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Engagement, Motivations, and Trust: How New Zealanders Use and Evaluate Mental Health Content on Social Media

A thesis presented in partial fulfilment of the requirements for the degree of

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In

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Aston Caron Garratt
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Abstract

This study explored how New Zealand residents who are interested in mental health content on social media engage with, evaluate, and perceive this material, a highly relevant topic given the growing unmet need for mental health support in New Zealand. A cross-sectional online survey was conducted with a sample of 915 participants (aged 16 and older) meeting these criteria. Participants ranked their platform and format preferences, identified motivations and perceived benefits and downsides, and rated the value and trustworthiness of various mental health influencer types. Results indicated a strong preference for short-form video on platforms such as Facebook and Instagram. Participants primarily engaged for learning-oriented reasons, valuing the 24/7 accessibility, anonymity, and access without direct payment. However, they also recognised significant risks, frequently citing misinformation, oversimplification, and a lack of professional guidance. Qualified mental health professionals and individuals sharing lived experiences were rated as the most valuable and trustworthy sources, whereas social media influencers with large followings were rated the lowest. Exploratory analyses revealed broad similarities between Māori and non-Māori participants, alongside nuanced differences in relational motivations and source evaluations. Ultimately, social media functions as an accessible, informal mental health information environment, highlighting the need for credible, safe, and culturally appropriate digital public health communication.

Keywords: mental health, social media engagement, health communication, digital wellbeing, source credibility, Aotearoa, New Zealand

Dedication

This research is dedicated to anyone who has experienced the grief of losing a loved one to suicide, as well as those who have chosen to pursue a career to support the mental health of our nation.

Preface

Mental health is a significant public health concern in New Zealand. Suicide is unnecessarily prevalent, and too many of us are faced with grieving the loss of a loved one. As I was writing this thesis, I lost a friend and colleague who chose to end his life out of desperation to escape unbearable chronic pain. Another industry colleague also took their life by suicide. Recently, I had to support my 11-year-old son through grieving the loss of his 23-year-old intermediate school teacher and her partner, both to suicide.

I myself was challenged with mental health in my youth, and it was through utilising the system and long-term psychotherapy that I was able to overcome my challenges and live a prosperous life now free from mental illness. I learnt what worked and what didn't in our mental health system when you are in crisis. I hope to utilise that experience, together with my passion for the pursuit of knowledge and understanding, to contribute to the mental health of New Zealand.

Acknowledgements

This research was conducted as part of a Master of Science Degree in Psychology. The purpose of this research was to seek public opinion and collect data around New Zealanders' attitudes and behaviours regarding their engagement with mental health content on social media.

I am grateful to the university for their commitment to student success, and for their ongoing support in facilitating this research and bringing it to completion. I would like to extend my sincere thanks to my supervisor, Dr. Matt Williams, for his guidance and supervision in finalising this thesis. I also wish to acknowledge Dr. Marthinus Bekker for his support during the inception and ethics approval phases of this project. Full approval of human ethics was obtained from the Massey University Human Ethics Ohu Matatika 3, Application OM3 23/26.4.

Declaration of Generative AI Use

OpenAI's ChatGPT was used primarily during the final stages of revising this thesis. The original thesis, including its research design, analysis, interpretation, arguments, and early full drafts, was completed independently without the use of generative AI.

During the final review, ChatGPT was used to help coordinate a systematic plan for addressing the supervisor's feedback across the complete thesis, identify potential inconsistencies between sections, and highlight areas requiring greater clarity, coherence, precision, or alignment. It was also used to check grammar and the consistency of formatting and presentation, including headings, tables, figures, numbering, cross-references, citations, and reference formatting, and to suggest possible revisions to wording or organisation. All generated suggestions were based on material provided by the author and were limited to reviewing, refining, and presenting the author's existing work. Generative AI was not used to develop the research design, conduct the analysis, interpret the findings, or generate original arguments or conclusions, including the initial complete drafts.

No generative AI output was incorporated without critical review by the author. All suggested factual or source-based content was checked against the research data and original scholarly sources, where relevant. Any AI-suggested wording used to inform final revisions was evaluated and rewritten in the author's own words to ensure that it accurately represented the intended meaning. The author made all final decisions concerning the thesis's content, wording, analysis, interpretation, formatting, and conclusions and accepts full responsibility for the submitted work.

Table of Contents

Engagement, Motivations, and Trust: How New Zealanders Use and Evaluate Mental Health Content on Social Media ..... *i*

Abstract ..... *ii*

Dedication ..... *iii*

Preface ..... *iv*

Acknowledgements ..... *v*

Declaration of Generative AI Use ..... *vi*

Table of Contents ..... *vii*

List of Tables ..... *xii*

List of Figures ..... *xiv*

Engagement, Motivations, and Trust: How New Zealanders Use and Evaluate Mental Health Content on Social Media *1*

1.1 The New Zealand Mental Health Crisis and the 'Unmet Need' **1**

1.2 Social Media as a Public Health Environment: Defining the Opportunity **3**

1.3 Theoretical Perspectives on Mental Health-Related Social Media Engagement **5**

1.3.1 Motivations and Media Selection 5

1.3.2 Source Credibility, Heuristics, and Platform Affordances 6

1.3.3 Perceived Benefits and Barriers 6

1.4 Current Landscape **7**

1.4.1 Mental health content shared on social media 7

1.4.2 Social media use and mental health outcomes 8

1.4.3 Structured mental health interventions delivered through social media 9

1.4.4 Populations and forms of engagement studied to date 10

1.5 Practical Gap 11

1.6 The Current Study: Aims and Contribution 12

Method 15

2.1 Research Design 15

2.2 Participants 15

2.2.1 Inclusion Criteria 15

2.2.2 Participant Flow and Final Sample 16

2.2.3 Sample Size Calculation 18

2.3 Recruitment 18

2.4 Procedure 19

2.5 Measures 19

2.5.1 Questionnaire 20

2.5.2 Demographics and Background (Items 1-5) 20

2.5.3 Active Engagement Indicator (Item 6) 20

2.5.4 Content Format Preference (Item 7) 20

2.5.5 Platform Preference (Item 8) 22

2.5.6 Rationale for Forced Ranking (Items 7–8) 22

2.5.7 Motivations for Engaging (Items 9–10) 23

2.5.8 Perceived Benefits and Downsides (Items 11–12) 24

2.5.9 Influencer Characteristics: Value and Trustworthiness (Items 13–14) 25

2.6 Ethics and Participant Wellbeing 26

2.7 Data Preparation 26

2.8 Data Analysis Plan 27

2.8.1 Descriptive Statistics 27

2.8.2 Rank-Order Items 27

2.8.3 “Select All That Apply” Items 28

2.8.4 Slider Ratings 29

2.8.5 Exploratory Māori and Non-Māori Comparisons (RQ4) 29

2.8.6 Open-Text Analysis 30

2.9 Data Availability Statement 31

Results 32

3.1 Participant Characteristics (RQ1) 32

3.2 Engagement Profile (RQ2) 36

3.2.1 Formats Ranked 36

3.2.2 Platforms Ranked 39

3.2.3 Motivations (Self vs. Others) 45

3.2.4 Open-Text Motivations 48

3.2.5 Benefits 51

3.2.6 Open-Text Benefits 52

3.2.7 Downsides 55

3.2.8 Open-Text Downsides 56

3.3 Social Media Influencer Evaluations (RQ3) 58

3.3.1 Perceived Value by Influencer Type 58

3.3.2 Perceived Trustworthiness by Influencer Type 61

3.3.3 Descriptive Comparison of Value and Trustworthiness 63

3.4 Exploratory Māori and Non-Māori Comparisons (RQ4) 63

3.4.1 Content Format Rankings 63

3.4.2 Platform Rankings 65

3.4.3 Motivations for Engagement 66

3.4.4 Influencer Value & Trust 67

Discussion ***70***

4.1 Overview of Findings **70**

4.2 Social Media as an Informal Mental Health Information Environment **71**

4.3 Accessibility, Anonymity, and the "Missing Middle" **73**

4.4 Platform and Format Preferences **75**

4.5 Credibility, Lived Experience, and the Limits of Popularity **77**

4.6 Māori and Non-Māori Engagement Patterns **79**

4.7 Reasons for Engagement for the Self Versus for Others **81**

4.8 Implications for Public Health Communication in New Zealand **82**

4.9 Strengths and Limitations **84**

4.10 Future Directions **87**

Conclusion ***90***

References ***92***

Appendix A ***105***

Recruitment Advertisement **105**

Appendix B ***106***

Participant Information Sheet **106**

Appendix C ***109***

Questionnaire **109**

Appendix D *117*

Content Format Post Hoc Comparisons **117**

Appendix E *118*

Social Media Platform Post Hoc Comparisons **118**

List of Tables

Table 1 Researcher-Developed Content Format and Platform Ranking Items.....21

Table 2 Researcher-Developed Motivation Items.....23

Table 3 *Researcher-Developed Perceived Benefit and Downside Items* 24

Table 4 Researcher-Developed Mental Health Influencer Rating Items.....25

Table 5 Core Participant Characteristics.....33

Table 6 *Highest Educational Qualification Reported by Participants*.....34

Table 7 *Ethnicity Reported by Participants* 35

Table 8 Ranked Content Formats by Likelihood of Engagement (N = 738).....36

Table 9 Generation Differences in Content Format Rankings: Kruskal-Wallis Tests and Mean Ranks.....38

Table 10 Ranked Social Media Platforms by Likelihood of Engagement (N = 798) 40

Table 11 User-Submitted Other Platforms or Online Channels for Engaging With Mental Health Content.....43

Table 12 Generation Differences in Platform Preferences: Kruskal-Wallis Tests and Mean Ranks.....44

Table 13 Reasons for Engaging in Mental Health Content on Social Media (N = 860) 45

Table 14 Holm-Adjusted McNemar Comparisons of Self Versus Others Motivations for Engaging With Mental Health Content on Social Media (N = 860).....47

Table 15 Generation Differences in Self-Reported Motivations for Engaging With Mental Health Content: Chi-Square Tests of Independence (N = 860) 48

Table 16 Content Analysis of User-Submitted Reasons for Engaging With Mental Health Content on Social Media.....50

Table 17 Benefits of Engaging in Mental Health Content on Social Media (N = 831).....52

Table 18 Content Analysis of User-Submitted Benefits of Engaging With Mental Health Content on Social Media 54

Table 19 Downsides to Engaging in Mental Health Content on Social Media (N = 819) 55

Table 20 Content Analysis of User-Submitted Downsides of Engaging With Mental Health Content on Social Media 57

Table 21 Perceived Value of Content by Mental Health Influencer Type 58

Table 22 Perceived Trustworthiness by Mental Health Influencer Type 61

Table 23 Mean Content Format Ranks by Ethnicity (Māori vs. Non-Māori) 64

Table 24 Mean Social Media Platform Ranks by Ethnicity (Māori vs. Non-Māori) 65

Table 25 Value and Trustworthiness Ratings by Influencer Type and Ethnicity 69

Table D1 Holm-Adjusted Durbin-Conover Post Hoc Pairwise Comparisons for Ranked Likelihood of Engagement by Content Format (N = 738) 117

Table E1 Holm-Adjusted Durbin-Conover Post Hoc Pairwise Comparisons for Ranked Likelihood of Engagement by Social Media Platform (N = 798) 118

List of Figures

Figure 1 Participant Flow Through Screening, Consent, and Inclusion in Analysis 17

Figure 2 Distribution of Content Format Rankings by Likelihood of Engagement 37

Figure 3 Distribution of Social Media Platform Rankings by Likelihood of Engagement 41

Figure 4 Self-Reported Motivations for Engaging With Mental Health Content on Social Media by Ethnicity 67

Engagement, Motivations, and Trust: How New Zealanders Use and Evaluate Mental Health Content on Social Media

1.1 The New Zealand Mental Health Crisis and the 'Unmet Need'

Mental health is a leading cause of disability worldwide, with approximately one in eight people living with a mental health condition (World Health Organization, 2022). In New Zealand, the high prevalence of psychological distress has been a persistent public health concern for some time, with recent data indicating the issue is not only ongoing but escalating. The latest *New Zealand Health Survey (2023/24)* found that 13.0% of all adults experienced high or very high levels of psychological distress in the past four weeks, a statistically significant increase from 8.3% in 2018/19. Disproportionately high rates were found in key demographic groups in New Zealand: young adults aged 15–24 years (22.9%), disabled adults (33.2%), Pacific Islander adults (20.0%), and Māori adults (19.5%) (Ministry of Health, 2024). Effectively addressing mental health difficulties in our society continues to be a challenge, as highlighted by the government inquiry, *He Ara Oranga* (Government Inquiry into Mental Health and Addiction, 2018) while it is often noted in the media (e.g., Hill, 2025; Meier & Lourens, 2021; Rudd, 2022; Spence, 2022).

Existing literature highlights a sizeable treatment gap, both worldwide (e.g., World Health Organization, 2025), and in New Zealand (e.g., Ministry of Health, 2024; Te Hiringa Mahara, n.d.). This gap, often termed 'unmet need', is widening, making it increasingly difficult for people to access adequate care. In New Zealand, the proportion of adults with an unmet need for professional mental health support more than doubled from 4.9% in 2016/17 to 10.7% in 2023/24 (Ministry of Health, 2024).

This growing 'unmet need' is driven by well-documented barriers to traditional care. The *He Ara Oranga* inquiry, for instance, cited significant obstacles, which included long wait

times, high service thresholds, and a system too overworked to provide timely support (Government Inquiry into Mental Health and Addiction, 2018). Furthermore, the *New Zealand Health Survey* identifies cost as a primary reason for unmet need, alongside attitudinal barriers such as stigma (concern about what others might think) and a desire to self-manage (Figure.NZ, 2023; Ministry of Health, 2024). These barriers are particularly prohibitive for the "missing middle" - those in distress but not deemed "acute" enough for specialist services (Government Inquiry into Mental Health and Addiction, 2018).

It is in the context of these barriers that social media may present an underexplored opportunity. With 79.1% of the total New Zealand population (4.14 million people) actively using these platforms (Kemp, 2025), and usage concentrated among the 15–24-year-old, “young adult” demographic (SocialMedia.org.nz, 2025) who report the highest distress among the age groups (Ministry of Health, 2024), social media presents a highly scalable avenue for extending mental health resources beyond traditional clinical settings. This digital environment may provide a novel pathway to engage the wider community by potentially reducing some of the barriers, such as cost, wait times, and stigma, that define the current treatment gap. This may create opportunities to provide psychoeducation and peer-support frameworks to the "missing middle" and to deliver culturally appropriate support directly to other disproportionately affected demographics, such as rangatahi Māori and Pacific peoples (Government Inquiry into Mental Health and Addiction, 2018). In essence, social media may offer a way to "meet people where they are”. Its reach and frequency of use create the potential to support mental health literacy and help seeking, although whether these benefits materialise depends on the quality, credibility, and suitability of the content and cannot be assumed to reduce unmet need.

1.2 Social Media as a Public Health Environment: Defining the Opportunity

The potential for social media to contribute to addressing the mental health treatment gap stems from its role as an established environment in which information is shared (Chen & Wang, 2021), health-related behaviours are formed (Paul & Headley-Johnson, 2025), and public health interventions can take place (Abroms, 2019). Unlike other preventive health interventions where health service users will need to make an active attempt to reach a clinical setting, New Zealanders may now be engaged through social media, which has become a key social environment in their daily lives, where they already spend considerable time (Kemp, 2025). Social media platforms are interactive, networked environments in which users create, share, and respond to content and form online communities (Chen & Wang, 2021; Johnson et al., 2022). Their interactive and user-driven nature may make them useful environments for health communication, while also allowing health information to circulate largely outside the oversight of traditional health institutions (Naslund et al., 2017).

Within the social media environment the ability to aid with mental wellbeing takes place through several principal pathways including psychoeducation, peer-to-peer support, and stigma reduction. Psychoeducation refers to the provision of information regarding mental health problems, coping mechanisms, and how to access services (Morgado et al., 2022). Ideally this information should be evidence-based. On social media, psychoeducation may take the form of accessible informational content about symptoms, coping strategies, treatment options, and service access.

Peer support enables the sharing of feelings and emotions with others who share a common experience. Social media may extend the reach of peer support as it enables users to find community, validate those experiences, and share their advice on forums and

comment sections, as well as by following creators who share their own journeys of mental health (Naslund et al., 2016).

Social media interactions may contribute to stigma reduction as these interactions normalise conversations about mental distress. Specifically, these platforms have the potential to lessen both self-stigma (the internalisation of negative stereotypes) and public stigma (attitudinal barriers to help-seeking) by offering a space for discussion and a platform for declarations of lived experience (Naslund et al., 2020; Z. Zhang et al., 2025).

However, content cannot contribute to outcomes unless users encounter and engage with it. Engagement is a multidimensional concept that can involve behavioural actions such as viewing, liking, sharing, or saving content, as well as cognitive and emotional responses (Heldman et al., 2013; Trunfio & Rossi, 2021). The present study focuses on self-reported engagement history, likelihood of engaging with different formats and platforms, motivations, perceived benefits and downsides, and evaluations of influencer types.

Mental health content, as defined in this thesis, encompasses any content on social media that addresses mental distress, wellbeing, coping, diagnosis, treatment, recovery, or help-seeking (Naslund et al., 2020). This includes informational or psychoeducational posts such as symptom explanations, advice, signposting to services, lived-experience narratives, practical self-help or coping strategies, along with emotionally or socially oriented content such as motivational messages, humour, and memes (Akram & Drabble, 2022; Fergie et al., 2016; Naslund et al., 2016). Material of this nature exists in various modalities such as short-form video, long-form video, text posts, carousels, live streams, and image- or meme-based media (Fettig, 2025; Naslund et al., 2019), each of which provides different levels of depth, emotional effect, interactivity, and cognitive processing demand (Sundar, 2008). Short-form video, story, and meme formats may encourage relatively rapid assessments, whereas

longer videos, guided explanations, and text-based posts may permit more sustained attention and elaboration (Feng et al., 2025). As a result, “mental health content” should not be treated as a homogeneous category; its structure, modality, and platform-specific affordances contribute to the ways users engage with it and their perceptions of the relevance of the content to their own or others’ wellbeing (Fettig, 2025; Naslund et al., 2020).

1.3 Theoretical Perspectives on Mental Health-Related Social Media Engagement

Because the present study is descriptive and was not designed to test a single theory, the following perspectives are used as interpretive lenses rather than as an integrated theoretical framework. Uses and gratifications theory (Katz et al., 1973) provides the primary account of motivations and media selection, source credibility theory (Hovland et al., 1953) informs the interpretation of influencer evaluations, and the Health Belief Model (Rosenstock, 1974) provides a limited lens for perceived benefits and barriers. Heuristic processing and platform affordances are used more selectively to interpret particular findings.

1.3.1 Motivations and Media Selection

To illustrate why New Zealanders choose certain platforms and formats (e.g., short video, long videos, text posts, and memes), we draw upon the uses and gratifications theory. This perspective frames media use as an active process in which users select platforms to meet specific needs, such as information-seeking, social connection, coping, and entertainment (Falgoust et al., 2022; Katz et al., 1973; Whiting & Williams, 2013). For example, short video content is chosen for efficiency and immediacy, while long video or text-based content allows for greater depth and archivability. Ultimately, this theory

provides a useful context for interpreting participants' reported motivations and format preferences, rather than representing variables directly tested in the study.

1.3.2 Source Credibility, Heuristics, and Platform Affordances

Dual-process accounts of persuasion distinguish effortful evaluation from quicker reliance on cues. In rapidly scrolling social media environments, users may rely on heuristics such as source expertise, familiarity, popularity, or social proof when judging content (Chaiken, 1980; Metzger & Flanagin, 2013). The present study did not measure processing routes; this distinction is used only to help interpret participants' evaluations of influencer types and qualities.

Engagement is also influenced by source and platform factors. Source credibility, commonly defined in terms of expertise, trustworthiness, and attractiveness, has been well established as a central factor in influencing message acceptance (Hovland et al., 1953; Ohanian, 1990) and contributes to why different influencer types (e.g., clinicians, peer advocates, or public figures) stimulate dissimilar levels of receptivity.

Platform affordances, such as visibility, persistence, editability, and association may also shape how content and its creator are encountered (Treem & Leonardi, 2013). Design cues such as verification, creator identity, and responsiveness may influence credibility judgments and willingness to engage (Metzger & Flanagin, 2013; Sundar, 2008). These concepts provide context for interpreting platform, format, and influencer evaluations, rather than representing variables directly tested by the study.

1.3.3 Perceived Benefits and Barriers

The Health Belief Model is used to link engagement with the mental health decision-making process. The model proposes that health-related behaviour is shaped by individuals' perceived susceptibility, perceived severity, perceived benefits, perceived barriers, self-

efficacy, and cues to action (Champion & Skinner, 2008; Janz & Becker, 1984; Rosenstock, 1974).

The present study did not test the full Health Belief Model. However, its questions about perceived benefits and downsides broadly correspond to the model's perceived benefits and perceived barriers constructs. The model is therefore used as a limited interpretive lens for those findings, rather than as an account of all platform, format, motivation, and influencer variables examined.

1.4 Current Landscape

The theoretical perspectives outlined above identify several factors that may shape engagement. To establish what the present study adds, the existing evidence must be considered in relation to the content available, its associations with mental health outcomes, the effectiveness of structured interventions, and the populations and forms of engagement studied to date.

1.4.1 Mental health content shared on social media

Research on the contribution of social media to mental health has increased significantly over the past ten years, highlighting the pervasive nature of social media as a communication environment and platform for the widespread dissemination of health information. Social media platforms now function as parallel, not peripheral, public health spaces where people seek information, observe others' experiences, form impressions about help-seeking, and negotiate their own wellbeing (Abroms, 2019). Mental health-related content takes place on all key platforms, including TikTok, Instagram, YouTube, Facebook, Reddit, and X (formerly Twitter), all with their own affordances, algorithms, and interaction structures, shaping the form and the effect of mental health content (Chen & Wang, 2021; Fettig, 2025; Naslund et al., 2017).

Existing research has documented a wide range of mental health content on social media, including psychoeducational material, coping advice, lived-experience narratives, peer-support exchanges, and humour-oriented posts (Ahmed et al., 2024; Subba & Kumar, 2024; Sulaiman et al., 2024; Yuan et al., 2023). Work in this area has identified both advantages, such as enhanced mental health literacy, normalisation of distress, emotional validation, and peer-support-based empowerment, alongside risks, such as misinformation, stigma reinforcement, encouraging maladaptive norms, and exposure to triggering material (Naslund et al., 2020; Paul & Headley-Johnson, 2025; Z. Zhang et al., 2025). This duality highlights the need to know not only what exists, but also how people perceive the content and react to it.

1.4.2 Social media use and mental health outcomes

The links between social media use and mental health outcomes are another key theme in the literature. The findings across studies are mixed. Some research reports beneficial effects, such as strengthened social connection and improved coping (Bekalu et al., 2019; Karim et al., 2020), while others identify associations with increased distress, depressive symptoms, or anxiety – particularly in the context of passive consumption, social comparison, or exposure to harmful content (Berryman et al., 2018; Seabrook et al., 2016). A meta-analysis examining 61 studies with nearly 20,000 participants, found only a small negative association between time spent on social media and psychological wellbeing, concluding that only excessive use appears to predict poorer mental health (Huang, 2017). This research, however, included studies that relied heavily on student samples, limiting generalisability.

New Zealand population-level studies suggest that total time spent on social media has only weak associations with psychological distress. Two large studies based on data

from the New Zealand Attitudes and Values Study (NZAVS) investigated these associations (Jarman et al., 2023; Stronge et al., 2019). Both studies found very low correlations between social media use and psychological distress when viewed at the population level, with social media use ranking below most other predictors, including sleep. Importantly, Jarman et al. (2023) reported that social media use and wellbeing are bidirectional, with psychological distress more strongly predicting subsequent increases in social media use than the reverse. This pattern is consistent with psychological distress preceding some increases in social media use, rather than social media use being the stronger predictor of subsequent distress. However, both studies are purely dependent on "hours of use" as their measure of engagement, which provides little information about what people actually do online or whether different forms of engagement associate with mental health. This mirrors a larger general limitation in the international literature where research often focuses on frequency rather than type of usage despite evidence that positive, active uses (e.g., social connection, content creation) are related to lower levels of depression, while negative, passive uses (e.g., social comparison, scrolling without interaction) are associated with poorer mental health (Best et al., 2014; Escobar-Viera et al., 2018; Seabrook et al., 2016).

1.4.3 Structured mental health interventions delivered through social media

Evidence for structured mental health interventions delivered through social media is promising but remains uncertain. A recent meta-analysis by Q. Zhang et al. (2025) reviewed randomised controlled trials and reported small-to-moderate reductions in depression, anxiety, and stress for interventions delivered through social media platforms, particularly when they were social in nature and guided by humans. While this is encouraging, these findings have limited applicability to everyday mental health engagement on social media because these included studies examined structured,

intervention-based content, not the organic user-generated posts that dominate most platforms. The researchers also reported substantial heterogeneity ($I^2 \approx 88\%$), a small pool of eligible trials, and indications of publication bias, suggesting caution needs to be taken when generalising these effects to broader, unmoderated environments. As such, while social media may hold promise as a delivery channel for formal interventions, this evidence does not clarify how people experience, interpret, or are affected by the unstructured mental health content they encounter in daily social media use, highlighting the need for research into naturalistic, community-level engagement patterns.

1.4.4 Populations and forms of engagement studied to date

Evidence concerning everyday engagement is also concentrated in clinical populations. Several studies explore how individuals with diagnosed mental illness use social media as an adjunct to traditional care. Naslund and colleagues have produced a cluster of influential work on social media engagement among people with mental illness, documenting how users share lived experiences, seek support, and find information about coping and treatment (Naslund & Aschbrenner, 2019; Naslund et al., 2016; Naslund et al., 2019; Naslund et al., 2020). Although these studies provide valuable insights, their findings may not generalise to the wider population, as they focus on clinical groups. Furthermore, recruitment via X (formerly Twitter) in one of their largest surveys (Naslund et al., 2017) resulted in no New Zealand participants, likely due to low platform popularity in New Zealand (Kemp, 2025), further limiting its applicability to this context.

More detailed New Zealand evidence comes from research on young people's digital help-seeking, although its scope is narrower than that of the present study. Garrett et al. (2024) surveyed 1,471 young New Zealanders on the online platforms they employ to manage their mental health. Participants described using different digital tools, such as

videos, mental health websites, online peer spaces, and advertising on social media. Their narratives provide an example of the benefits and drawbacks of online help-seeking; a large proportion of people found that digital content was practical, relevant, and accessible, while others were concerned about misleading information, overwhelming volume, triggering content, and negative comparisons. Although this research offers great insights into young people's online experiences, it is more about online support and less on social media in general. It thus has much to teach us about youth digital help-seeking, but less to tell us about patterns and preferences in mental-health-related engagement among a wider age range of New Zealand adults.

Taken together, the New Zealand literature provides evidence about overall social media use and youth digital help-seeking, but offers limited insight into how New Zealand residents who are interested in mental health content engage with it across social media platforms. In particular, the literature reviewed here does not provide a single account of how this group prioritises platforms and formats, why they engage, how they evaluate influencer types, and what benefits and downsides they report.

1.5 Practical Gap

While the current evidence is helpful for establishing key indicators, it does not yet provide the necessary practical understanding to inform public health strategy, clinical communication, or digital-wellbeing initiatives in New Zealand. Across both international and local studies, one critical gap is evident: we know very little about how everyday New Zealand residents who are interested in mental health content on social media actually engage with this material. Hours of use reveal little about what people are watching, why certain formats resonate, or how various influencer types impact trust, perceived credibility, and willingness to act. Without that information, it's hard to know whether social media is

functioning as an informal extension of the existing mental health ecosystem, is a source of risk, or more likely, a combination of both, depending on who is engaging and how.

Existing evidence provides limited information about which platforms and formats New Zealanders interested in mental health content on social media prioritise, what motivates their engagement, and how they evaluate different influencer types. This information could have practical implications. The knowledge may help shape the way health agencies communicate online, the way clinicians present digital psychoeducation, the way non-government organisations design support campaigns, and the way young people and adults negotiate their own wellbeing within digital spaces. Without data on people's preferences, perceptions, and everyday behaviours, public-health efforts risk misalignment with the realities of social media environments. Addressing this gap could help inform mental health communication in New Zealand, while recognising that the present study describes an interest-based sample rather than the general population.

1.6 The Current Study: Aims and Contribution

Addressing the theoretical and empirical limitations in the existing literature, the current study offers a broad overview of how New Zealand residents who are interested in engaging with mental health content report interacting with such content on social media. Although international research on mental health content on social media has grown rapidly, the platforms, formats, motivations, and types of media or influencers associated with how New Zealanders engage with this content remain underexamined. Local research has predominantly focused on the time spent on social media or on digital help-seeking in general, without providing a clear picture of the content people encounter, why they engage with it, and how they evaluate its credibility and usefulness. Filling this gap is important for understanding how social media functions as an informal mental health

information environment, and for informing culturally relevant public health communication.

This gap is particularly important in the context of persistent inequalities in mental health outcomes and access to culturally responsive support for Māori (Russell, 2018; Theodore et al., 2022). Māori models of health emphasise cultural connectedness, relationality, whānau, and trust-based relationships (Russell, 2018; Wilson et al., 2021), suggesting that these considerations may also be relevant to how Māori perceive mental health content and those communicating it online. Therefore, the study included an exploratory comparison of Māori and non-Māori participants to identify similarities and differences in their engagement with mental health content on social media.

To address these gaps, this study explores the preferences and engagement patterns of New Zealand residents aged 16 and over who indicated an interest in engaging with mental health content on social media. This research asks the following questions:

- **RQ1.** What are the demographic and experiential characteristics of New Zealanders aged 16 and older who report engaging with mental health content on social media?
- **RQ2.** How do participants rank content formats and social media platforms according to their likelihood of engaging with mental health content, what motivates their engagement, and what benefits and downsides do they perceive?
- **RQ3.** How do participants evaluate the value and trustworthiness of different mental health influencer types (e.g., clinicians, lived-experience creators, social media influencers with a significant following, and peers), and which influencer qualities do they consider important?
- **RQ4.** What similarities and differences are evident in how Māori and non-Māori participants engage with and evaluate mental health content on social media?

By addressing these research questions, this study makes four main contributions. First, it provides a detailed demographic and experiential profile of participants in New Zealand who reported an interest in engaging with mental health content on social media. Second, it identifies how participants rank different content formats and platforms, alongside their motivations for engaging and their perceptions of the benefits and downsides. Third, it provides insight into how different mental health influencer types are evaluated in terms of value and trustworthiness, and the qualities participants consider important in these evaluations. Fourth, it offers an exploratory comparison of Māori and non-Māori participants, identifying similarities and differences in how they engage with and evaluate mental health content on social media.

In summary, the purpose of this study is not to assess the causal impact of social media on mental health, but to describe the patterns, preferences, and perceptions that underpin how mental health content is encountered and used in everyday digital life. Descriptive and exploratory research is valuable in underexamined areas because identifying and characterising real-world patterns can provide an empirical foundation for subsequent theory development and hypothesis testing (Rozin, 2001; Stebbins, 2001). The findings provide descriptive evidence from this sample that may help researchers, clinicians, and public health agencies seeking to understand and make effective use of the social media spaces in which many New Zealanders encounter and engage with information about mental health and wellbeing.

Method

2.1 Research Design

Using a cross-sectional online survey, this study was designed to capture a snapshot of engagement with mental health content among New Zealand residents who indicated an interest in this content at a single point in time. This design was chosen as it allowed fast, low-barrier participation by a geographically dispersed sample within the digital domains being studied. As a cross-sectional study, it was not designed to test whether social media engagement caused changes in mental health or other outcomes.

2.2 Participants

2.2.1 Inclusion Criteria

Eligible participants were aged 16 years or older, were currently residing in New Zealand, and indicated they were interested in engaging with mental health content on social media. Eligibility was enforced using three screening questions at the beginning of the Qualtrics survey. Respondents who indicated that they did not meet an eligibility criterion were thanked and exited from the survey. Cases with incomplete screening information were reviewed during data preparation to determine whether eligibility could be established from the available responses.

The age threshold (16+) was chosen because the study focused on social media engagement and health-seeking behaviour among people with sufficient autonomy to make independent decisions about their online engagement, while still including older adolescents. The study also assumed basic secondary schooling exposure and reading comprehension for this age group, given compulsory schooling requirements until age 16 in New Zealand (Ministry of Education, 2024).

In the screening questions, participants were asked whether they were interested in engaging with "mental health content on social media", using this wording without further definition. This interest criterion was used because the questionnaire asked participants to rank forms of mental health content and report motivations, benefits, and downsides associated with engaging with it; these questions would have limited relevance to people with no interest in such content. For the purposes of reporting and interpretation in this thesis, mental health content is used as an umbrella term for social media material that relates to mental wellbeing or mental illness including, but not limited to, coping strategies, help-seeking information, lived-experience narratives, psychoeducation, and discussion of services and support. Because the sample was intentionally restricted to people who reported an interest in mental health content, findings are interpreted as describing New Zealanders who are already open to or engaged with this content, rather than representing the general New Zealand population.

2.2.2 Participant Flow and Final Sample

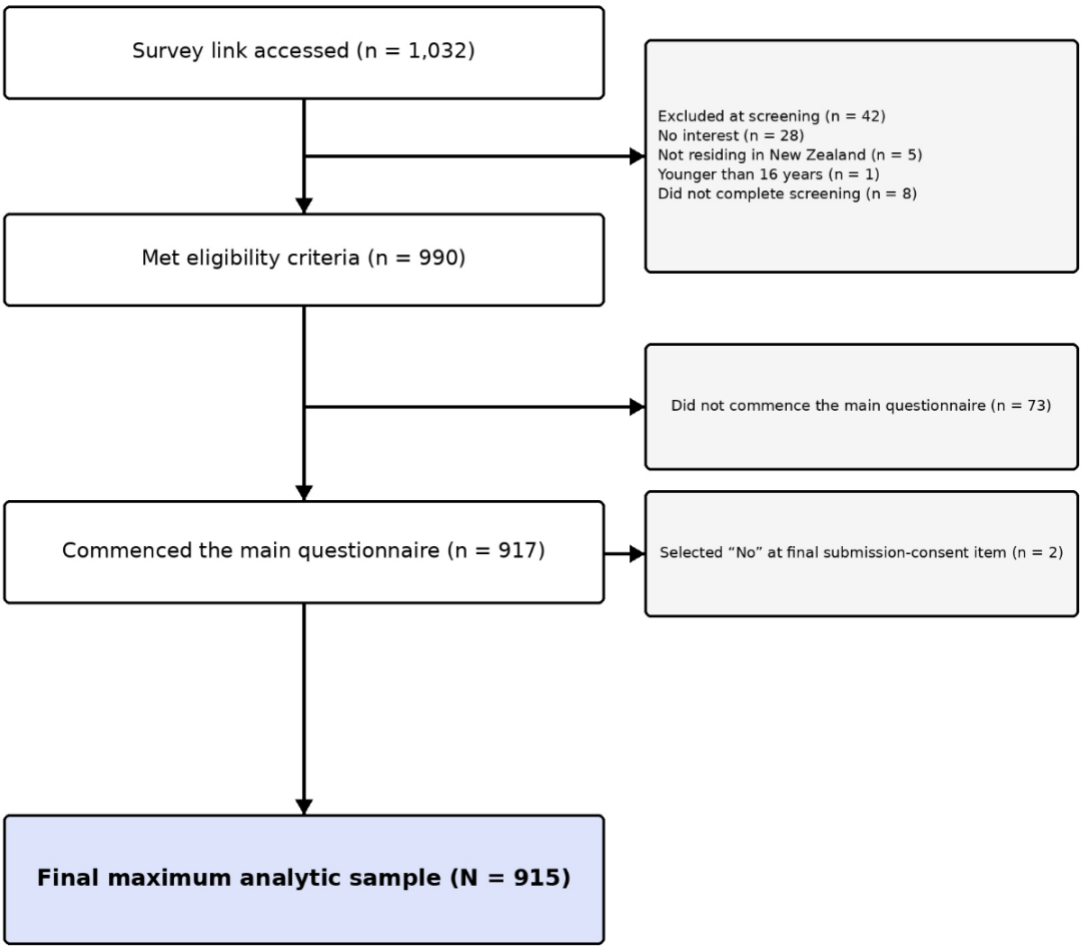
Across the recruitment period, 1,032 people accessed the survey link. Of these, 42 were excluded during screening, leaving 990 respondents retained after screening. Seventy-three respondents did not commence the main questionnaire. Commencement of the main questionnaire was operationalised as a Qualtrics Progress score greater than 33, which was the highest Progress value observed among retained cases with no post-screening responses. A total of 917 participants commenced the main questionnaire. Two participants selected "No" at the final submission-consent item and were excluded, resulting in a final maximum analytic sample of N = 915 (see Figure 1).

Because participants were able to skip questions, the number of responses varies across items and sections. Unless otherwise stated, analyses are based on available

responses for each item, and the relevant denominator (n) is reported alongside results and tables. Percentages are calculated using valid responses for each item (excluding missing responses).

Figure 1

Participant Flow Through Screening, Consent, and Inclusion in Analysis



*Note***.** The number included in individual analyses varied because participants could skip questions or discontinue the questionnaire.

2.2.3 Sample Size Calculation

A target sample size of 385 participants was set using a standard sample size calculation for estimating a proportion with 95% confidence and a 5% margin of error, assuming a conservative population proportion of 50% when the true proportion is unknown (Calculator.net, n.d.). This calculation was used as a recruitment target for estimating descriptive proportions within the eligible survey group, rather than as a formal power analysis for every inferential test.

Because eligibility required participants to be aged 16 years or older and to indicate interest in mental health content on social media, the sample size calculation was not used as a basis for claiming representativeness. The non-probability recruitment method and interest-based screening criterion mean that findings are interpreted as describing this sample and supporting only tentative conclusions about the wider population of New Zealand residents interested in mental health content on social media.

2.3 Recruitment

Recruitment occurred primarily via Facebook and Instagram using paid targeted advertising, supported by organic sharing and snowballing through the researcher's networks. The advertisement contained a brief invitation and a URL link to the questionnaire (see Appendix A). The advertisement was also shared organically to community pages and personal profiles, and members of the public were encouraged to share the link or tag others who may be interested.

The recruitment campaign ran for 42 days, while the survey remained open for 45 days between 13 September to 28 October 2023. Paid advertising included a Facebook boost spend of NZD $240.98 (reach: 11.3k accounts across a six-week period) and Instagram targeted advertising spend of NZD $112.74 (reach: 16.5k accounts across a five-week

period). The advertisement was organically shared approximately 60 times, primarily on Facebook and also on Instagram.

2.4 Procedure

The study was hosted on Qualtrics. Participants accessed the survey link on a computer, tablet, or smartphone. After the screening questions, eligible participants were shown the Participant Information Sheet (see Appendix B) and provided consent electronically by selecting “Start Survey”. The questionnaire was designed to take approximately 5 minutes to complete, with the total time commitment (including screening, consent, and debrief information) estimated at approximately 10 minutes.

At the end of the questionnaire, participants completed a final submission consent item confirming whether they consented to submit their responses for analysis. Participants were informed that once responses were submitted, they could not be withdrawn because the survey data was anonymous and not linked to identifying details.

Following completion, participants were thanked and shown support contacts for mental distress, including 1737, Lifeline, Depression Helpline, Samaritans, the Suicide Crisis Helpline, the Alcohol Drug Helpline, Kidsline, and 0800 WHATSUP. Participants were then offered the option to provide contact details to (a) receive a summary of research outcomes and/or (b) enter a prize draw for a $100 Prezzy card. These contact details were collected through a separate Qualtrics form so that identifying information was not stored together with survey responses. The prize draw winner was selected using a random number generator in Microsoft Excel.

2.5 Measures

The questionnaire was developed for this study because no single established measure covered the combination of participant characteristics, engagement rankings,

motivations, perceived benefits and downsides, and evaluations of mental health influencer types required by the study aims. Items were mapped to these aims, established response categories were used where applicable (e.g., Stats NZ demographic categories), and study-specific response options were selected to represent the main formats, platforms, motivations, benefits, downsides, and influencer types identified through the literature review. “Other” fields were included where appropriate. Exact item wording and response options are provided in Appendix C.

2.5.1 Questionnaire

The questionnaire (Appendix C) included 14 items organised around participant characteristics, engagement preferences and experiences, and evaluations of mental health influencer types. In addition to the 14 items, the survey included three screening questions, an electronic consent step, a final submission-consent item, and a debrief page.

2.5.2 Demographics and Background (Items 1-5)

Participants reported age (numeric entry), gender (male, female, non-binary/third gender, prefer not to say), ethnicity (multiple selection using Stats NZ Level 1 categories with an “other” text option) (Stats NZ, 2023a), highest level of education (NZ census-aligned categories) (Stats NZ, 2023b), and whether they had experienced financial hardship in the past 12 months (yes/no).

2.5.3 Active Engagement Indicator (Item 6)

Participants indicated whether they had previously or currently actively sought out mental health content on social media (yes/no).

2.5.4 Content Format Preference (Item 7)

Participants ranked how likely they were to engage with different content formats, using a forced ranking format (1 = most likely; 7 = least likely). The content format options

were selected to represent the principal text, image, audio, and video formats available across major social media platforms. Exact question wording and response options for Item 7 are shown in Table 1.

Table 1

Researcher-Developed Content Format and Platform Ranking Items

Item	Question Presented to Participants	Response Format and Options
7	Please rank how likely are you to engage in the following types of mental health content.	Forced ranking: 1 = most likely; 7 = least likely. Short-form video (Shorts, Reels, TikTok, etc.); long-form video; live video; audio/podcast; images, GIFs, or memes; infographics; text-based posts.
8	Please rank how likely are you to engage in mental health content on the following social media platforms.	Forced ranking: 1 = most likely; 8 = least likely. Facebook; Instagram; YouTube; TikTok; Twitter; Pinterest; Reddit; Other (please specify).

Note. Question stems and response options reproduce the questionnaire content, with minor spelling, capitalisation, and punctuation corrections. The platform item contained eight ranked options; therefore, its operational ranking range was 1–8.

2.5.5 Platform Preference (Item 8)

Participants ranked how likely they were to engage with mental health content across platforms (1 = most likely; 8 = least likely). Platform options were selected to cover major mainstream, visual, video, and discussion-based social media services relevant when the questionnaire was developed, while an "other" option allowed participants to rank and specify additional platforms. Exact question wording and response options for Item 8 are shown in Table 1.

2.5.6 Rationale for Forced Ranking (Items 7–8)

A forced-ranking format was used for content format and platforms to capture relative preference (i.e., what participants would prioritise when options compete), rather than absolute endorsement. Ranking reduces common rating scale problems where respondents give many options similarly high scores, which can limit discrimination between items and introduce response-style distortions and biases (e.g. acquiescence or extreme responding) (de Chiusole & Stefanutti, 2011; Del Grande & Kaczorowski, 2023; Heo et al., 2022). In contrast, ranking requires participants to make explicit trade-offs, which is useful when the research question concerns relative prioritisation of formats and platforms rather than independent ratings of each option, and when engagement is realistically constrained by finite attention and time. The limitations of this approach are considered in the Discussion.

Because rank data are ordinal, ranking results were summarised using first-choice frequencies (rank = 1) and median ranks (with interquartile ranges) to describe the preference pattern across the sample. These summaries were interpreted as comparative ordering rather than as absolute likelihood of engagement with any single option.

2.5.7 Motivations for Engaging (Items 9–10)

Participants selected all applicable reasons they personally engage with mental health content (Item 9) and reasons they are aware of that motivate others to engage (Item 10). The options represented information-seeking, self-management, social connection, experience-sharing, and help-seeking motivations identified through the literature review (Naslund et al., 2016; Naslund et al., 2019; Naslund et al., 2020; Whiting & Williams, 2013). Each item also included an open-text "other" field. Exact question wording and response options for Items 9 and 10 are shown in Table 2.

Table 2

Researcher-Developed Motivation Items

Item	Question Presented to Participants	Response Format and Options
9	What are your reasons for engaging in mental health content on social media? Please select all that apply to you.	Learn about mental health; learn strategies for living with or around mental illness; learn strategies to improve my mental health; connect with others to talk about mental health; share personal experiences about mental health; find out how to seek help for mental health; Other (please describe).
10	What reasons, that you are aware of, have motivated others to engage in mental health content on social media? Please select all that apply.	Learn about mental health; learn strategies for living with or around mental illness; learn strategies to improve their mental health; connect with others to talk about mental health; share personal experiences about mental health; find out how to seek help for mental health; Other (please describe).

Note. Participants could select more than one response option for each item.

2.5.8 Perceived Benefits and Downsides (Items 11–12)

Participants selected all perceived benefits and downsides they had personally experienced from engaging with mental health content. The response options were selected to cover access, connection, information-quality, social, stigma-related, and engagement-related experiences identified in prior literature (Garrett et al., 2024; Naslund et al., 2016; Naslund et al., 2020; Seabrook et al., 2016). An open-text "other" field was also included to allow participants to provide additional benefits and downsides. Exact question wording and response options for Items 11 and 12 are shown in Table 3.

Table 3

Researcher-Developed Perceived Benefit and Downside Items

Item	Question Presented to Participants	Response Format and Options
11	What benefits have you personally experienced in engaging in mental health content on social media? Select all that apply.	I don't have to go anywhere to access the content, saving me time and travel costs; I don't have to pay money to access the content because social media is free; I can access the content anonymously, and no one needs to know about it; I can access the content on demand, 24/7; I can connect to others interested in the same topic; I have the ability to share content with others, and others can share relevant content with me; I can see how popular the content is, helping me decide on the quality of the content; Other (please describe).
12	What downsides have you experienced in engaging in mental health content on social media? Select all that apply.	Inaccurate or misleading information; difficulty finding the right topic; triggering or distressing content; risk of online harassment and negativity; lack of professional guidance; social comparison that can negatively impact self-esteem; oversimplification and stigma; I can get addicted or dependent on social media; Other (please describe).

Note. Participants could select more than one response option for each item. Question wording and response options are reproduced with minor punctuation corrections.

2.5.9 Influencer Characteristics: Value and Trustworthiness (Items 13–14)

For the purposes of this study, a person delivering mental health content on social media was described as a "mental health influencer". Participants rated the perceived value and trustworthiness of content delivered by five influencer types using a 0–100 slider scale (0 = low; 100 = high). The influencer categories were selected to compare professional expertise, lived experience, popularity, personal familiarity, and demographic similarity as potential bases for evaluation. Exact question wording, influencer types, and response scales for Items 13 and 14 are shown in Table 4.

Table 4

Researcher-Developed Mental Health Influencer Rating Items

Item	Question Presented to Participants	Response Format and Options
13	What characteristics of the mental health influencer impact the value of the content?	0–100 slider (0 = low value; 100 = high value) for each influencer type: qualified professional; someone sharing their lived experience regarding mental health; social media influencer with a significant following; ally, colleague, or someone I personally know; person of a similar demographic (e.g., age, gender, ethnicity) to me.
14	What characteristics of the mental health influencer impact the trustworthiness of the content?	0–100 slider (0 = low trustworthiness; 100 = high trustworthiness) for each influencer type: qualified professional; someone sharing their lived experience regarding mental health; social media influencer with a significant following; ally, colleague, or someone I personally know; person of a similar demographic (e.g., age, gender, ethnicity) to me.

Note. The sliders permitted values from 0 to 100. Higher scores indicated greater perceived value or trustworthiness.

2.6 Ethics and Participant Wellbeing

Ethics approval was granted by Massey University Human Ethics Ohu Matatika 3 (Application OM3 23/26). Participation was voluntary, and participants could decline to answer any question. Participants could withdraw at any point up until submitting their responses by exiting the survey. Because responses were collected anonymously and were not linked to identifying information, participants were informed that withdraw was not possible after submission.

Given the study's focus on mental health, participants were provided with a debrief screen containing mental health support resources and were encouraged to seek support if needed. Survey data were collected using Qualtrics. After the survey closed, the data file was transferred to the researcher's cloud-based, password-protected storage and was accessible only to the researcher and supervisor. The data will be retained for seven years and then securely destroyed. Only non-identifiable data were analysed and reported.

2.7 Data Preparation

Survey data were exported from Qualtrics and screened prior to analysis. Participants who did not meet eligibility criteria or who did not provide final submission consent were excluded from the analytic dataset. Four respondents who did not answer the age-screening item but subsequently reported an eligible age in the demographic section were retained.

Because participants were able to skip questions, analyses used available responses for each item. Open-text responses submitted under "other" fields were extracted for qualitative coding.

2.8 Data Analysis Plan

Data were exported from Qualtrics and cleaned in Microsoft Excel (Microsoft 365). Descriptive statistics and figures were produced in Excel, and inferential analyses were conducted in Jamovi (version 2.7.38). Analyses were organised to address each research question: RQ1 (participant characteristics), RQ2 (content-format and platform rankings, motivations, benefits, downsides, and open-text additions), RQ3 (the perceived value and trustworthiness of different mental health influencer types), and RQ4 (exploratory comparisons between Māori and non-Māori participants). Unless otherwise stated, inferential tests were two-tailed, with $\alpha = .05$. Where families of related tests or post hoc comparisons were conducted, Holm-adjusted p-values were reported (Holm, 1979). Effect sizes were reported where applicable.

2.8.1 Descriptive Statistics

RQ1 was addressed descriptively. Demographics, experiential, categorical, and binary variables were summarised using counts and percentages. Continuous variables were summarised using means and standard deviations, medians and interquartile ranges, and ranges as appropriate. “Select all that apply” items were summarised using endorsement frequencies and percentages.

2.8.2 Rank-Order Items

RQ2 included rank-order items measuring participants’ likelihood of engaging with different content formats and social media platforms. These rankings were interpreted as relative prioritisation, with lower ranks indicating a greater likelihood of engagement. Analyses were based on participants who completed the full ranking set for the relevant item. Rankings were summarised using first-choice frequency (the percentage ranking each option first), mean rank, median rank, and interquartile range.

Friedman tests were used to determine whether rankings differed across options within each set. Kendall's *W* was reported as a measure of agreement and effect size. Higher values of Kendall's *W* indicated greater consistency among participants in the relative ordering of the options. When the Friedman test was significant, Holm-adjusted Durbin-Conover pairwise comparisons were conducted to identify differences between individual options.

Exploratory Kruskal–Wallis tests were used to examine whether ranking scores differed across generations for each content format and each listed platform, excluding the "other" platform category. Holm adjustments were applied across the seven tests within each ranking set. Group-specific mean ranking scores were reported to describe the direction of any generational differences.

2.8.3 "Select All That Apply" Items

For the motivations, benefits, and downsides included in RQ2, each response option was treated as a binary variable indicating whether it was endorsed. Endorsement frequencies and percentages were reported for each option.

Because the same participants reported motivations relating to themselves and motivations relating to others, paired McNemar tests were used to compare endorsement of each motivation across the two perspectives. Holm adjustments were applied across the six matched comparisons.

Chi-square tests of independence were also used to examine generational differences in endorsement of the six self-related motivations. Cramér's *V* was reported as the effect size, and Holm adjustments were applied across the six tests. Benefits and downsides were otherwise analysed descriptively.

2.8.4 Slider Ratings

RQ3 was addressed using slider ratings of value and trustworthiness of five mental health influencer types on scales ranging from 0 to 100. Ratings for each influencer type were initially summarised using means and standard deviations.

Separate mixed-design repeated-measures analyses of variance were conducted for perceived value and trustworthiness. Each analysis included participants with valid ratings for all five influencer types for the relevant outcome and a valid generation category. Influencer type was included as the within-participant factor and generation as the between-participant factor. The analyses examined the main effects of influencer type, the main effect of generation, and the interaction between influencer type and generation. Mauchly's test was used to assess the assumption of sphericity, and Greenhouse–Geisser-corrected degrees of freedom and *p*-values were reported when this assumption was violated. Partial eta squared (ηp^2) was reported as the effect size. Group-specific means were inspected to describe the pattern of significant interactions.

Differences between perceived value and trustworthiness were examined descriptively by comparing the mean value and trust ratings for each influencer type. No inferential tests were conducted on these differences.

2.8.5 Exploratory Māori and Non-Māori Comparisons (RQ4)

RQ4 was addressed through exploratory descriptive comparisons between participants who identified as Māori and non-Māori participants. Comparisons examined mean ranking scores for content formats and social media platforms, endorsement percentages for motivations, and mean value and trustworthiness ratings for the different mental health influencer types.

Given the exploratory purpose of RQ4 and the non-probability sampling design, no inferential tests of differences between Māori and non-Māori participants were conducted. These comparisons were intended to identify patterns within the sample rather than support population-level conclusions about ethnic differences.

2.8.6 Open-Text Analysis

Open-text responses entered in the “other” fields were analysed using inductive qualitative content analysis (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005) to support RQ2. This approach was appropriate because the categories were developed directly from participants’ responses rather than from a predetermined coding framework. Each submitted response to an individual “other” field was treated as a separate unit of analysis, and all coding was conducted by the researcher.

Responses were read repeatedly and divided into distinct meaning units where they contained multiple ideas. Meaning-based codes were developed and refined iteratively as the responses were reviewed, before being grouped under broader descriptive category labels. Categories were not mutually exclusive: a response could be assigned to multiple categories when it contained several relevant ideas or listed different forms of content. However, a response was counted only once within any individual category.

Frequencies were calculated to indicate the number of responses coded to each category. Consequently, the sum of category frequencies could exceed the total number of open-text responses. Responses that did not contain interpretable content relevant to the question were excluded and reported separately where applicable.

Some categories overlapped conceptually with the fixed-response options. These responses were retained because they reflected participants’ own descriptions or elaborations of those motivations, benefits, or downsides. However, they were analysed

separately and were not added to the quantitative endorsement frequencies for the fixed-response options. Illustrative quotations were selected to demonstrate the content represented by each category. The analysis was intended to identify and summarise contributions that extended or elaborated on the fixed-response options rather than to provide a deeper interpretive analysis of participants' experiences.

2.9 Data Availability Statement

Participant-level survey data are not publicly available because participant consent did not include public data sharing and combinations of demographic characteristics and open-text responses may create a risk of re-identification. The survey data will be retained securely for seven years in accordance with the approved ethics documentation and then destroyed. Raw open-text responses will not be shared.

Results

The final analytic sample comprised *N* = 915 participants. Because participants could skip questions, the number of responses varied across analyses. Unless otherwise stated, results are based on available data for each item, with the relevant denominators reported accordingly.

3.1 Participant Characteristics (RQ1)

Participants ranged from 16 to 81 years (*n* = 913, *M* = 36.8, *SD* = 11.9; *Md* = 36). Of the 914 participants who reported their gender, 85.2% identified as female. Among respondents to the relevant items, 69.5% reported experiencing financial hardship during the previous 12 months, and 86.5% had previously or currently actively sought out mental health content on social media (see Table 5).

Table 5

Core Participant Characteristics

Characteristic	n	Summary / %
Age (years)	913	*M* = 36.8, *SD* = 11.9; *Md* = 36, *IQR* = 18; range 16–81
Gender	914	
Female	779	85.2%
Male	85	9.3%
Non-binary/third gender	43	4.7%
Prefer not to say	7	0.8%
Financial hardship past 12 months	914	
Yes	635	69.5%
No	279	30.5%
Previously actively sought out mental health content on social media	912	
Yes	789	86.5%
No	123	13.5%

Note. M = mean; *SD* = standard deviation; *Md* = median; *IQR* = interquartile range. Sample sizes vary because of missing responses. Percentages are based on valid responses.

Educational qualifications were reported by 911 participants. A bachelor's degree or Level 7 certificate was the most commonly reported qualification (n = 272, 29.9%), although a range of lower and higher qualification levels was represented (see Table 6).

Table 6

Highest Educational Qualification Reported by Participants

Education	n	%
No qualification	95	10.4%
Level 1 Certificate	47	5.2%
Level 2 Certificate	46	5.0%
Level 3 Certificate	113	12.4%
Level 4 Certificate	111	12.2%
Level 5 & 6 Certificate	113	12.4%
Bachelor Degree / Level 7 Certificate	272	29.9%
Master's Degree	88	9.7%
Doctorate Degree	12	1.3%
Overseas secondary school qualification	14	1.5%

Note. Percentages are based on the 911 participants who reported their highest educational qualification.

Ethnicity data were provided by 914 participants, who could select more than one ethnic group. European was the most frequently reported ethnicity (n = 754, 82.5%), followed by Māori (n = 195, 21.3%; see Table 7).

Table 7

Ethnicity Reported by Participants

Ethnicity, n = 914	Counts	Percent of Total %
European	754	82.5%
Māori	195	21.3%
Pacific Peoples	43	4.7%
Asian	53	5.8%
Middle Eastern, Latin American, African	16	1.8%
Other / unclear	15	1.6%

Note. Ethnicity was collected as a multiple-response variable. Percentages are based on the 914 participants who provided ethnicity data and therefore sum to more than 100%. Free-text "other" responses were reviewed and recoded into existing categories where appropriate, in alignment with Statistics New Zealand ethnicity classifications. For example, responses such as "New Zealander" (where Māori identity was not indicated) and non-Indigenous North American identities were coded as European. Specific national identities (e.g., Indian, Japanese) were coded as Asian. Indigenous North American identities (e.g., Native American, First Nations) were retained in the "Other" category. Recoding decisions were applied consistently based on available information.

3.2 Engagement Profile (RQ2)

3.2.1 Formats Ranked

Participants ranked seven content formats in terms of how likely they were to engage with mental health content (1 = most likely; 7 = least likely). Analyses included the 738 participants who ranked all seven formats. A Friedman test indicated that rankings differed significantly across formats, $\chi^2(6) = 1001.93$, $p < .001$. Kendall's *W* was .23, indicating modest agreement among participants in the relative ordering of the formats.

Short-form video received the lowest mean rank and was ranked first by 43.6% of participants, making it the format participants were most likely to engage with. This was followed by images/GIFs/memes and text-based posts. Live video received the highest mean and median ranks and was ranked first by only 2.2% of participants, making it the least preferred format overall (see Table 8). The complete distributions of rankings are presented in Figure 2. All 21 Durbin–Conover pairwise comparisons remained significant after Holm adjustment (all adjusted *p*s < .001; see Appendix D).

Table 8

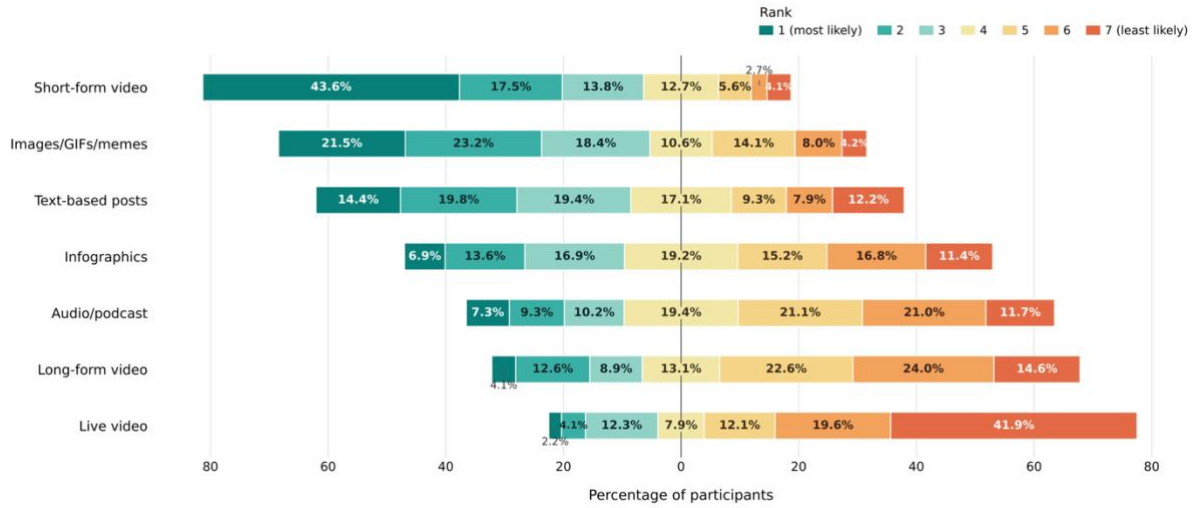
Ranked Content Formats by Likelihood of Engagement (N = 738)

Content format	First choice, *n* (%)	Mean rank	Median rank	IQR
Short-form video	322 (43.6)	2.43	2	2.75
Images/GIFs/memes	159 (21.5)	3.13	3	3.00
Text-based posts	106 (14.4)	3.60	3	3.00
Infographics	51 (6.9)	4.18	4	3.00
Audio/podcast	54 (7.3)	4.47	5	3.00
Long-form video	30 (4.1)	4.68	5	3.00
Live video	16 (2.2)	5.50	6	3.00

Note. Lower ranks indicate greater likelihood of engagement (1 = most likely; 7 = least likely). First-choice percentages are based on the 738 participants who completed the full ranking set.

Figure 2

Distribution of Content Format Rankings by Likelihood of Engagement



Note. Percentages are based on 738 participants with complete content format rankings. Lower-numbered ranks indicate greater likelihood of engagement (1 = most likely; 7 = least likely). Each coloured segment represents the percentage of participants assigning that rank to the format. Ranks 1–3 are displayed to the left of the midline and ranks 5–7 to the right; rank 4 is divided equally across the midline for display purposes. Percentages may not total 100% because of rounding.

Figure 2 shows a clear gradient across content formats. Nearly three-quarters of participants (74.9%) ranked short-form video among their three most likely formats for engagement, compared with 12.4% who ranked it among their three least likely. Images/GIFs/memes and text-based posts also tended to receive higher rankings, whereas audio/podcasts, long-form video, and particularly live video were more frequently ranked toward the lower end. Live video showed the clearest reverse pattern, with 73.6% ranking it among their three least likely formats for engagement.

Exploratory Kruskal-Wallis tests examined whether content format rankings differed across generations. After Holm adjustment across the seven tests, significant generational

differences were found for live video, $\chi^2(3) = 79.33$, $p < .001$, and infographics, $\chi^2(3) = 12.06$, $p = .043$ (see Table 9). For live video, mean ranks decreased progressively from Gen Z (M = 6.21) to Baby Boomers and older (M = 4.00), indicating that older generations generally placed live video higher in their rankings. For infographics, Baby Boomers and older reported a higher mean rank (M = 5.03) than the younger generations (Ms = 4.02–4.35), indicating lower relative likelihood of engagement.

The adjusted test for short-form video did not reach statistical significance, $\chi^2(3) = 10.98$, $p = .059$. No significant generational differences were found for images/GIFs/memes, audio/podcast, text-based posts, or long-form video after adjustment. These results should be interpreted cautiously because the Baby Boomer and older group contained only 33 participants in the complete-case analysis.

Table 9

Generation Differences in Content Format Rankings: Kruskal-Wallis Tests and Mean Ranks

Content Format	χ^2 (3)	p (Holm)	Gen Z *M*	Millennials *M*	Gen X *M*	Boomers+ *M*
Live video	79.33	< .001	6.21	5.64	4.95	4.00
Infographics	12.06	.043	4.02	4.07	4.35	5.03
Short-form video	10.98	.059	2.17	2.36	2.78	2.42
Images/GIFs/memes	9.68	.086	2.82	3.10	3.35	3.73
Audio/Podcast	7.53	.171	4.71	4.43	4.43	3.91
Text-based posts	4.21	.479	3.51	3.65	3.47	4.24
Long-form video	1.58	.664	4.55	4.74	4.67	4.67

Note. Lower mean ranks indicate greater likelihood of engagement. Analyses included 737 participants with complete format rankings and a valid generation category: Gen Z, n = 157; Millennials, n = 349; Gen X, n = 198; and Baby Boomers and older, n = 33.

3.2.2 Platforms Ranked

Participants ranked eight social media platforms according to how likely they were to engage with mental health content on each platform (1 = most likely; 8 = least likely). Analyses included the 798 participants who ranked all eight platforms. A Friedman test indicated that rankings differed significantly across platforms, $\chi^2(7) = 2973.09$, $p < .001$. Kendall's W was .53, indicating moderate-to-strong agreement among participants in the relative ordering of the platforms.

Facebook received the lowest mean rank and was ranked first by 44.2% of participants, followed by Instagram, which was ranked first by 28.2%. YouTube received the third-lowest mean rank, although TikTok was selected as the first choice more frequently than YouTube. Other platforms received the highest mean and median ranks and were ranked last by 82.8% of participants (see Table 10). The complete distributions of platform rankings are presented in Figure 3. Holm-adjusted Durbin–Conover pairwise comparisons are reported in Appendix E.

Table 10

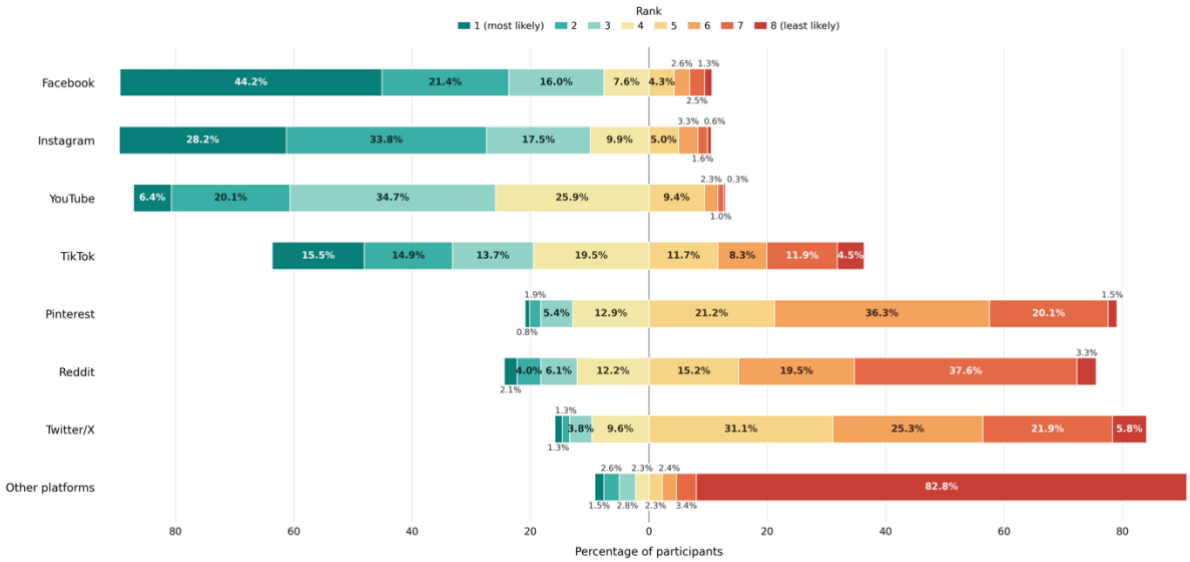
Ranked Social Media Platforms by Likelihood of Engagement (N = 798)

Social media platform	First choice, *n* (%)	Mean rank	Median rank	IQR
Facebook	353 (44.2)	2.30	2	2.00
Instagram	225 (28.2)	2.49	2	2.00
YouTube	51 (6.4)	3.24	3	2.00
TikTok	124 (15.5)	3.92	4	3.00
Pinterest	6 (0.8)	5.49	6	1.00
Reddit	17 (2.1)	5.60	6	2.00
X (formerly Twitter)	10 (1.3)	5.61	6	2.00
Other platforms	12 (1.5)	7.36	8	0.00

Note. Lower ranks indicate greater likelihood of engagement (1 = most likely; 8 = least likely). First-choice percentages are based on the 798 participants who completed the full ranking set.

Figure 3

Distribution of Social Media Platform Rankings by Likelihood of Engagement



Note. Percentages are based on 798 participants with complete platform rankings. Lower-numbered ranks indicate greater likelihood of engagement (1 = most likely; 8 = least likely). Each coloured segment represents the percentage of participants assigning that rank to the platform. Ranks 1–4 are displayed to the left of the midline and ranks 5–8 to the right, indicating relatively greater and lower likelihood of engagement, respectively. Percentages may not total 100% because of rounding.

Figure 3 shows that Facebook, Instagram, and YouTube were consistently concentrated in the upper half of participants' rankings, with 89.2%, 89.4%, and 87.1% of participants, respectively, placing them within their top four platforms. TikTok rankings were more dispersed: although it was selected as the first choice more frequently than YouTube, it was less consistently placed within the top four overall. In contrast, Pinterest, Reddit, X, and other platforms were predominantly ranked in the lower half, indicating substantially lower likelihood of engagement with mental health content on those platforms.

Open-text responses to the “other platforms” option suggested that a small number of participants engaged with mental health content on additional platforms not included among the fixed-response options. The most commonly mentioned platforms were Spotify or other podcast platforms, followed by LinkedIn, Snapchat, and Tumblr. Less frequently mentioned platforms included websites, Mastodon, Google, Discord, Bluesky, Threads, and Quora (see Table 11). Some responses, including websites, blogs, Google, and email, may not meet a strict definition of social media. These were retained because the table reflects participants’ own interpretations of the “other platforms” option rather than applying a researcher-defined classification of social media.

Table 11

User-Submitted Other Platforms or Online Channels for Engaging With Mental Health Content

Other platform submitted	*n*
Spotify / podcasts	19
LinkedIn	8
Snapchat	6
Tumblr	5
Websites / trusted websites	4
Mastodon	3
Google	3
Discord	3
Blogs	2
Bluesky	2
Threads	2
Quora	2
Clapper	1
Email	1
Tribel	1

Note. Open-text responses were coded into platform categories. Responses that duplicated existing platform options, contained comments about not using additional platforms, or did not provide interpretable platform information were excluded from analysis.

Exploratory Kruskal-Wallis tests examined whether platform rankings differed across generations. After Holm adjustment across the seven platform-specific tests, significant generational differences were found for all seven platforms included in these analyses (see Table 12).

The largest generational differences were found for Facebook, $\chi^2(3) = 145.07$, $p < .001$, and TikTok, $\chi^2(3) = 74.41$, $p < .001$. Mean ranks indicated that Facebook was placed progressively higher by older generations, whereas TikTok was generally placed higher by younger generations. Significant generational differences were also found for YouTube, $\chi^2(3) = 16.32$, $p = .005$; Reddit, $\chi^2(3) = 15.82$, $p = .005$; Instagram, $\chi^2(3) = 15.48$, $p = .004$; X (formerly Twitter), $\chi^2(3) = 11.78$, $p = .016$; and Pinterest, $\chi^2(3) = 8.27$, $p = .041$. Results involving the Baby Boomer and older group should be interpreted cautiously because this group contained only 33 participants.

Table 12

Generation Differences in Platform Preferences: Kruskal-Wallis Tests and Mean Ranks

Platform	χ^2 (df = 3)	p (Holm)	Gen Z *M*	Millennials *M*	Gen X *M*	Boomers+ *M*
Facebook	145.07	< .001	3.42	2.10	1.86	1.42
TikTok	74.41	< .001	2.86	4.03	4.57	4.33
YouTube	16.32	.005	3.39	3.31	3.02	3.03
Reddit	15.82	.005	5.37	5.49	5.87	6.30
Instagram	15.48	.004	2.15	2.54	2.67	2.61
X (formerly Twitter)	11.78	.016	5.79	5.64	5.44	5.24
Pinterest	8.27	.041	5.49	5.59	5.29	5.61

Note. Lower mean ranks indicate greater likelihood of engagement. Analyses included 797 participants with complete platform rankings and a valid generation category: Gen Z, *n* = 179; Millennials, *n* = 382; Gen X, *n* = 203; and Baby Boomers and older, *n* = 33. Holm-adjusted *p*-values are reported.

3.2.3 Motivations (Self vs. Others)

Participants selected all reasons that applied to their own engagement with mental health content and, in a separate item, all reasons they were aware had motivated other people to engage. Among the 860 participants who reached these items, the most commonly endorsed self-related motivations were learning strategies to improve their own mental health (82.4%), learning strategies for living with or around mental illness (80.0%), and learning about mental health (70.0%). For reasons relating to others, the most commonly endorsed motivations were learning strategies for living with or around mental illness (75.5%), connecting with others to talk about mental health (71.3%), and learning about mental health (70.5%; see Table 13).

Table 13

Reasons for Engaging in Mental Health Content on Social Media (N = 860)

Motivation	Self *n* (%)	Self 95% CI	Others *n* (%)	Others 95% CI
Learn about mental health	602 (70.0)	[66.9, 73.0]	606 (70.5)	[67.3, 73.4]
Learn strategies for living with or around mental illness	688 (80.0)	[77.2, 82.5]	649 (75.5)	[72.5, 78.2]
Learn strategies to improve my mental health	709 (82.4)	[79.8, 84.8]	580 (67.4)	[64.2, 70.5]
Connect with others to talk about mental health	413 (48.0)	[44.7, 51.4]	613 (71.3)	[68.2, 74.2]
Share personal experiences about mental health	336 (39.1)	[35.9, 42.4]	571 (66.4)	[63.2, 69.5]
Find out how to seek help for mental health	378 (44.0)	[40.7, 47.3]	536 (62.3)	[59.0, 65.5]

Note. Values represent the number and percentage of participants endorsing each motivation. Participants could endorse more than one motivation. Percentages are based on respondents who reached these items, including valid cases in which no response option was selected.

Paired McNemar tests compared endorsement of each motivation when framed as a reason for participants' own engagement versus a reason relating to others (see Table 14). After Holm adjustment, endorsement of learning about mental health did not differ significantly between the two perspectives (self and others), $\chi^2(1) = 0.06$, adjusted $p = .810$. Learning strategies for living with or around mental illness was endorsed significantly more frequently for participants' own engagement than for others, $\chi^2(1) = 6.53$, adjusted $p = .021$. Learning strategies to improve mental health was also endorsed more frequently for participants' own engagement, $\chi^2(1) = 59.20$, adjusted $p < .001$.

In contrast, connecting with others, sharing personal experiences, and finding out how to seek help were endorsed significantly more frequently as motivations relating to others than as motivations for participants' own engagement, χ^2s(1) = 70.50–142.00, all adjusted *ps* < .001.

Table 14

Holm-Adjusted McNemar Comparisons of Self Versus Others Motivations for Engaging With Mental Health Content on Social Media (N = 860)

Motivation	McNemar χ^2 (1)	Raw *p*	Holm-adjusted *p*
Learn about mental health	0.06	.810	.810
Learn strategies for living with or around mental illness	6.53	.011	.021
Learn strategies to improve my mental health	59.20	<.001	<.001
Connect with others to talk about mental health	119.00	<.001	<.001
Share personal experiences about mental health	142.00	<.001	<.001
Find out how to seek help for mental health	70.50	<.001	<.001

Note. McNemar tests compared endorsement of each motivation when framed as a reason for participants' own engagement versus a reason relating to others. Holm-adjusted p-values control familywise error across the six matched comparisons.

Chi-square tests of independence examined whether endorsement of the six self-related motivations differed across generations. After Holm adjustment, a significant generational difference was found only for learning strategies for living with or around mental illness, $\chi^2(3) = 13.30$, adjusted p = .024, Cramér's V = .121, indicating a small association (see Table 15).

The adjusted test for learning strategies to improve one's own mental health did not reach statistical significance, $\chi^2(3) = 11.00$, adjusted p = .058, Cramér's V = .110. No significant generational differences were found for learning about mental health, connecting with others, sharing personal experiences, or finding out how to seek help.

Table 15

Generation Differences in Self-Reported Motivations for Engaging With Mental Health Content: Chi-Square Tests of Independence (N = 860)

Motivation	χ^2	Holm-adjusted *p*	Cramér's *V*
Learn strategies for living with or around mental health	13.30	.024	.121
Learn strategies to improve my mental health	11.00	.058	.110
Learn about mental health	3.67	.897	.064
Connect with others to talk about mental health	3.09	.897	.058
Share personal experiences about mental health	2.56	.928	.053
Find out how to seek help with mental health	1.58	.664	.042

Note. Motivation variables were coded as binary (endorsed or not endorsed). Holm adjustment was applied across the six tests. Cramér's *V* is reported as the measure of effect size.

3.2.4 Open-Text Motivations

Additional open-text reasons for engaging with mental health content on social media were coded into descriptive categories (see Table 16). Some categories, including learning and education, social support, and information and help-seeking, overlapped conceptually with the fixed-response options. These responses were retained because participants sometimes used the open-text fields to reframe or elaborate on the available options, but they were not added to the quantitative endorsement totals reported in Table 13.

For self-related motivations, the most common categories were learning and education (n = 23); supporting, understanding, or advocating for others (n = 18); and personal and professional development (n = 17). Social support, connection, and validation

was also common (n = 13), with participants describing engagement as a way to feel less alone, understood, or connected with people who shared similar experiences.

Mood enhancement, humour, and distraction represented a further motivation not directly captured by the fixed-response options (n = 8). One participant referred to "Amusement, there are lots of self-reflective mental health memes and meme pages that are funny and insightful." These responses suggest that humour sometimes accompanied insight, normalisation, or mood management rather than functioning only as entertainment.

For motivations relating to others, the most common categories were social support, connection, and validation and information, resources, and help-seeking (both n = 7). Less frequently occurring categories included identity, belonging, and self-diagnosis; harmful or triggering engagement; and monetisation. Nine responses in the others field were excluded because they did not provide interpretable motivation content and instead indicated uncertainty about why other people engaged.

Table 16

Content Analysis of User-Submitted Reasons for Engaging With Mental Health Content on Social Media

Category	Self, *n*	Others, *n*	Illustrative quotation (perspective)
Learning and education	23	2	"Hear from reputable psychologists about helpful approaches to mental wellbeing and how to conceptualise mental distress" (self)
Supporting, understanding, or advocating for others	18	3	"To teach people how to handle daily struggles." (self)
Personal and professional development	17	1	"Work tools (I'm a therapist)" (self)
Social support, connection, and validation	13	7	"To find support from like-minded people!!" (others)
Mood enhancement, humour, and distraction	8	3	"Amusement, there are lots of self-reflective mental health memes and meme pages that are funny and insightful" (self)
Information, resources, and help-seeking	2	7	"Define the pathways for seeking help" (others)
Identity, belonging, and self-diagnosis	0	3	"Self-triggering themselves, creating an identity or belonging" (others)
Harmful or triggering engagement	0	2	"To find intentionally triggering content, look at self-harm, eating disorder content etc." (others)
Monetisation	0	1	"Make money" (others)

Note. Counts represent the number of responses coded to each category within the self and others "other" motivation fields. Categories were not mutually exclusive, and responses containing multiple ideas could be coded to more than one category. Each response was counted no more than once within an individual category; therefore, category frequencies may sum to more than the number of responses.

Illustrative quotations demonstrate the content of each category and do not indicate its relative frequency. Nine responses in the others field that did not provide interpretable motivation content—for example, “I don’t know”—were excluded. Categories overlapping with the fixed-response options were analysed separately and were not added to the quantitative endorsement totals.

3.2.5 Benefits

Participants endorsed a range of benefits associated with engaging in mental health content on social media. The most frequently endorsed benefit was being able to access content on demand, 24/7 (79.1%), followed by accessing content anonymously (73.9%), and without payment (72.6%). More than half endorsed avoiding the time and travel costs associated with accessing support elsewhere or in-person (56.4%). Using content popularity to assess its quality was the least commonly endorsed benefit (22.1%; see Table 17).

Table 17

Benefits of Engaging in Mental Health Content on Social Media (N = 831)

Benefit	*n* (%)	95% CI
I don't have to go anywhere to access the content, saving me time and travel costs	469 (56.4)	[53.0, 59.8]
I don't have to pay money to access the content; social media is free	603 (72.6)	[69.4, 75.5]
I can access the content anonymously; no one needs to know about it	614 (73.9)	[70.8, 76.8]
I can access the content on demand, 24/7	657 (79.1)	[76.2, 81.7]
I can connect with others interested in the same topic	409 (49.2)	[45.8, 52.6]
I can share content with others, and others can share relevant content with me	402 (48.4)	[45.0, 51.8]
I can see how popular the content is, helping me assess its quality	184 (22.1)	[19.5, 25.1]

Note. Values represent the number and percentage of participants endorsing each benefit. Participants could endorse more than one benefit. Percentages are based on the 831 participants who reached the item, including valid cases in which no benefit was selected. Confidence intervals are 95% Wilson intervals for the endorsement proportions and are presented as percentages.

3.2.6 Open-Text Benefits

Thirty-nine participants submitted an open-text response about other perceived benefits of engaging with mental health content on social media. These responses were coded into seven descriptive, non-mutually exclusive categories (see Table 18). The most frequently occurring categories were emotional support, validation, and connection (*n* = 11); convenience, accessibility, and reduced barriers to engagement (*n* = 10); and learning, insight, and understanding (*n* = 10).

Some categories overlapped conceptually with the fixed-response options reported in Table 17. These responses were retained because they elaborated on the perceived benefits in participants' own words, but they were analysed separately and were not added to the quantitative endorsement totals.

Responses concerning emotional support, validation, and connection described feeling less alone, more understood, or supported by people with similar experiences. Convenience, accessibility, and reduced barriers included being able to encounter content on platforms participants already used, revisit it when needed, and access information or professional expertise that might otherwise be unavailable because of cost, waiting times, location, or the need for direct interaction. Responses coded as learning, insight, and understanding described gaining knowledge, practical resources, or a better understanding of themselves and others.

Less frequently occurring categories included helping or supporting others, humour and uplifting content, and breadth and diversity of information. Humour was described as helping participants find levity in shared experiences, while breadth and diversity concerned access to a wider range of perspectives, experiences, and information. Three responses did not identify a benefit and instead described no benefit or potentially harmful effects.

Table 18

Content Analysis of User-Submitted Benefits of Engaging With Mental Health Content on Social Media

Category	*n*	Illustrative quotation
Emotional support, validation, and connection	11	"I feel supported by like-minded people even though they are strangers"
Convenience, accessibility, and reduced barriers to engagement	10	"There is no physical pressure. You can revisit as often as you want/need"
Learning, insight, and understanding	10	"It's helped me understand myself and others better"
Helping or supporting others	3	"I add motivation quotes to help others"
Humour and uplifting content	3	"Social media is much less dry than other forms of mental health information and makes it personal. We see how people are doing fine and laugh through their struggles which helps us do the same"
Breadth and diversity of information	2	"Broad range of opinions and ideas"
No benefit or harmful effects	3	"Absolutely none. It's the same info, which only works for those with minor symptoms, repeated over and over. It's actively harmful…"

Note. Counts reflect coding of 39 open-text responses. Categories were not mutually exclusive; responses could be coded to multiple categories but only once per category, so frequencies may exceed 39. Quotations illustrate category content, not frequency. Three responses that did not describe a benefit were coded as "No benefit or harmful effects." Categories overlapping with fixed-response options were analysed separately and excluded from the quantitative endorsement totals in Table 17.

3.2.7 Downsides

Participants endorsed several downsides to engaging in mental health content on social media. The most frequently endorsed downside was inaccurate or misleading information (65.0%). Lack of professional guidance and oversimplification and stigma were each endorsed by 53.8% of participants. Difficulty finding the right topic was the least frequently endorsed downside (27.5%), followed by becoming addicted or dependent on social media (34.6%; see Table 19).

Table 19

Downsides to Engaging in Mental Health Content on Social Media (N = 819)

Downside	*n* (%)	95% CI
Inaccurate or misleading information	532 (65.0)	[61.6, 68.1]
Difficulty finding the right topic	225 (27.5)	[24.5, 30.6]
Triggering or distressing content	332 (40.5)	[37.2, 43.9]
Risk of online harassment and negativity	332 (40.5)	[37.2, 43.9]
Lack of professional guidance	441 (53.8)	[50.4, 57.2]
Social comparison that can negatively impact self-esteem	365 (44.6)	[41.2, 48.0]
Oversimplification and stigma	441 (53.8)	[50.4, 57.2]
I can get addicted or dependent on social media	283 (34.6)	[31.4, 37.9]

Note. Values represent the number and percentage of participants endorsing each downside. Participants could endorse more than one downside. Percentages are based on the 819 participants who reached the item, including valid cases in which no downside was selected. Confidence intervals are 95% Wilson intervals for the endorsement proportions and are presented as percentages.

3.2.8 Open-Text Downsides

Forty-four participants submitted an open-text response describing other downsides of engaging with mental health content on social media. These responses were coded into seven descriptive, non-mutually-exclusive categories (see Table 20). The most frequently occurring category concerned barriers to relevant information, help-seeking, and support (*n* = 14), followed by misconceptions, misrepresentation, and self-diagnosis (*n* = 12). Quality, credibility, and trustworthiness and over-exposure, triggering content, and negative impacts each occurred in 10 responses.

Some categories overlapped conceptually with the fixed-response options reported in Table 19. These responses were retained because they elaborated on the downsides in participants' own words, but they were analysed separately and were not added to the quantitative endorsement totals.

Barriers to relevant information, help-seeking, and support included difficulty accessing recommended services, a lack of New Zealand-specific resources, irrelevant content generated by algorithms, and uncertainty about what information or assistance to seek. Responses concerning misconceptions, misrepresentation, and self-diagnosis described false diagnostic claims, the glorification of mental illness, and the circulation of misleading generalisations. Quality, credibility, and trustworthiness concerned unqualified content creators, contradictory information, insufficient depth, and difficulty determining whether content was valid.

Responses concerning over-exposure, triggering content, and negative impacts described feeling overwhelmed, repeatedly encountering distressing material, or experiencing adverse effects from prolonged engagement. Less frequently occurring categories concerned stigma, judgement, and negative social responses (*n* = 6) and

monetisation and commercialisation (*n* = 5). One participant reported experiencing no downsides.

Table 20

Content Analysis of User-Submitted Downsides of Engaging With Mental Health Content on Social Media

Category	*n*	Illustrative quotation
Barriers to relevant information, help-seeking, and support	14	"Not realistic. They say 'go see this service' but that service is fully booked or doesn't consider me 'bad enough' to help me"
Misconceptions, misrepresentation, and self-diagnosis	12	"A lot of generalisation and false 'diagnosis'. Attributing things like simple forgetfulness to ADHD or eating certain foods to autism."
Quality, credibility, and trustworthiness	10	"Anyone can post for any reason so any content is questionable in its validity"
Over-exposure, triggering content, and negative impacts	10	"Overwhelming of too much information, e.g constant exposure to the topic"
Stigma, judgement, and negative social responses	6	"Lack of empathy from people responding to Mental Health related content"
Monetisation and commercialisation	5	"Some people are only interested in making money out of you"
No downside reported	1	"No downsides"

Note. Counts represent the number of responses coded to each category among the 44 submitted open-text responses. Categories were not mutually exclusive, and responses containing multiple distinct ideas could be coded to more than one category. Each response was counted no more than once within an individual category; therefore, category frequencies sum to more than 44. Illustrative quotations demonstrate the content of each category and do not indicate its relative frequency. Two additional participants selected "Other" without entering a text response and were not included in the content analysis. Categories overlapping with the fixed-response options were analysed separately and were not added to the quantitative endorsement totals reported in Table 19.

3.3 Social Media Influencer Evaluations (RQ3)

3.3.1 Perceived Value by Influencer Type

Participants rated the perceived value of content associated with five different mental health influencer types (Table 21). The highest value ratings were observed for content from individuals sharing their lived experience regarding mental health (M = 80.4, SD = 20.5) and from qualified professionals (M = 78.5, SD = 24.1). In contrast, content from the social media influencers with a significant following received the lowest value rating (M = 29.8, SD = 26.4).

Table 21

Perceived Value of Content by Mental Health Influencer Type

Mental health influencer type	*n*	*M*	*SD*	95% *CI*
Someone sharing their lived experience regarding mental health	625	80.4	20.5	[78.8, 82.0]
Qualified professional	625	78.5	24.1	[76.7, 80.4]
Ally, colleague, or someone I personally know	625	53.7	29.3	[51.4, 56.0]
Person of a similar demographic (e.g., age, gender, ethnicity) to me	625	51.9	27.8	[49.8, 54.1]
Social media influencer with a significant following	625	29.8	26.4	[27.7, 31.8]

Note. Participants rated the value of content associated with each mental health influencer type on a scale from 0 to 100, with higher scores indicating greater perceived value. Descriptive statistics are based on participants with complete ratings for all five influencer types and a valid generation category. Confidence intervals are 95% confidence intervals for the mean.

A mixed-design repeated-measures ANOVA was conducted to examine differences in perceived value of influencer types across generations. The analysis included 625 participants: 154 members of Generation Z, 297 Millennials, 155 members of Generation X, and 19 Baby Boomers and older participants. Mauchly's test indicated that the assumption of sphericity was violated, $W = .847$, $p < .001$. Greenhouse–Geisser-corrected results are therefore reported ($\varepsilon = .918$).

There was a significant main effect of influencer type, $F(3.67, 2279.94) = 157.87$, $p < .001$, $\eta p^2 = .203$, indicating that perceived value differed across influencer types. There was no significant main effect of generation, $F(3, 621) = 0.79$, $p = .499$, $\eta p^2 = .004$, suggesting that average value ratings across influencer types did not differ across generations.

However, a significant interaction between influencer type and generation was observed, $F(11.01, 2279.94) = 2.79$, $p = .001$, $\eta p^2 = .013$. Although this interaction was small, it indicated that the relative value assigned to the influencer types varied somewhat across generations. Inspection of group-specific means showed a broadly similar overall pattern across all generations: qualified professionals and people sharing lived experience were rated most highly, whereas social media influencers were rated least highly. The interaction principally reflected higher ratings for social media influencers among Baby Boomers and older participants ($M = 40.6$) than among the other generations ($Ms = 28.0$–32.8), and lower ratings for someone personally known among Generation Z ($M = 46.8$) than among the other generations ($Ms = 55.0$–57.5). These patterns should be interpreted cautiously given the small interaction effect and the comparatively small Baby Boomer and older subgroup.

Levene's tests indicated that the homogeneity-of-variance assumption was met for four of the five influencer types. It was violated for ratings of social media influencers, $F(3, 621) = 4.39$, $p = .005$.

3.3.2 Perceived Trustworthiness by Influencer Type

Participants rated the perceived trustworthiness of five different mental health influencer types (Table 22). Qualified professionals received the highest trustworthiness ratings (*M* = 82.5, *SD* = 21.8) followed by individuals sharing their lived experience regarding mental health (*M* = 76.4, *SD* = 21.7). In contrast, content from the social media influencers with a significant following received the lowest trustworthiness ratings (*M* = 27.1, SD = 25.9).

Table 22

Perceived Trustworthiness by Mental Health Influencer Type

Mental health influencer type	*n*	*M*	*SD*	95% *CI*
Qualified Professional	567	82.5	21.8	[80.7, 84.3]
Someone sharing their lived experience regarding mental health	567	76.4	21.7	[74.6, 78.2]
Ally, colleague, or someone I personally know	567	54.7	28.3	[52.4, 57.0]
Person of a similar demographic (e.g., age, gender, ethnicity) to me	567	46.2	28	[43.9, 48.5]
Social media influencer with a significant following	567	27.1	25.9	[25.0, 29.2]

Note. Participants rated the trustworthiness of each mental health influencer type on a scale from 0 to 100, with higher scores indicating greater perceived trustworthiness. Descriptive statistics are based on participants with complete trustworthiness ratings for all five influencer types and a valid generation category. Confidence intervals are 95% confidence intervals for the mean.

A mixed-design repeated-measures ANOVA was conducted to examine differences in the perceived trust of influencer types across generations. The analysis included 567 participants: 135 members of Generation Z, 265 Millennials, 142 members of Generation X, and 25 Baby Boomers and older participants. Mauchly's test indicated that the assumption of sphericity was violated, $W = .824$, $p < .001$. Greenhouse–Geisser-corrected results are therefore reported ($\varepsilon = .903$).

There was a significant main effect of influencer type, $F(3.61, 2033.77) = 242.40$, $p < .001$, $\eta p^2 = .301$, indicating that perceived trustworthiness differed across influencer types. The main effect of generation did not reach statistical significance, $F(3, 563) = 2.55$, $p = .055$, $\eta p^2 = .013$, indicating that average trustworthiness ratings across the five influencer types did not differ significantly between generations.

However, there was a significant interaction between influencer type and generation, $F(10.84, 2033.77) = 2.80$, $p = .001$, $\eta p^2 = .015$. Although the interaction was small, it indicated that the relative trustworthiness assigned to the influencer types varied somewhat across generations. Inspection of group-specific means showed the same broad pattern across all generations: qualified professionals and people sharing lived experience were rated most highly, whereas social media influencers were rated least highly. The interaction appeared to reflect comparatively higher ratings among Baby Boomers and older participants for social media influencers ($M = 41.5$) and people of a similar demographic ($M = 59.5$), alongside lower ratings among Generation Z for someone personally known ($M = 48.2$). These patterns should be interpreted cautiously because of the small interaction effect and the comparatively small Baby Boomer and older subgroup.

Levene's tests were nonsignificant for all five influencer types ($ps \geq .055$), indicating that the homogeneity-of-variance assumption was met.

3.3.3 Descriptive Comparison of Value and Trustworthiness

Across the two analyses, the overall ordering of influencer types was similar: qualified professionals and individuals sharing lived experience received the highest ratings, while social media influencers received the lowest ratings. Qualified professionals were rated somewhat more trustworthy than valuable, whereas individuals sharing lived experience, those of a similar demographic, and social media influencers were rated somewhat more valuable than trustworthy. Ratings for personally known individuals were similar across the two dimensions. Because the value and trustworthiness means were based on different complete-case samples and no inferential comparison was conducted, these differences are descriptive only.

3.4 Exploratory Māori and Non-Māori Comparisons (RQ4)

Exploratory analyses were conducted to examine similarities and differences between Māori and non-Māori participants within the study sample. Participants were classified as Māori if they selected Māori either alone or alongside another ethnicity. This included one participant whose free-text ethnicity response was recoded as Māori. Of the 914 participants who provided ethnicity data, 195 (21.3%) were classified as Māori and 719 (78.7%) as non-Māori.

The comparisons were descriptive and were not intended to test whether the observed differences generalised to the wider Māori and non-Māori populations. The number of participants included varied across outcomes because participants could skip survey items.

3.4.1 Content Format Rankings

Short-form video was the content format with which both Māori and non-Māori participants were most likely to engage, followed by images, GIFs, or memes and text-based

posts (Table 23). Live video received the highest mean rank in both groups, indicating the lowest likelihood of engagement.

The overall ordering of formats was broadly similar. Descriptively, Māori participants assigned lower mean ranks to short-form video and live video than non-Māori participants, indicating a greater likelihood of engaging with these formats within the sample. Māori participants assigned higher mean ranks to images, GIFs, or memes, infographics, and text-based posts.

Table 23

Mean Content Format Ranks by Ethnicity (Māori vs. Non-Māori)

Content Format	Māori (n = 148)	Non-Māori (n = 590)
Short-form video	2.05	2.53
Images/GIFs/memes	3.29	3.09
Text-based posts	3.91	3.52
Audio/podcast	4.34	4.51
Long-form video	4.59	4.71
Infographics	4.62	4.07
Live video	5.19	5.58

Note. Values are mean ranks among participants who completed the full content-format ranking set and provided ethnicity data. Lower ranks indicate a greater likelihood of engagement (1 = most likely; 7 = least likely). Comparisons are descriptive only.

3.4.2 Platform Rankings

Facebook received the lowest mean platform rank among both Māori and non-Māori participants, indicating the greatest likelihood of engagement (Table 24). Instagram, YouTube, and TikTok were the next most highly ranked platforms, while X (formerly Twitter), Pinterest, and Reddit received the highest mean ranks in both groups.

The most notable descriptive difference concerned TikTok, which received a lower mean rank among Māori participants (*M* = 3.29) than non-Māori participants (*M* = 4.08). Conversely, Instagram received a higher mean rank among Māori participants (*M* = 2.86) than non-Māori participants (*M* = 2.40). Rankings of Facebook, YouTube, X (formerly Twitter), Pinterest, and Reddit were comparatively similar across the two groups.

Table 24

Mean Social Media Platform Ranks by Ethnicity (Māori vs. Non-Māori)

Social media platform	Māori (*n* = 161)	Non-Māori (*n* = 637)
Facebook	2.25	2.32
Instagram	2.86	2.40
YouTube	3.29	3.23
TikTok	3.29	4.08
X (formerly Twitter)	5.62	5.60
Pinterest	5.65	5.45
Reddit	5.71	5.57

Note. Values are mean ranks among participants who completed the full platform-ranking set and provided ethnicity data. Lower scores indicate greater likelihood of engagement (1 = most likely; 8 = least likely). Comparisons are descriptive only.

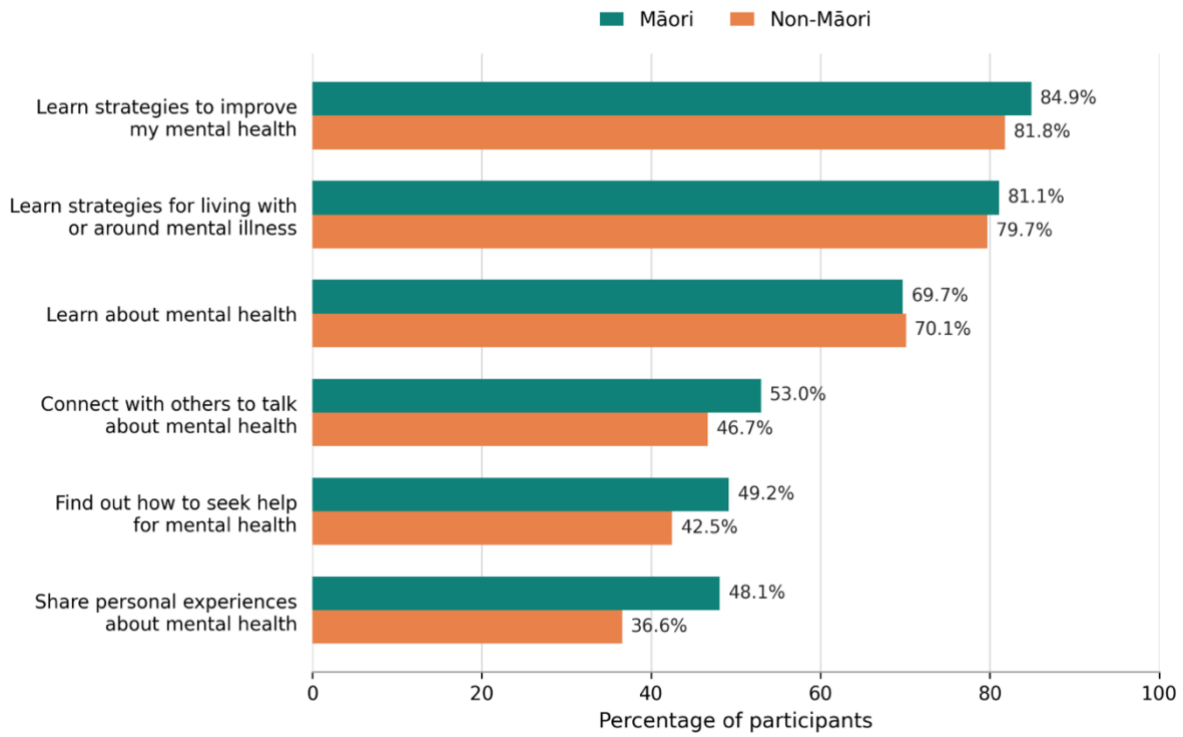
3.4.3 Motivations for Engagement

Informational motivations were commonly endorsed by both Māori and non-Māori participants (Figure 4). Learning strategies to improve their own mental health was the most frequently endorsed motivation among Māori participants (84.9%) and non-Māori participants (81.8%), followed by learning strategies for living with or around mental illness. Endorsement of learning about mental health was also similar across the groups.

Larger descriptive differences were observed for relational and help-seeking motivations. Māori participants more frequently endorsed sharing personal experiences about mental health (48.1% vs. 36.6%), finding out how to seek help (49.2% vs. 42.5%), and connecting with others to talk about mental health (53.0% vs. 46.7%). These percentages describe patterns within the sample and were not tested for statistical significance.

Figure 4

Self-Reported Motivations for Engaging With Mental Health Content on Social Media by Ethnicity



Note. Values represent the percentage of participants endorsing each motivation. Participants could endorse more than one motivation. Percentages are based on 185 Māori and 675 non-Māori participants who reached the motivations items and provided ethnicity data. Comparisons are descriptive only.

3.4.4 Influencer Value & Trust

The overall ordering of mental health influencer types was broadly similar across the two groups (Table 25). Among Māori participants, people sharing their lived experience received the highest mean value rating (*M* = 82.1), followed by a qualified professional (*M* = 71.0). Among non-Māori participants, this ordering was reversed: qualified professionals received the highest value rating (*M* = 80.5), followed by someone sharing their lived experience (*M* = 79.9). When rating trustworthiness, among Māori participants, people

sharing lived experience received the highest mean rating (M = 77.8), closely followed by qualified professionals (M = 76.7). Among non-Māori participants, qualified professionals received the highest mean trustworthiness rating (M = 83.8).

Within the study sample, Māori participants gave higher mean value and trustworthiness ratings to individuals sharing lived experience, social media influencers, personally known individuals, and people of a similar demographic. The largest differences concerned people of a similar demographic, who received higher value and trustworthiness ratings among Māori participants. Qualified professionals, however, received lower mean value and trustworthiness ratings among Māori participants than among non-Māori participants.

Table 25

Value and Trustworthiness Ratings by Influencer Type and Ethnicity

Mental health influencer type	Māori value *M* (*SD*)	Non-Māori value *M* (*SD*)	Māori trustworthiness *M* (*SD*)	Non-Māori trustworthiness *M* (*SD*)
Someone sharing their lived experience regarding mental health	82.1 (20.1)	79.9 (20.6)	77.8 (24.4)	76.1 (21.1)
Qualified professional	71.0 (28.7)	80.5 (22.4)	76.7 (25.6)	83.8 (20.7)
Person of a similar demographic to me	62.6 (26.0)	49.1 (27.6)	57.8 (26.9)	43.3 (27.6)
Ally, colleague, or someone I personally know	58.6 (28.7)	52.4 (29.3)	61.5 (26.7)	53.0 (28.4)
Social media influencer with a significant following	36.9 (28.6)	27.9 (25.4)	33.8 (27.9)	25.8 (25.7)

Note. Ratings ranged from 0 to 100, with higher scores indicating greater perceived value or trustworthiness. Complete-case samples were 131 Māori and 495 non-Māori for value, and 118 Māori and 454 non-Māori for trustworthiness; comparisons are descriptive only.

Overall, the two groups showed similar broad patterns, particularly their high ratings of qualified professionals and people sharing lived experience and their low ratings of social media influencers. Within this sample, Māori participants showed relatively greater engagement with TikTok, more frequent endorsement of relational motivations, and higher ratings of personally relevant or demographically similar sources. These patterns should be interpreted as exploratory because no inferential comparisons were conducted and the non-probability sample was not designed to represent the wider Māori or non-Māori populations.

Discussion

4.1 Overview of Findings

This study explored how New Zealanders who are interested in mental health content on social media engage with, evaluate, and make sense of this content. The findings suggest that social media is already functioning as an informal mental health information environment for many participants. Within this environment, people learn about mental health, seek strategies to improve their wellbeing, observe others' experiences with mental health, assess the credibility of those delivering mental health content, and weigh the accessibility of this content against their concerns about misinformation, oversimplification, stigma, and a lack of professional guidance.

A key finding in this study was that participants valued the accessibility of mental health content on social media, while also holding concerns about its quality, trustworthiness, and safety. Participants commonly endorsed convenience, anonymity, access without direct payment, and around-the-clock availability as benefits. At the same time, they identified inaccurate or misleading information, a lack of professional guidance, the oversimplification of complex mental health issues, and the contribution to stigma as the important downsides. This reflects a tension in mental health communication over social media: the same features that make the content accessible and easy to distribute may also make its accuracy, quality, and safety more difficult to evaluate.

Short-form video was the most strongly preferred content format, while Facebook and Instagram were the highest-ranked platforms, although these platform findings should be interpreted in the light of recruitment occurring primarily through Facebook and Instagram, as well as generational differences in platform preference. Engagement was primarily learning-oriented, but participants more frequently attributed relational and help-

seeking motivations to others than themselves. Qualified mental health professionals and people sharing their lived experience with mental health were rated as the most valuable and trustworthy sources, while social media influencers with a significant following were rated the lowest. The exploratory Māori and non-Māori comparisons showed broadly similar overall patterns, alongside some differences in platform preference, relational motivations, and evaluations of personally relevant sources.

Overall, the findings suggest that participants valued mental health content that was accessible, practical, credible, and relatable, while remaining alert to at least some of the risks associated with receiving mental health information through social media.

4.2 Social Media as an Informal Mental Health Information Environment

One way to interpret the findings from this study is that social media is essentially functioning as an informal mental health information environment. Rather than being equivalent to therapy, clinical assessment, or professional mental health care, it provides a space where people encounter mental health language, learn strategies, observe others' experiences, and make early judgments about what kinds of support or information may be relevant to them.

This interpretation is supported by the strong endorsement of learning-oriented motivations. Participants most commonly reported using mental health content to find strategies to help themselves improve mental health, learn coping strategies with or around mental illness, and learn about mental health more generally. These findings suggest that participants were not only engaging with mental health content for emotional reassurance or social connection, although these were also present, but were using social media as a practical information source. This is consistent with the uses and gratifications theory, which views media engagement as an active process through which users seek to meet needs such

as information-seeking, coping, and social connection (Katz et al., 1973; Whiting & Williams, 2013). In this sense, mental health content on social media may function as a form of low-barrier psychoeducation.

At the same time, the findings suggest that participants were aware of at least some limits of this information environment. Their concerns about oversimplification, stigma, and lack of professional guidance indicate they did not view mental health content on social media as automatically safe or reliable. Instead, they appeared to recognise a trade-off: social media offers immediate and accessible information, but with uncertainty about quality, credibility, and relevance. This pattern is consistent with the Health Belief Model's distinction between perceived benefits and barriers, although the present study was not designed to test that model directly (Champion & Skinner, 2008; Janz & Becker, 1984).

This tension reflects a broader challenge in using social media for mental health communications. In professional health services, information is subject to professional standards, organisational accountability, and clinical context. Social media content, by contrast, may be created and circulated without moderation or oversight, while its visibility is influenced by platform algorithms, creator visibility, emotional appeal, shareability, and engagement. These features can help mental health information reach people who may be otherwise difficult to reach, while they can also facilitate the distribution of low-quality, oversimplified, or misleading content (Denniss et al., 2022). Therefore, the value of social media as a mental health environment may depend less on whether it is "good" or "bad" overall, and more on the conditions in which content is created, encountered, interpreted, and acted upon (Ferguson, 2025).

This has important implications for how mental health content is developed and shared online. If social media is already functioning as an informal mental health

information environment, an important question is how credible, culturally appropriate, and practically useful content can be made visible within these environments, while also reducing the risk of misinformation, oversimplification, and exposure to distressing material (Carter, 2025; Chen & Wang, 2021; Naslund et al., 2020). On this basis, social media may be best understood as one part of a broader mental health information and support ecosystem.

4.3 Accessibility, Anonymity, and the "Missing Middle"

The benefits of engaging with mental health content on social media endorsed by participants are particularly important when considered in relation to the wider issue of the unmet need for mental health support in New Zealand (Government Inquiry into Mental Health and Addiction, 2018). Participants most commonly endorsed benefits that reduced practical or social barriers to engagement: being able to access content on demand and around-the-clock; being able to access content anonymously; not having to pay for content; and not needing to travel to access it. These findings suggest that, for this sample, the perceived value of mental health content on social media was closely tied to its accessibility.

These findings concern access to mental health information rather than access to care. This study did not measure mental health outcomes, service use, or symptom change, and therefore cannot show that social media improves mental health, replaces therapy, or closes the treatment gap. However, the findings do suggest several mechanisms through which social media may reduce some early barriers to mental health information and informal support.

First, social media can remove some practical barriers to accessing mental health information. Unlike traditional services, which may require appointments, transport, time away from other responsibilities, or payment, social media content can generally be

accessed immediately at no direct cost. This may be particularly relevant in a sample where a substantial proportion reported recent financial hardship. Although this study cannot determine whether financial hardship influenced participants to seek mental health content online, the strong endorsement of free and on-demand access suggests that cost and convenience were valued features.

Second, anonymity appears to be an important benefit. Although social media use is not completely anonymous, since platforms may track user activity, users can generally access mental health content privately and without people they know being aware of their engagement. This may allow people to explore mental health information before they are ready to disclose their concerns or seek support from others. This is important because stigma remains a major barrier to mental health help-seeking (Government Inquiry into Mental Health and Addiction, 2018; Naslund et al., 2016; Z. Zhang et al., 2025).

Third, these access-related barriers may be relevant to New Zealand's "missing middle": people with mild-to-moderate or moderate-to-severe mental health needs who are unable to access appropriate support and care (Government Inquiry into Mental Health and Addiction, 2018). Participants commonly used mental health content to learn strategies, improve their own wellbeing, and understand mental health more generally. Social media may therefore provide an informal layer of psychoeducation that sits alongside other forms of support, although the study cannot establish whether participants used it in place of, while awaiting, or alongside professional care.

Participants' endorsement of free, on-demand, and travel-free access, together with their concerns about misinformation, oversimplification, and lack of professional guidance, suggests that they valued the accessibility of social media without necessarily viewing it as a sufficient replacement for care. Therefore, its strongest application may be as an accessible

entry point to mental health information that also directs users towards appropriate professional, community, or crisis support when needed.

4.4 Platform and Format Preferences

Participants' varied platform and format preferences have practical implications for how mental health content is delivered on social media. Engagement may depend not only on what is communicated, but also on where and how it is delivered.

Short-form video was the most preferred content format overall, while live video was least preferred. Short-form video can communicate a single idea or introduce a coping strategy in a format requiring relatively little time or effort from the user (Liao, 2024; Zhu et al., 2023). By contrast, live video requires users to be available at a particular time and may place greater social demands on the viewer. The preference for content formats that can be viewed privately, paused, saved, ignored, or returned to later may reflect the importance of convenience and control over engagement. This interpretation is consistent with the uses and gratifications theory, in which people select media that meets needs such as efficiency and information-seeking (Katz et al., 1973; Whiting & Williams, 2013). However, the preference for short-form video should not be equated with its suitability for communicating complex or clinically nuanced information, particularly given participants' concerns about oversimplification, misinformation, and lack of professional guidance.

Facebook and Instagram were ranked as the most likely platforms for engaging with mental health content, followed by YouTube and TikTok. These findings may partly reflect broader platform use within New Zealand, as Facebook and Instagram were already widely used when the study was conducted (Kemp, 2023). However, the pattern did not simply reproduce estimates of general platform reach, with YouTube having a larger potential audience but ranking third for engagement with mental health content in this study.

Because the study did not measure participants' general use of each platform, it cannot determine whether these rankings reflect mental-health-specific preferences, existing platform habits, or both. Recruitment primarily through Facebook and Instagram may also have contributed to higher rankings. The generational differences further indicate that rankings were partly shaped by the age composition of the sample, as Facebook was preferred more strongly by older participants and TikTok by younger participants.

Platform preferences may also reflect differences in platform functionality, including how content is discovered, how visible its creator is, and whether users can interact or share it. These features can influence attention, credibility judgments, and willingness to engage (Sundar, 2008; Treem & Leonardi, 2013). The rankings may therefore reflect preferences not only for particular platforms, but also for the modes of engagement those platforms provide.

The rank-order design of this study should also be considered when interpreting the findings. Ranking required participants to prioritise formats and platforms relative to one another. This was useful for identifying relative preference and reducing the possibility that participants would endorse several platforms or formats at similarly high levels. However, rankings do not indicate absolute willingness to engage with each option. For example, a participant who ranked Facebook first and Instagram second may be highly likely to use both, while another participant with the same ranking may only be moderately likely to use either. Similarly, a low-ranked option should not necessarily be interpreted as one the participant would never use, only that it was ranked below the other available options. Therefore, the findings are strongest when interpreted as relative prioritisation, rather than as evidence of absolute engagement levels. Nevertheless, relative prioritisation remains useful when communication strategies require decisions about which platforms and formats

to prioritise. The findings should therefore be understood as identifying participants' relative preferences rather than their absolute willingness to engage with each option.

Overall, platform and format rankings should be interpreted as relative preferences shaped by participants' existing platform use, generational differences, platform affordances, and the study's recruitment strategy.

4.5 Credibility, Lived Experience, and the Limits of Popularity

The findings on mental health influencers suggest that participants made clear distinctions between different types of influencers. The survey used the term "mental health influencer" as a broad umbrella label for categories of people whose mental health content participants were asked to evaluate: qualified mental health professionals, people sharing lived experience, people personally known to the participant, people of a similar demographic, and social media influencers with a significant following.

Qualified mental health professionals were rated the most trustworthy source of mental health content, while also rating highly for value. This likely reflects the importance of perceived expertise, training, and accountability when mental health information is being presented. This is consistent with source credibility theory, where perceived expertise and trustworthiness are central to whether a message is accepted (Hovland et al., 1953; Ohanian, 1990). In mental health contexts, professional status may be especially important because inaccurate, unsafe, or poorly contextualised advice can have serious consequences (Suarez-Lledo & Alvarez-Galvez, 2021).

People sharing lived experience had the highest mean value rating of all influencer types, while also being rated as relatively trustworthy. This suggests that participants saw experiential knowledge as an important part of mental health communication. Lived-experience content may provide relatability, emotional validation, normalisation, and a

sense that someone understands the experience from the inside. This aligns with previous research showing that people engage with mental health content online to connect with others, learn from shared experiences, and feel less alone (Naslund et al., 2017; Naslund et al., 2016; Naslund et al., 2020). In this sense, lived experience may not be valued because it replaces professional knowledge, but because it provides a different form of credibility and connection.

The distinction between value and trustworthiness is important here because the two concepts are related but not identical. A message may be accurate and professionally credible, but fail to engage if it feels like it is detached from lived reality. Conversely, a message may feel relatable and validating, but become unsafe if personal experience is presented as universal advice. Effective mental health content may therefore benefit from both credibility and connection.

Popularity indicators such as follower counts, likes, and shares, can operate as heuristic credibility cues or forms of social proof (Chaiken, 1980; Metzger & Flanagin, 2013). However, the comparatively low ratings for social media influencers with a significant following suggests that participants did not regard popularity alone as a reliable cue for quality. Reach may be useful, but it does not necessarily produce trust.

People personally known to the participant and people of a similar demographic received mid-range ratings, suggesting that familiarity and similarity may support relevance without necessarily establishing credibility. A known person may be trusted interpersonally, but not regarded as a reliable source of mental health guidance, while demographic similarity may make content feel more relevant without making it more accurate or valuable.

Overall, participants appeared to distinguish between professional expertise and experiential credibility from popularity. They valued mental health content that was both credible and human, while not treating follower count as a substitute for trustworthiness or value.

4.6 Māori and Non-Māori Engagement Patterns

The exploratory comparison of Māori and non-Māori participants showed broad similarities alongside several meaningful descriptive differences. Both groups most strongly preferred short-form video, commonly endorsed learning-oriented motivations, and gave relatively high ratings to qualified professionals and people sharing lived experience. These similarities are important because they indicate that the central findings of the study were not confined to one ethnic group. However, the comparisons were descriptive and were not designed to establish statistically significant differences or represent the wider Māori and non-Māori populations. The patterns should therefore be interpreted as directions for further investigation rather than evidence of distinct engagement preferences among Māori generally.

Some differences were apparent in participants' format, platform, and engagement preferences. Within this sample, Māori participants showed a stronger preference for short-form video and TikTok, while non-Māori participants showed a stronger preference for Instagram. Māori participants also more frequently endorsed connecting with others to talk about mental health. These patterns may be relevant to Māori models of health, such as *Te Whare Tapa Whā*, that emphasise relationality, whānau, cultural connectedness, and trust-based relationships (Durie, 1985; Russell, 2018; Wilson et al., 2021). However, this study did not measure whether participants' responses were shaped by these cultural values, and whether other demographic or experiential differences between the groups may also have

contributed. The findings therefore cannot establish that Māori engagement was more relational because of cultural identity.

The influencer ratings provide further indication that relevance and relational credibility may warrant closer examination. Among Māori participants, people sharing lived experience received the highest mean ratings for both value and trustworthiness, although their trustworthiness rating was very close to that of qualified professionals. Māori participants also gave higher mean ratings than non-Māori participants to people of a similar demographic and people they personally knew, while qualified professionals received lower mean ratings for value. Descriptively, this pattern suggests that professional expertise remained important, but may not have been the only basis on which Māori participants evaluated mental health content. Relatability, lived experience, familiarity, and personal relevance may also have contributed to perceptions of value and trust.

These findings may be particularly relevant to culturally tailored mental health communication in New Zealand. Although demographic similarity was included in the survey, this broad measure cannot capture the complexity of culture, ethnicity, whānau, community connection, or shared lived experience. It also combined age, gender, and ethnicity within one item, meaning that the present study cannot identify which form of similarity participants considered important. Future research should examine how culturally grounded expertise, lived experience, professional training, relational trust, and community accountability interact in Māori mental health communication. Although the present comparison focused on Māori and non-Māori participants, these questions may also be relevant within Pacific, Asian, and other communities in New Zealand. Trusted mental health communication in these contexts may depend not on a single type of influencer, but

on an appropriate combination of cultural connection, lived experience, professional expertise, and community accountability.

4.7 Reasons for Engagement for the Self Versus for Others

A notable finding was the difference between participants' reported reasons for their own engagement and the reasons they perceived in others. Participants most commonly endorsed learning-oriented motivations for themselves, particularly learning strategies to improve their own mental health, learning strategies for living with or around mental illness, and learning about mental health more generally. In contrast, when considering why others might engage with mental health content, participants more strongly endorsed connecting with others, sharing personal experiences, and finding out how to seek help.

One possible interpretation is that participants found it easier to describe their own engagement in practical or educational terms rather than explicitly social or help-seeking terms. Learning strategies and gaining information may feel more private, self-directed, and acceptable than describing oneself as seeking help, sharing personal experiences, or trying to connect with others about mental health. Stigma or discomfort with disclosing support needs may contribute to this pattern. However, responses concerning others reflected participants' perceptions rather than reports from those other people, so the difference cannot establish why participants described the two perspectives differently. The prominence of both informational and social motivations is consistent with the uses and gratifications theory, which proposes that people engage with media to meet different needs, including information-seeking, coping, and social connection (Katz et al., 1973; Whiting & Williams, 2013).

The difference between self and others also highlights the relational nature of mental health content on social media. People may engage with this content not only for themselves, but also to understand, support, or communicate with whānau, friends, partners, colleagues, clients, or wider communities. Mental health information may circulate through networks of care as well as through individual help-seeking. A person may encounter or share a post because they are trying to understand someone else's experience, find language for a supportive conversation, or provide information that may help another person. Participants' endorsement of the ability to share content provides further support for this relational interpretation.

The self-other distinction may also have implications for future research. Because participants reported only their perceptions of others' motivations, the study cannot determine whether other people actually engaged for these reasons. Future studies could examine private viewing, saving posts, sharing content with trusted people, commenting, direct messaging, and using content to support someone else to provide a more detailed account of how engagement moves between private reflection and interpersonal support.

Overall, engagement with mental health content may be both personal and relational. Participants primarily described their own motivations in learning-oriented terms, while more strongly associating others' engagement with connection, disclosure, and help-seeking. Although the reasons for this difference cannot be established from the present data, the findings indicate that mental health content may be used both for self-directed learning and to understand or support other people.

4.8 Implications for Public Health Communication in New Zealand

The findings indicate that public health communication needs to consider how mental health information is presented, who delivers it, where it appears, and what

safeguards accompany it. Accessibility should remain a core design principle. Mental health content should be freely available, easy to understand and revisit, and connected to local services and crisis support where appropriate.

Platform and format choices should reflect the intended audience rather than assuming that the same approach will work across groups. Short-form video may provide an accessible entry point, but participants' concerns about oversimplification and misinformation indicate that brief content should connect users to fuller explanations, credible sources, or appropriate support.

The influencer-type findings suggest that credibility should be made visible through professional qualifications, organisational affiliation, cultural or community expertise, or clear identification of lived experience. Collaboration between qualified professionals and people sharing lived experiences may be especially valuable, as this could combine clinical accuracy with relatability and emotional resonance, while follower count should not be treated as a substitute for credibility.

Mental health content should also accommodate relational use. This could include information for whānau, friends, and other supporters about starting conversations, responding to when someone discloses distress, recognising when further help may be needed, and directing someone towards appropriate support.

Addressing these risks cannot depend only on individual creators voluntarily communicating responsibly. Harm reduction approaches may also require creator guidance and training, clearer identification of credible sources, platform-level reporting and moderation processes, links to reliable information around high-risk content, and media-literacy initiatives that help users evaluate mental health claims. Public-health agencies may

therefore need to work with platforms, professional bodies, community organisations, and content creators rather than focusing only on the content they produce themselves.

In New Zealand, these approaches should reflect local pathways to support and be developed with the communities they are intended to reach. Co-design is particularly important where culturally grounded support, whānau involvement, community connection, and relational trust influence engagement. Social media is therefore best approached as one component of a broader, culturally responsive mental health communication system, supported by credible information, appropriate safeguards, and pathways to further help.

4.9 Strengths and Limitations

This study provides one of the first detailed accounts of how New Zealanders interested in mental health content on social media describe their engagement with this material. Much of the existing literature has focused on general social media use or broad exposure measures, or specific demographic or clinical subpopulations, which limits how directly the findings can be applied to broader adult populations (Aschbrenner et al., 2019; Garrett et al., 2024; Huang, 2017; Jarman et al., 2023; Naslund et al., 2017; Naslund et al., 2016; Naslund et al., 2020; Stronge et al., 2019). In contrast, the present study examined the specific platforms, content formats, motivations, perceived benefits, perceived downsides, and influencer qualities associated with mental health content. This provides a more practical understanding of how mental health-related social media engagement occurs in everyday digital environments.

A further strength lies in the study's sample and methodological design. The sample also included participants across a wide age range and 195 Māori participants (21.3%), a proportion slightly higher than the 17.8% of the New Zealand population who identified as

Māori in the 2023 census (Stats NZ, 2024). Furthermore, recruiting online was an appropriate strategy for reaching people with direct experience of or interest in the digital environment being investigated. Finally, the fixed-response items allowed broad patterns to be summarised, while the open-text responses provided additional context and identified issues not fully captured by the prespecified options.

Despite these strengths, several limitations need to be considered. The most important limitation is that the sample was not representative of the New Zealand population. Participants were recruited through non-probability methods, and were required to report an interest in mental health content on social media. The study also did not include a comparison group of people who were not interested in such content. It therefore cannot determine how New Zealanders interested in mental health content differ demographically from those who are not interested, or whether the characteristics of the sample reflect wider patterns of engagement, recruitment pathways, topic salience, or willingness to participate.

Recruitment primarily through Facebook and Instagram may have overrepresented users of those platforms and contributed to their higher rankings. The findings should therefore be interpreted as relative preferences within this sample, rather than as estimates of platform use among all New Zealanders interested in mental health content.

The cross-sectional design cannot establish whether engagement with mental health content affects mental health, help-seeking, reduces unmet need, or determines the direction of any relationships. The findings are therefore descriptive and exploratory, rather than causal.

The survey measures were developed specifically for this study, and their psychometric properties are therefore unknown. In addition, forced rankings measure

relative prioritisation rather than participants' absolute likelihood of engagement with each platform or format.

The open-text responses were optional and therefore reflect only participants who chose to provide information beyond the fixed-response options. Therefore, category frequencies should not be interpreted as estimates of prevalence across the sample. In addition, the content analysis identified and summarised recurring categories and patterns but did not undertake a deeper interpretive analysis of underlying meanings or concepts.

The broad definition of mental health content meant that the study could not determine whether participants' responses differed across content types such as psychoeducation, humour, lived-experience narratives, diagnostic information, or crisis content. These content types may differ substantially in their usefulness, risks, and credibility, meaning the overall findings may mask important variations in how users engage in specific topics.

The findings are also time-sensitive because platform popularity, algorithmic distribution, content formats, and patterns of user behaviour can quickly change. Platform and format rankings should therefore be interpreted in relation to the social media environment at the time of data collection.

Overall, the study should be understood as exploratory and descriptive. It does not show that social media improves mental health or reduces unmet need, and its findings should not be generalised to all New Zealanders. Rather, it describes the preferences and perceptions of a sample of New Zealanders who reported an interest in mental health content on social media.

4.10 Future Directions

The findings of this study provide several directions for future research. The most important priorities are comparative research using improved measures, experimental testing of specific content, longitudinal research, and culturally grounded and co-designed research in New Zealand.

The first priority is to examine mental health-related social media engagement using samples that allow clearer comparisons between groups. Because the present study intentionally recruited people interested in mental health content on social media, it cannot determine how this group differs from people who are not interested in such content. Future research could compare people who actively engage with mental health content, people who encounter it passively, and people who avoid or reject it. Studies could measure participants' general platform use and combine stated preferences with behavioural measures and absolute ratings. This would help distinguish mental-health-specific engagement from existing platform habits and determine whether stated preferences correspond with actual engagement. Further assessment and refinement of the study-specific measures would also provide stronger evidence concerning their reliability and validity.

Future research should consider testing social media-based mental health content experimentally. The present study suggests that participants value accessible content, professional expertise, lived experience, and practical strategies, but it cannot determine whether these features improve engagement, trust, understanding, help-seeking, or wellbeing. Related experimental and intervention research already exists in areas such as digital mental health literacy and media narratives (Niederkrotenthaler et al., 2022; Yeo et al., 2024). The more specific contribution would therefore be to test the combinations of

source, format, and content identified in the present study within New Zealand. Randomised experiments could expose participants to otherwise equivalent mental health messages while systematically varying factors such as influencer type, content format, message framing, or the inclusion of professional and lived-experience perspectives. Outcomes could include attention, perceived credibility, understanding, recall, behavioural intentions, and help-seeking intentions. Experiments could also compare specific forms of content, such as psychoeducation, lived-experience narratives, humour, diagnostic content, coping strategies, or crisis-related content, rather than treating mental health as a single content category.

Longitudinal research would also be valuable. Longitudinal designs have previously been used to examine participation in specific online mental health communities (e.g., Feldhege et al., 2021), but further research could examine whether broader patterns of engagement with mental health content predict later changes in mental health literacy, help-seeking, social connection, or distress. Such research would also help clarify whether psychological distress leads people toward mental health content, whether exposure and engagement affect later outcomes, or whether these processes are reciprocal. This could include examining how viewing, saving, sharing, and direct messaging are used over time for personal reflection or to support whānau and others.

Culturally grounded and co-designed research is also needed in New Zealand. Although the present study included Māori participants, it was not designed to examine Māori engagement in depth, or to evaluate culturally grounded mental health communication. Research co-designed with Māori communities and guided by kaupapa Māori approaches, where appropriate, could examine how professional expertise, lived experience, cultural identity, whānau connection, community accountability, language, and

knowledge of local support pathways interact in shaping credibility and engagement. Community-specific research may also be valuable for other populations whose experiences were not examined in depth in the present study.

Overall, future research should move from broad descriptions towards more targeted, comparative, experimental, longitudinal, and co-designed methods that examine how mental health content can support safe, credible, and culturally appropriate engagement in New Zealand.

Conclusion

This study explored how New Zealanders who are interested in mental health content on social media engage with, evaluate, and make sense of this content. The findings suggest that social media is already operating as an informal mental health information environment for many participants. People used or valued this content for learning strategies, improving mental health literacy, understanding lived experience, supporting others, and accessing information in ways that are immediate, private, free, and convenient.

At the same time, participants were aware of the risks of mental health content online. Misinformation, oversimplification, lack of professional guidance, triggering content, and monetisation were all identified as important concerns. These findings suggest that social media should not be viewed as a simple solution to unmet mental health needs. Rather, it is a complex and uneven environment where useful support, credible information, lived-experience knowledge, and harmful or misleading content can exist side-by-side.

The study also highlights the importance of content format, platform selection, and influencer characteristics. Participants preferred short-form and visual content, but also raised concerns about oversimplification, lack of nuance, and misinterpretation in mental health content. Platform preferences differed across age groups, indicating that social media-based mental health communication needs to be tailored rather than treated as a single channel. Participants also distinguished clearly between influencer types, rating qualified professionals and people sharing lived experience as the most valuable and trustworthy sources, while rating popularity alone as a poor marker of credibility.

Overall, the findings support a cautious but practical view of social media's role in mental health communication in New Zealand. Social media is not a replacement for professional care, nor can this study determine whether engagement with mental health

content improves wellbeing or increases help-seeking. However, it does show that many participants see value in accessible, credible, and relatable mental health content online. Future work should build on these findings through comparative, longitudinal, experimental, and co-designed research that examines which forms of content are safest, most useful, and most appropriate for different communities in New Zealand.

As mental health information continues to circulate through digital spaces, the question is no longer whether people will encounter mental health content on social media. They already do. The more important question is how this content can be made more credible, culturally relevant, accessible, and safe. This study contributes to that task by identifying how New Zealand residents who are interested in mental health content prioritise platforms, formats, motivations, benefits, risks, and influencer qualities, within everyday social media environments.

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Appendix A

Recruitment Advertisement

📣 Attention Social Media Users! 📣

🤔 Do you have an interest in engaging in mental health content on social media? Are you aged 16 or over and currently residing in New Zealand? If so, we want to hear your valuable insights!

📋 Participate in our online survey and contribute to a better understanding of mental health content on social media platforms. 📝

🎁 As a token of appreciation, all participants are invited into a draw to win a $100 Visa Prezzy card. The survey takes only 5-10 minutes to complete.

🌍 Help us make a difference by providing your input on the following topics:

- Who are the New Zealanders engaging in mental health content on social media
- What types of mental health content are New Zealanders engaging in and why
- What qualities of a Mental Health Influencer impact the perceived trustworthiness and value of the mental health content?

📣 Join us in this exciting research initiative and make your voice heard! 🗣️

📎 Click the link below to take part in the survey:

https://bit.ly/socialmediapsychresearch

This research is being undertaken towards a Master's Degree in Psychology from Massey University.

📣 Spread the word and share this post with your friends and family. Let's reach as many individuals as possible and gather diverse perspectives! 🌟

#MentalHealthMatters #SocialMediaSurvey #JoinTheConversation #ShapeTheFuture

Appendix B

Participant Information Sheet

Researcher Introduction

This research is being conducted by Aston Garratt for fulfilment of the requirements for the degree of Master of Science in Psychology. This research is supervised by Clinical Psychologist Dr. Marthinus Bekker (Massey University School of Psychology, Albany). This research contributes to our understanding of New Zealanders' engagement in mental health content on social media, which may serve to inform mental health organisations and government bodies who might like to consider social media-based mental health campaigns and digital interventions. This research is "scoping research" designed to generate data that will inform future research.

Participant Description and Invitation

This study is looking for a minimum of 100 participants who are aged 16 or older, currently residing in New Zealand, and have an interest in engaging in mental health content on social media.

You are invited to take part in this study investigating New Zealanders' mental health-seeking behaviour in social media. Whether or not you take part is your choice. If you don't want to take part, you don't have to give a reason. If you do want to take part now, but change your mind once you have begun, you can pull out of the study at any time up until you complete the questionnaire and submit your data by simply stopping and closing the browser window containing the questionnaire. Given the nature of the study, in order to maintain anonymity of the data, a participant cannot withdraw after submission of the data.

This Participant Information Sheet will help you decide if you'd like to take part. It sets out why we are doing the study, what your participation would involve, what the benefits and risks to you might be, and what would happen after the study ends.

Participant Identification and Recruitment

Participants for this research will be recruited via social media using paid targeted advertising and snowballing. Advertising will contain a URL to the online questionnaire.

Forwarding and sharing of this URL widely through networks of New Zealanders is encouraged.

Selection criteria

Those aged 16 or older who are currently residing in New Zealand who indicate they have an interest in engaging in mental health content on social media.

Exclusion criteria

Participants who indicate they are not currently residing in New Zealand, are not aged 16 years or older, or do not have an interest in engaging in mental health content on social media.

Project Procedures

Your participation involves reading this information sheet in order to give informed consent and then completing an online questionnaire that takes approximately 5 minutes, once you have given digital consent. Participation will be completed in one sitting once the questionnaire commences. Upon completion of the survey, or after a participant indicates they want to exit the survey, participants will be given the opportunity to provide their email in order to be sent a copy of the research report on completion of the study, as well as to be entered into a prize draw to receive a $100 Visa Pressie card. The total time required to participate in this study is approximately 10 minutes.

Data Management

Data will be collected using Qualtrics Software. When the survey closes, a file containing the survey data will be transferred to the researcher's cloud-based, password-protected storage device and accessed by the researcher and supervisor only. This data will be destroyed after 7 years.

Non-identifiable data will be analysed and a summary of findings will be reported. Any identifiable information collected will not be reported and all efforts will be made to ensure such information is accessible only to the researcher.

Participant Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study at any point until the data is submitted for analysis;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.
- Completion and return of the required forms implies consent. You have the right to decline to answer any particular question

Contact information

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Massey University | Te Kunenga ki Pūrehuroa

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This project has been reviewed and approved by the Massey University Human Ethics Ohu Matatika 3, Application OM3 23/26. If you have any concerns about the conduct of this research, please contact the Chairperson, Massey University Human Ethics Ohu Matatika 3, email humanethics3@massey.ac.nz

Appendix C

Questionnaire

Please answer the following questions as openly and honestly as you can.

1. What is your age?

[Numeric Field]

2. What is your gender?

(1)Male

(2)Female

(3)Non-binary / third gender

(4)Prefer not to say

3. What ethnicities do you associate with?

(1)European

(2)Māori

(3)Pacific Peoples

(4)Asian

(5)MELAA (Middle Eastern / Latin American / African)

(6)Other ethnicity – please specify [open text field]

4. What is your highest level of education?

(1)No qualification

(2)Level 1 Certificate

(3)Level 2 Certificate

(4)Level 3 Certificate

(5)Level 4 Certificate

(6)Level 5 & 6 Diploma

(7)Bachelors Degree or Level 7 Qualification

(8)Masters Degree

(9)Doctorate Degree

(10)Overseas Secondary School Qualification

5. Have you experienced financial hardship in the past year?

(1)Yes

(2) No

6. Have you previously or do you currently actively seek out mental health content on social media?

(1)Yes

(2) No

7. Please rank how likely are you to engage in the following types of mental health content

1 = most likely 7 = least likely

(1)Short form video

(2)Long form video

(3)Live video

(4)Audio/Podcast

(5)Images / GIFs / memes

(6)Infographics

(7)Text-based posts

8. Please rank how likely are you to engage in mental health content on the following social media platforms

1 = most likely 7 = least likely

(1)Facebook

(2)Instagram

(3)YouTube

(4)TikTok

(5)Twitter

(6)Pinterest

(7)Reddit

(8)Other - please specify [open text field]

9. What are your reasons for engaging in mental health content on social media.

Please select all that apply to you:

Learn about mental health

Learn strategies for living with or around mental illness

Learn strategies to improve my mental health

Connect with others to talk about mental health

Share personal experiences about mental health

Find out how to seek help for mental health

Other (please describe) [open text field]

10. What reasons, that you are aware of, have motivated others to engage in mental health content on social media?

Please select all that apply:

Learn about mental health

Learn strategies for living with or around mental illness

Learn strategies to improve my mental health

Connect with others to talk about mental health

Share personal experiences about mental health

Find out how to seek help for mental health

Other (please describe) [open text field]

11. What benefits have you personally experienced in engaging in mental health content on social media?

Select all that apply

I don’t have to go anywhere to access the content, saving me time and travel costs

I don’t have to pay money to access the content, social media is free

I can access the content anonymously, no one needs to know about it

I can access the content on demand, 24/7

I can connect to others interested in the same topic

I have the ability to share content with others, and others can share relevant content with me

I can see how popular the content is, helping me decide on the quality of the content.

Other (please describe) [open text field]

12. What downsides have you experienced in engaging in mental health content on social media?

Select all that apply

Inaccurate or misleading information

Difficulty finding the right topic

Triggering or distressing content

Risk of online harassment and negativity

Lack of professional guidance

Social comparison that can negatively impact self esteem

Oversimplification and stigma

I can get addicted or dependent on social media

Other (please describe) [open text field]

For the purposes of this study, a person delivering mental health content on social media is called a ‘mental health influencer’

13. What characteristics of the mental health influencer impact the value of the content?

Adjust the slider for each item rating it between 0-100

1 = low value, 100 = high value

Qualified professional

Someone who is sharing their lived experience regarding mental health

Social media influencer with a significant following

Ally, colleague or someone I personally know

Person of a similar demographic (e.g. age, gender, ethnicity) to me.

14. What characteristics of the mental health influencer impact the trustworthiness of the content?

Adjust the slider for each item rating it between 0-100

1 = low trustworthiness, 100 = high trustworthiness

Qualified professional

Someone who is sharing their lived experience regarding mental health

Social media influencer with a significant following

Ally, colleague or someone I personally know

Person of a similar demographic (e.g. age, gender, ethnicity) to me.

This is the end of the questionnaire. Please confirm you consent to the submission of your data.

NOTE: Once submitted, you will no longer be able to withdraw your data, as it will not be stored with any identifiable information.

Yes – I consent to submitting my data for analysis

No – Please withdraw my data

[both responses will continue to the next screen, any data with this question indicating no will be removed from the dataset]

All done! Thank you for your time. If you would like to receive a copy of the research outcomes and/or be entered into the draw for the $100 Prezzy card, please indicate below so we can get these details separate from your answers above.

Thank you for taking part in this survey.

Are you concerned about your own or someone else's mental health?

You can seek support using these services for mental distress.

24 hour/day, 7 day/week services are available.

• Need to talk? - Free call or text 1737 any time for support from a trained mental health and addiction professional (for issues such as depression, gambling and alcohol and/or drugs).

• Lifeline - 0800 54 33 54 to speak to a counsellor, available 24/7 (or free text HELP to 4357). www.lifeline.org.nz

• Depression Helpline - 0800 111 757 or text 4202. https://depression.org.nz

• Samaritans - 0800 726 666, for confidential, non-religious and non-judgemental support to anyone who may be feeling depressed, lonely, or even be contemplating suicide. www.samaritans.org.nz

• Suicide Crisis Helpline - 0508 828 865 (0508 TAUTOKO). This is a service for people who may be thinking about suicide, or those who are concerned about family or friends. •

Alcohol Drug Helpline - 0800 787 797. You can also text 8691 for free.

https://alcoholdrughelp.org.nz

• Kidsline - 0800 54 37 54 is for children aged 5 to 18 years. Those who ring between 4-9pm on weekdays will speak to a Kidsline buddy - specially trained teenage telephone counsellors.

• 0800 WHATSUP children's helpline - 0800 9428 787, available between 1-10pm on weekdays and from 3-10pm on weekends. Online chat is available from 7-10pm every day at www.whatsup.co.nz.

Appendix D

Content Format Post Hoc Comparisons

Table D1

Holm-Adjusted Durbin-Conover Post Hoc Pairwise Comparisons for Ranked Likelihood of Engagement by Content Format (N = 738)

Comparison (A vs B)	Durbin–Conover statistic	Raw *p*	Holm-adjusted *p*
Short-Form Video vs Live Video	30.96	< .001	< .001
Live Video vs Images/GIFs/Memes	23.91	< .001	< .001
Short-Form Video vs Long-Form Video	22.70	< .001	< .001
Short-Form Video vs Audio/Podcast	20.59	< .001	< .001
Live Video vs Text-Based Posts	19.23	< .001	< .001
Short-Form Video vs Infographics	17.64	< .001	< .001
Long-Form Video vs Images/GIFs/Memes	15.65	< .001	< .001
Audio/Podcast vs Images/GIFs/Memes	13.54	< .001	< .001
Live Video vs Infographics	13.32	< .001	< .001
Short-Form Video vs Text-Based Posts	11.73	< .001	< .001
Long-Form Video vs Text-Based Posts	10.96	< .001	< .001
Images/GIFs/Memes vs Infographics	10.60	< .001	< .001
Live Video vs Audio/Podcast	10.38	< .001	< .001
Audio/Podcast vs Text-Based Posts	8.86	< .001	< .001
Long-Form Video vs Live Video	8.27	< .001	< .001
Short-Form Video vs Images/GIFs/Memes	7.05	< .001	< .001
Infographics vs Text-Based Posts	5.91	< .001	< .001
Long-Form Video vs Infographics	5.05	< .001	< .001
Images/GIFs/Memes vs Text-Based Posts	4.68	< .001	< .001
Audio/Podcast vs Infographics	2.94	< .001	< .001
Long-Form Video vs Audio/Podcast	2.11	< .001	< .001

Note. Holm-adjusted p-values control familywise error within the content-format ranking family (21 comparisons). Lower ranks indicate greater likelihood of engagement (1 = most likely; 7 = least likely)

Appendix E

Social Media Platform Post Hoc Comparisons

Table E1

Holm-Adjusted Durbin-Conover Post Hoc Pairwise Comparisons for Ranked Likelihood of Engagement by Social Media Platform (N = 798)

Comparison (A vs B)	Durbin–Conover statistic	Raw *p*	Holm-adjusted *p*
Facebook vs YouTube	11.14	< .001	< .001
Facebook vs TikTok	19.23	< .001	< .001
Facebook vs X (formerly Twitter)	39.33	< .001	< .001
Facebook vs Pinterest	37.91	< .001	< .001
Facebook vs Reddit	39.21	< .001	< .001
Facebook vs Other	60.24	< .001	< .001
Instagram vs YouTube	8.92	< .001	< .001
Instagram vs TikTok	17.01	< .001	< .001
Instagram vs X (formerly Twitter)	37.11	< .001	< .001
Instagram vs Pinterest	35.69	< .001	< .001
Instagram vs Reddit	36.99	< .001	< .001
Instagram vs Other	58.01	< .001	< .001
YouTube vs X (formerly Twitter)	28.19	< .001	< .001
YouTube vs Pinterest	26.77	< .001	< .001
YouTube vs Reddit	28.07	< .001	< .001
YouTube vs Other	49.10	< .001	< .001
TikTok vs X (formerly Twitter)	20.10	< .001	< .001
TikTok vs Pinterest	18.68	< .001	< .001
TikTok vs Reddit	19.98	< .001	< .001
TikTok vs Other	41.00	< .001	< .001
X (formerly Twitter) vs Other	20.91	< .001	< .001
Pinterest vs Other	22.32	< .001	< .001
Reddit vs Other	21.03	< .001	< .001
YouTube vs TikTok	8.09	< .001	< .001
Facebook vs Instagram	2.23	.026	.104
X (formerly Twitter) vs Pinterest	1.42	.156	.468
Pinterest vs Reddit	1.30	.194	.468
X (formerly Twitter) vs Reddit	0.12	.905	.905

Note. Holm-adjusted p values control familywise error within the social media platform ranking family (28 comparisons). Lower ranks indicate greater likelihood of engagement (1 = most likely; 8 = least likely).