></td>
</tr>
<tr>
<td>AI01</td>
<td>.758</td>
<td></td>
</tr>
<tr>
<td>AI02</td>
<td>.734</td>
<td></td>
</tr>
<tr>
<td>AI05</td>
<td>.518</td>
<td>.202</td>
</tr>
<tr>
<td>AI06</td>
<td></td>
<td>.792</td>
</tr>
<tr>
<td>AI07</td>
<td>.259</td>
<td>.582</td>
</tr>
<tr>
<td>AI08</td>
<td>.783</td>
<td></td>
</tr>
</tbody>
</table>

### 7.5.3 Attitude (Novelty and Informative)

*Factor Loadings for the items Measuring Attitudes towards the Campaign Messages (Informative and Novelty)*

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor 1</th>
<th>Factor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>AN03 This ad is memorable</td>
<td>.81</td>
<td></td>
</tr>
<tr>
<td>AI08 The image used made the campaign ad more relatable</td>
<td>.76</td>
<td></td>
</tr>
<tr>
<td>AN04 This ad is visually interesting</td>
<td>.71</td>
<td></td>
</tr>
<tr>
<td>AN06 This ad is different</td>
<td>.71</td>
<td></td>
</tr>
<tr>
<td>AI07 This campaign ad was able to convey its message well</td>
<td>.64</td>
<td></td>
</tr>
<tr>
<td>AI06 This ad encourages my thoughts about mental health</td>
<td>.63</td>
<td></td>
</tr>
<tr>
<td>AN05 This adverts message is interesting</td>
<td>.56</td>
<td></td>
</tr>
<tr>
<td>AN01 This ad is original</td>
<td>.48</td>
<td></td>
</tr>
<tr>
<td>AN02 This ad is different from my expectations of a print advertisement</td>
<td>.24</td>
<td></td>
</tr>
<tr>
<td>AI03 This ad provides me with practical information</td>
<td>-.81</td>
<td></td>
</tr>
<tr>
<td>AI04 This ad provides me with additional information about mental health</td>
<td>-.81</td>
<td></td>
</tr>
<tr>
<td>AI01 This ad has provided me with relevant information on the topic of mental health awareness</td>
<td>-.76</td>
<td></td>
</tr>
<tr>
<td>AI02 This ad does a good job of presenting the issues surrounding mental health</td>
<td>-.76</td>
<td></td>
</tr>
<tr>
<td>AI05 This ad explained the link between mental health and rugby well</td>
<td>-.55</td>
<td></td>
</tr>
</tbody>
</table>

### 7.5.4 Perceived Barriers to Help Seeking

*Factor Loadings for the Items Measuring Perceived Barriers to Help Seeking*

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor Loadings</th>
<th>Factor Loadings</th>
</tr>
</thead>
<tbody>
<tr>
<td>PBHS02</td>
<td>I wouldn't want to overreact to a problem that wasn't serious</td>
<td>.860</td>
</tr>
<tr>
<td>PBHS03</td>
<td>I would prefer to just 'suck it up' than dwell on my problems</td>
<td>.710</td>
</tr>
<tr>
<td>PBHS01</td>
<td>I would not want to seek help from others out of fear of appearing weak to my mates/peers</td>
<td>.584</td>
</tr>
<tr>
<td>PBHS05</td>
<td>I wouldn't know where to find help for mental health challenges</td>
<td>-.961</td>
</tr>
<tr>
<td>PBHS04</td>
<td>I wouldn't know what sort of help was available</td>
<td>-.905</td>
</tr>
</tbody>
</table>