

**Barriers to psychological help-seeking in  
young men who have attempted suicide: An  
Interpretative Phenomenological Analysis**

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## **Overview**

This thesis is presented in three parts. Part one is a review of the literature relating to the role of help-seeking in understanding and managing suicide. The focus of the review is not restricted to young men but looks at the literature more broadly. The research and clinical implications emerging from the literature are discussed, emphasizing the need for qualitative studies of higher risk groups. Part two presents the empirical paper, a study of help-seeking barriers in young men who have attempted suicide using Interpretative Phenomenological Analysis (IPA). The data analysis yielded nine themes that are organized into three domains, 'escaping unbearable feelings', 'barriers to help-seeking' and 'making changes and looking ahead'. In part three, the critical review, issues related to the process of conducting the research are discussed along with a more detailed look at the limitations of the study.

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## **Part 1**

# **Understanding and managing suicide: What is the role of help-seeking?**

## **Literature review**



## **Abstract**

The current paper reviews literature on help-seeking in relation to suicide and attempted suicide. An overview of the extensive research into risk factors associated with suicide is given highlighting the link between mental health problems and suicide. A minority of people with mental health problems seek professional help and even fewer people will go on to receive help from specialist mental health services. The same pattern is seen in those at risk of suicide. The majority will not be receiving specialist support at the time of their death although about half will have had recent contact with their GP. Reasons for not seeking help in times of emotional distress are discussed. Finally, clinical implications arising from the literature are addressed and suggestions are made for future research.

## **Introduction**

Despite raised awareness and government targets to tackle rates, suicide accounts for approximately 5000 deaths a year in the UK (Tylee & Walters, 2004) and it is the most common cause of death in young men (Brook & Griffiths, 2003). There has been considerable research to identify risk factors for suicide (Mann, 2002; Beautrais, 2003a). Having a mental health problem has been established as a principal risk factor (e.g. Cavanagh, Carson, Sharp & Lewis, 2003), however, only a minority of people with mental health problems will commit suicide (Mann, Waternaux, Haas & Malone, 1999). In fact, suicide does not have a clearly identifiable causal pathway; instead, there are a range of risk factors that increase vulnerability to suicide (Gunnell and Lewis, 2005). Help-seeking behaviour has been identified as one of the potential factors that may discriminate between those who are at risk but do not kill themselves from those who do (Biddle, Gunnell, Sharp & Donovan, 2004).

The concept of help-seeking is complex and poorly understood (Kuhl, Jarkon-Horlick & Morrissey, 1997) and various studies have highlighted the importance of understanding and promoting help-seeking behaviour in the management of suicide (e.g. Biddle et al., 2004). Help-seeking refers to people's attempts to get help from either professional or non-professional sources in relation to a perceived problem. There is reliable evidence that the majority of people with mental health problems do not seek professional help (e.g. Bebbington et al., 2000a; Kessler et al., 1999) and the same is true for people who are at risk of suicide (e.g.

Biddle et al, 2004). In addition, many people are aware of potential sources of support but are unwilling or unable to access help in times of need (Meltzer et al., 2000; Wells et al., 1994).

There are various forms of help available to people who are in distress. In the first instance, social support from friends and families can protect against the development of mental health problems and suicidal behaviour (Beautrais, 2003). Formal sources of help for people at risk of suicide include psychological therapy, medication and full and part-hospitalisation. Arguments are made both for the treatment of mental health problems as an indirect intervention for suicide risk (e.g. Gunnell & Lewis, 2005) and for focussing primarily on suicidal behaviour (Van Heeringen & Hawton, 2000). Although it is generally agreed that encouraging people to get professional help is a good thing, there is not a strong evidence base for treatment of suicidal behaviour (Heard, 2000).

#### *A note on language*

There is a range of language used in the literature in relation to suicide and attempted suicide. It can be difficult to differentiate between phenomena such as *deliberate self-harm*, *attempted suicide* and *suicidal behaviour*. *Attempted suicide* is generally considered as an act carried out by an individual with the intention of ending their own life. *Deliberate self-harm* typically relates to a deliberate act towards oneself that, although causing harm, was not intended to cause death. There are difficulties in making distinctions, for example, self-harm may cause accidental death, whereas, on occasions, an attempted suicide may seem

to be relatively harmless even though the individual believed it would cause death (Brown, Henriques, Sosdjan & Beck, 2004).

*Suicidal behaviour* is a more general term that includes both self harm and medically serious suicide attempts. *Suicidal ideation* and *suicidal thoughts* refer to thoughts a person may have about killing themselves. In the current paper I have endeavoured to distinguish between self-harm, attempted suicide and suicidal ideation. However, many studies are unclear or group different phenomena together. In such instances I have used the language of the original source or made more general references to suicidal behaviour.

## **Overview**

The current paper is a literature review aiming to explore the role of help-seeking in understanding and managing suicide and attempted suicide. Initially, a brief summary of factors that are associated with increased risk of suicide is given. There has been extensive research addressing suicide risk and this summary provides an introduction to the literature rather than an exhaustive review; however, it does provide the context within which the issues of help-seeking can be discussed. Help-seeking literature is then discussed in some depth. An introduction to the concept of help-seeking is given followed by a review of help-seeking in relation to mental health problems and help-seeking in relation to people who have attempted or completed suicide. Barriers to help-seeking are also discussed within the context of suicide risk specifically and mental health problems more generally. Finally, clinical implications and

recommendations for future research that arise in the literature are addressed. Relevant literature was identified using web-based searches on Psychlit and Google Scholar and by following chains of citations and references in associated literature.

### **Who is at risk of suicide?**

This section summarises the extensive literature relating to factors associated with increased suicide risk. It begins with examining demographic factors, followed by substance misuse, psychiatric history and finally intrapersonal factors – personality traits and cognitive styles. Suicide risk factors have been extensively researched and the majority of the following section is based on findings from literature reviews and robust clinical and epidemiological studies involving large samples.

#### *Gender differences in suicide*

The World Health Organisation (1999) identifies men aged 24-35 as the demographic group in which suicide most commonly occurs and, as mentioned earlier, it is the most common cause of death in young men in England and Wales (DOH, 2003). Across the life span, there are over three times more deaths in men as a result of suicide than there are in women (DOH, 1999a). These differences can be accounted for, in part, by suicide method; men are more likely to use a method that will result in fatality and there are suggestions that the suicide rate in women would be higher if they used more effective methods (Beautrais, 2003a).

One explanation is that risk taking, purportedly an aspect of masculinity, may contribute to the higher completed suicide rates in men (Connell, 2000). In addition, reluctance to seek help may make them more at risk of suicide (Hearn et al., 2002) with men being less likely to disclose suicidal thoughts or ask for help concerning emotional problems (Biddle et al., 2004). They are also less likely to discuss emotional problems more generally (Van Heeringen, Hawton & Williams, 2000). If men do seek help it is usually not until the problem has become more serious, by which time they have more negative perceptions of their mental health and potential outcomes (Albizu-Garcia, Alegria, Freeman & Vera, 2001).

#### *Poverty and unemployment*

Several studies have identified areas of higher deprivation as associated with higher levels of suicide (e.g. Bunting & Kelly, 1998; Hearn et al., 2002). Although absolute poverty has decreased nationally over previous decades, relative poverty has increased, with greater disparity between the economically successful and unsuccessful. This may be particularly relevant for men who are more susceptible to peer comparisons relating to perceived economic failure (Smalley et al., 2005). Platt and Hawton (2000) conducted a systematic review which established a link between suicide and unemployment. However, there is also evidence that when psychiatric history, amongst other variables, is controlled for there is no independent effect of unemployment on suicide risk (Mortensen et al., 2000). This suggests a reciprocal interaction between psychiatric illness and unemployment: having a mental health problem can make it difficult

to get and keep a job and being out of work can have negative effects on one's mental health (Gunnell & Lewis, 2005).

### *Substance misuse*

Substance misuse, alcohol in particular, is associated with elevated suicide risk (e.g. Beautrais, 2003a; Gunnell, 2000). Of those engaging in suicidal behaviour, men are more likely than women to have co-morbid substance misuse (Smalley et al., 2005). Smalley et al. (2005) suggest that increased rates of suicide in men may be influenced by men using alcohol as a means of anaesthetisation from emotional pain. Using alcohol in this way may exacerbate problems in other domains, such as personal relationships and employment, which also impact on vulnerability to suicide (Murphy, 2000). In addition to the elevated risk associated with substance misuse, it can mask signs of depression and make it harder for practitioners to accurately assess risk (DOH, 2001).

### *Psychiatric history*

The majority of people, 67-90%, who kill themselves have a diagnosable psychiatric disorder at the time of death (Mann, 2002; Owens, Lloyd & Campbell, 2004). In many instances these diagnoses are made following death using the psychological autopsy method (e.g. Houston, Hawton & Shepperd, 2000) as only a minority will have had contact with specialist mental health services or with generic health services with regard to their mental health problem (Bebbington et al., 2000a; Biddle et al., 2004).

Diagnoses most associated with elevated suicide risk are major

depression (Beautrais, 2003b), borderline and antisocial personality disorders (Foster, Gillespie, McClelland & Patterson, 1999; Schneider et al., 2006) and substance misuse (Gunnell, 2000). However, even within these sub-categories only a relative minority will kill themselves.

Therefore, although mental health problems and psychiatric diagnoses are major risk factors they cannot be used in isolation to determine who will attempt suicide.

### *Personality variables*

Impulsivity and aggression have been identified as key variables in the personality disorder cluster that predict suicidal behaviour. Impulsivity is observed across psychiatric presentations and is consistently associated with increased suicidal behaviour (De Leo, Cerin, Spathonis & Burgis et al., 2005; Mann et al., 1999). Soloff et al. (2003) have demonstrated that impulsive aggression increases suicide risk independent of diagnosis of personality disorder. They report that impulsivity represents a vulnerability which can be triggered by stressors such as negative life events. Impulsivity is also closely associated with violence and aggression in relation to suicidal behaviour (Brodsky et al., 2001). De Leo et al. (2005) argue that more attention needs to be paid to the role of impulsivity, finding that two out of three suicide attempts in their study were impulsive acts. This has implications for help-seeking as impulsivity may affect the likelihood of an individual accessing help during a crisis even if their attitude towards getting help is positive at other times.



### *Hopelessness*

Abramson, Metalsky and Alloy (1989) drew upon Seligman's (1975) study of learned helplessness to identify certain cognitive styles that comprise hopelessness. These include attributions about the self, the future and the world that are essentially pessimistic, with expectations that bad things will happen, hoped for things will not occur and that nothing will change these circumstances. Although hopelessness is closely associated with depression it has been shown to predict suicidal intent independent of depression (Beck, Brown & Steer, 1989; Schotte & Clum, 1987).

Hopelessness may be associated with the development of beliefs that inhibit help-seeking such as not believing help will make a difference. Such beliefs are cited in qualitative (e.g. Wilson & Deane, 2001) and quantitative research (e.g. Kuhl et al., 1997) and implicate hopelessness as a barrier to help-seeking.

### *Clinical models of risk and conclusions*

As discussed, there is a range of factors associated with suicide risk (see table 1 below for summary). Attempts have been made to develop clinical models to understand the relationship between various risk factors. Mann et al. (1999) proposed a model whereby psychiatric illness is understood as a stressor, with risk of suicide being mediated by impulsivity and level of suicidal ideation. Williams (2001) 'Cry of Pain' model of suicide was based on observations that an individual is at greater risk of suicide when he or she is in intense emotional pain, feels trapped with no perceived opportunities for rescue or escape.

Both these models have implications for help-seeking. Impulsivity will affect the likelihood of accessing help in a crisis, particularly if there are no immediate and easily accessible sources of support, and the ability for an individual to see that there may be a way out of their current circumstances requires them to know sources of help and believe that those sources can ease their distress. There are a variety of potential sources of support to people in distress, both professional and non-professional, the remaining sections of this review explore what is known about help-seeking and what role this may have in the understanding and management of suicide and attempted suicide.

**Table 1: Suicide Risk Factors**

<b>Risk Factors</b>	<b>Study</b>
<b>Demographics:</b>	
Gender – being male	Beautrais (2003b); Hawton (2000)
Age – 16 – 34	Cheng, Chen, Chen and Jenkins (2000); W.H.O (1999)
Poverty	Bunting and Kelly (1998); Hearn et al. (2002); Platt and Hawton (2000)
Lack of educational qualifications	Beautrais (2003b)
Current unemployment	Foster et al. (1999)
Living alone	Crawford and Prince (1999); Smalley et al. (2005)
<b>Mental health:</b>	
Diagnosable psychiatric disorder	Beautrais (2003b); Gunnell and Frankel (1994); Mann (2002); Owens, Lloyd and Campbell (2004)
History of deliberate self harm	Foster et al. (1999); Gunnell and Frankel (1994)
Mood disorder	Beautrais (2003b); Cheng et al. (2000)
Drug and Alcohol misuse	Beautrais (2003a); Gunnell and Frankel (1994); Gunnell (2000)
<b>Personality variables:</b>	
Personality disorder	Cheng et al. (2000); Foster et al. (1999); Schneider et al. (2006)
Impulsivity	De Leo et al. (2005); Mann et al. (1999)
Hopelessness	Schotte and Clum (1987)
Violence and Aggression	Brodsky et al. (2001)
<b>Life events:</b>	
Suicidal behaviour in relative	Cheng et al. (2000); Gunnell and Frankel (1994)
Stressful life event/loss	Beautrais (2003b); Cheng et al. (2000)
<b>Other Risk Factors:</b>	
Contact with GP within 26 weeks	Foster et al. (1999)
Serious physical illness	Gunnell and Frankel (1994)
Prisoners	Gunnell and Frankel (1994)
Increased access to lethal means of suicide, e.g. fire arms	Gunnell and Lewis (2005)

## **Introduction to help-seeking**

People use a range of pathways to seek help when in need. From their review of the literature, Kuhl et al. (1997) suggest that help-seeking behaviour is poorly understood, complex and differs across populations. Psychological help-seeking has sometimes been categorised into formal and informal help-seeking. Formal helpers include psychologists, psychiatrists and counsellors; whereas informal help-seeking refers to support from untrained helpers, for example, family, friends and neighbours (Pistrang & Barker, 2002). In reality, these categories are not discrete and lie on a continuum that incorporates trained and untrained helpers and will include people with some form of training or experience in psychological helping, e.g. GPs, spiritual leaders, helpline workers and mentors (Pistrang & Barker, 2002).

A wealth of literature and research has been accrued to demonstrate the benefits of seeking formal help (Lambert & Bergin, 1994), to the extent that studies now concern themselves with what is most helpful (e.g. Roth & Fonagy, 2004). However, a minority of people with mental health problems seek formal help (e.g. Bebbington et al., 2000a; Biddle et al., 2004; Goldberg & Huxley, 1992) with the majority seeking help informally or not at all. The benefits of informal helping are unclear; however, there is evidence that good social support is a protective factor in both mental and physical health (Cohen, 2004). There is evidence that seeking informal help aids decision making about the presence or absence of mental illness and may facilitate formal help-seeking (Cornford & Cornford, 1999).

Eagles et al. (2003) interviewed individuals receiving help for long term psychiatric problems. They asked patients about their experiences when they were 'at their lowest'. Patients reported finding contact with mental health services helpful, and those who discussed their feelings with friends and relatives found that just as helpful as talking to mental health professionals. In addition, religious beliefs and affiliations were reported as being helpful. They also found that media coverage and the stigma associated with mental illness were both negative influences.

### **Help-seeking for mental health problems**

As discussed, having a mental health problem is associated with increased risk of suicide. Receiving help for mental health problems can protect against the development of suicide risk (Gunnell & Lewis, 2005). Literature regarding help-seeking for mental health problems, therefore, is an important component in the study of help-seeking in relation to suicide and attempted suicide.

Bebbington et al. (2000b) in the UK and Kessler et al. (1994) in the USA both assessed the prevalence of psychiatric disorders in the general population using structured clinical interviews. Kessler et al. (1994) found that less than 40% of respondents that reported a lifetime disorder received treatment from professional services and less than 20% of those who had a disorder in the previous twelve months received treatment. Bebbington et al. (2000a) had similar findings from their household

survey, which used a large sample to provide robust data regarding the prevalence of mental health problems in the UK general population.

Using a national probability sample of over 10 000 households, it was found that even participants who scored in the high symptom range on the revised Clinical Interview Schedule (CIS-R) were unlikely to make contact with their GP. Of the high symptom group, less than 40% of men had made contact with their GPs whereas women were more likely to contact their GP. As a result, Bebbington et al. (2000a) suggest that many people who have a treatable mental health problem live in unnecessary suffering and disability.

It is questionable whether symptoms as measured by lay interviewers using the CIS-R can reliably indicate a diagnosable mental health problem in need of treatment. The measure does have good evidence for inter-rater reliability as it does not depend on clinician judgement (Pothen, Kuruvilla, Philip, Joseph & Jacob, 2003) and has been shown to be a cost-effective method of providing prevalence data in a variety of settings (Botega, Pereira, Bio, Garcia & Zomignani, 1995); however, determining mental health and need for treatment is difficult even within specialist services and even more so within primary care settings. It can be difficult to make diagnostic decisions regarding the presence or absence of mental health problems and degree of suicide risk; this has been highlighted in the case of assessments made by non-specialist practitioners such as GPs (Owens et al., 2004).

### *Pathways to mental health care*

Goldberg and Huxley (1992) identified three filters in the pathway to psychiatric care. The first of these is access to primary care, the second is whether a mental disorder is identified in the primary care setting. The third is the referral to specialist services should it be required. An extensive national psychiatric morbidity survey provides evidence that the central position of primary care in the UK does allow relatively easy access for initial (1<sup>st</sup> filter) contact for people with mental health problems whilst onward access to specialist services (3<sup>rd</sup> filter) remains low (Bebbington et al., 2000a; Goldberg & Huxley, 1992). Although there is evidence of under-recognition of mental health problems by General Practitioners (Scott, Jennings, Standart, Ward & Goldberg, 1999) findings from a retrospective review of GPs' contacts with patients who committed suicide suggested that GPs were able to recognise the presence of a mental health problem in most of the patients they saw. However, they were unlikely to refer these patients on to specialist mental health services and, as a result, Owens et al. (2004) suggest that there may be more that can be done to support GPs in assessing risk in order to ensure that those in need are referred for specialist services. This is covered in greater depth in the context of help-seeking for people at risk of suicide below.

### *Community Surveys*

Biddle et al. (2004) used postal questionnaires to detect mental distress and help-seeking behaviour in 16-24 year olds in the general population

within the Avon Health Authority, South West England. The study involved using self-report items from the General Health Questionnaire (GHQ) as their measure to identify the possibility of minor mental disorder in respondents with additional questions to identify presence of suicidal thoughts. They found that, consistent with the above studies, men were less likely to seek help than women and that severity (i.e. higher GHQ scores) was associated with higher levels of help-seeking. This study only found a weak effect of sex difference, although male respondents appeared to have a higher threshold of distress before they were likely to seek help.

Overall, of the respondents identified as having possible mental disorder, only 21.8% of males and 34.8% of females reported seeking any help either formal or informal. They also observed that contrary to previous studies (e.g. Bebbington et al., 2000b) there was no effect for marital and employment status. They suggest that these factors may not be so pertinent in the younger age group. The pitfalls of conducting postal surveys are discussed in greater depth below and Biddle and colleagues (2004) emphasise the limit to which a postal survey can attempt to untangle the complex influences involved in help-seeking. This is particularly with regard to the 48% response rate, which, although being consistent with most other postal surveys, has serious implications for how representative of the population the results can be when the study itself is concerned with respondents' attitudes towards making contact with others regarding their well-being. It is probable that non-responders may be more likely to be non-help seekers.



Biddle and colleagues attempt to control for this by comparing the responses of respondents who only returned their questionnaire following a reminder with those who responded without a prompt. They found similar help-seeking and GHQ scores in the late responding group. However, it is not possible to determine whether this group represents non-responders any better than the whole sample. An additional problem is the use of the 12 point GHQ self-report measure as an indicator of mental disorder. Although self-report measures such as the GHQ have been used extensively in clinical practice, they do not represent a clinical diagnosis and only provide a rough indication of mental distress, particularly when using a cut-off of four out of twelve. Problems in using screening measures to determine prevalence have been acknowledged elsewhere (e.g. Hand, 1987). For example, cut-offs can be arbitrarily designated at times and in the case of the GHQ and may be set at a specific low score because the clinical implications of missing a positive case are of greater concern than misclassifying a 'non-case'. However, within a research setting maintaining these clinical rigours are likely to over-estimate prevalence of mental health problems although representing potentially vulnerable individuals (Hand, 1987).

Gathering information from individuals in the community who experience mental health problems is problematic (De Leo et al., 2005) but several other studies have targeted both help-seeking and non-help-seeking populations (e.g. De Leo et al., 2005; Oliver, Pearson, Coe & Gunnell, 2005). Community research using postal and telephone questionnaires

are limited in terms of the ability to provide information about personal beliefs and motivations underlying help-seeking intentions and behaviour (Oliver et al., 2005). There is also the risk of obtaining biased results due to the under-representation of non-help-seeking young men at risk of suicide (Cottler, Zipp, Robins & Spitznagel, 1987; De Leo et al. 2005; Kessler et al. 1999; Oliver et al. 2005). However, such studies also have the potential to provide a cross-sectional view that includes those who do not have contact with services, unlike studies with clinical populations.

Using a postal survey, Oliver et al. (2005) found that men were more likely to seek informal rather than formal help and that people from more affluent areas were less likely to seek help for common mental health problems than those from areas of lower socio-economic level. This is in contrast to previous assertions that help-seeking for mental health problems is less likely in individuals with lower educational levels where education is invariably associated with higher socio-economic status (Leaf et al., 1996). The role of informal help-seeking could prove to be an important but under-researched area in the field of suicide, self harm and mental health more broadly (Howard et al. 1996; Nada-Raja, Morrison & Skegg, 2003). In addition, those who seek help informally are more likely to seek help formally. This link has not been well explored and it is unclear whether individuals who seek help informally are encouraged by their confidantes to seek formal help or whether those who seek help informally have a more positive attitude towards help-seeking in general (Nada-Raja et al., 2003).

## **Barriers to help-seeking for mental health problems**

Asking for help can be difficult and painful and requires emotional effort to overcome social and psychological barriers that prevent many people from doing so (Cohen, 1999). Reasons given for not seeking help by young people who self harm are largely attitudinal rather than practical, for example, feeling they should be strong enough to manage on their own and believing that the problem will resolve itself (Nada-Raja et al., 2003). These responses relate to previous findings of attitudes to seeking help as reflecting weakness (Murphy, 1998) or as a sign of incompetence (Tannen, 1990). Another study indicates that adolescents who did not seek help for their mood disorders felt that their problems were not important and that they should be able to deal with them themselves (Culp & Clyman, 1995). This is particularly relevant for men who are more likely to experience the need for help as an assault on their sense of masculinity and self-concept. The tasks of help-seeking, which include, identifying emotional problems and relying on others, are at odds with messages men receive about the need to be self-reliant and in control of their emotions (Addis & Mahalik, 2003).

Wilson and Deane (2001) suggest that attitudes towards help-seeking are defined within social networks. These are formed through observing others, word of mouth and through help being sought on your behalf by someone else. It is within these social networks where peer support may occur and also the likelihood of help-seeking from professional sources is determined. Using focus groups with adolescents, Coggan, Patterson and Fill (1997) found that young people stressed the importance of family

support when experiencing distress but highlighted fear of criticism as a potential barrier to accessing family support. Coggan and colleagues concluded that these adolescents stressed the need for unconditional love and non-judgemental support. There is a limit to how generalisable these findings are due to the small sample size; however, qualitative research of this nature allows the researcher to identify significant personal meanings amongst participants in relation to help-seeking in ways that quantitative methods are often unable (Oliver et al., 2005).

There is reliable evidence that perceived stigmatisation of mental illness is associated with reluctance to seek help and, accordingly, the under-recognition of mental health problems (Jorm et al., 2000); for example people are embarrassed to talk to their GP about depression (Sims, 1993). In the USA, help-seeking for mental health problems varied between rural and urban settings (Rost, Smith & Taylor, 1993). These findings were attributed to the anonymity associated with urban life; whereas in more rural settings, where communities are smaller and more familiar, stigmatisation is more likely to affect help-seeking.

Stigmatisation has been shown to hinder help-seeking behaviour in older as well as younger populations (Segal, Coolidge, Mincic & O'Reilly, 2005). Findings that older adults may hold negative beliefs about people with mental health problems, for example that they lack interpersonal skills, has been identified as a barrier to help-seeking (Segal et al., 2004). However, barriers for older populations tend to be more practical rather than attitudinal, for example, not understanding how to access health

care and locate points of entry (Robb, Haley, Becker, Polivka & Chwa, 2003).

### *Help-seeking for mental health problems: Summary*

The majority of people with mental health problems do not seek professional help for their difficulties. There are difficulties in assessing the extent of the problems experienced by people who are not in contact with services although attempts have been made to do so using large scale psychiatric morbidity studies. Further evidence has been accrued from community and postal surveys; however, these may be affected by participation in these studies not reflecting the target population. Using Goldberg and Huxley's (1992) three filters, it is argued that there is relatively easy access to health care with GPs playing a central role in access to services. However, many people with mental health problems will not access help at primary care level and far fewer will be referred on for specialist support.

Attempts have been made to identify help-seeking behaviours in those who are not in contact with services; however, patterns of informal help-seeking remain poorly understood. Young men are the least likely group to seek help from both informal and formal sources and they have a higher threshold of severity before they are likely to seek help. Young people's attitudes to help-seeking are constructed within social networks and barriers include associating seeking help as a sign of weakness and believing that problems should be resolved on one's own. Perceived

stigmatisation of mental health problems is a barrier to help-seeking across age-groups.

### **Help-seeking and suicide**

As discussed above, mental health and suicide risk are related and interact with one another. The following section reviews literature that specifically relates to suicide and attempted suicide. Seeking appropriate help can provide protection at any point in the development of a mental health problem, potentially keeping it from developing into suicide risk (Wilson & Deane, 2001). There is consistent evidence from psychological autopsy studies that the majority (up to 90%) of people who commit suicide have a diagnosable mental disorder at the time of death (Beautrais, Joyce & Mulder, 1998; Oliver et al., 2005). Although there is some controversy regarding whether attention should be focussed on suicidal behaviour or underlying pathology (Gunnell & Lewis, 2005) it is widely agreed that seeking help for less distressing problems has the dual benefit of tackling current problems as well as protecting against the development of more severe problems such as self harm (Rubenstein, Halton, Kasten, Rubin & Stechler, 1998).

#### *Evidence from psychological autopsy studies*

A review of evidence from the UK based on psychological autopsy studies indicate that between 70-75% of individuals who commit suicide in the UK are not in contact with mental health services at the time of death (Booth & Owens, 2000) and only a limited number of people are in

contact with mental health services in the year preceding suicide (Gunnell & Frankel, 1994). The psychological autopsy method is currently the most robust tool for gathering data in relation to suicide (Cavanagh et al., 2003). Data is collected through interviews with relatives of the deceased, coroners' reports and medical and psychiatric records. The following evidence was accrued from reviewing psychological autopsy studies and another study using comparable rigorous methodology (Suominen, Isometsa, Martunnen, Ostama & Lonnqvist, 2004).

Those who have a history of contact with psychiatric services are more likely to consult their General Practitioners in the month prior to attempting suicide (Booth & Owens 2000; Suominen et al., 2004) but, at best, contact is only made by half of those who go on to attempt suicide, meaning that health practitioners only have the opportunity to intervene in less than half of cases (Suominen et al., 2004). In another psychological autopsy study GP contact was reviewed in people who killed themselves but were not in contact with mental health services. Many people did not pass the first of Goldberg and Huxley's (1992) filters, with 44% of the sample not having consulted with their GP in the month prior to suicide. However, in cases where individuals did consult, GPs tended to recognise the presence of mental health problems (2<sup>nd</sup> filter) but considered them manageable in primary care (Owens et al., 2004). This raises questions about risk assessment at primary care level. In this study the presence of mental health problems were widely recognised in people who later killed themselves and treatments at primary care level were offered, however, the eventual outcome indicates that the individual

may have required specialist support. Concerns regarding suicide risk assessment at primary care have been expressed elsewhere (e.g. Milton, Ferguson & Mills, 1999). These concerns are well-founded particularly as men, who are more likely to kill themselves than women, are less likely to show easily identifiable "classic" symptoms of depression, particularly if they are using drugs and alcohol to manage their distress (Angst, Strassen, Clayton & Angst, 2002).

#### *Contact with services before and after attempted suicide*

In a review of health care contacts, Suominen et al. (2004) reports that a large proportion of 15 to 24 year old suicide attempters do not receive psychiatric provision before or after attempting suicide despite having a diagnosable mental disorder at the time. This is of particular concern as half of all completed suicides will follow a previous attempt (Smalley et al., 2005). There is evidence that up to 25% of people not in contact with mental health services who completed suicide had attended Accident and Emergency in the previous year (Foster et al., 1999). One study showed that approximately half of those attending Accident and Emergency services were discharged without receiving a psychological assessment (Kapir et al. cited in Higgit, 2000).

### **Barriers to help-seeking in suicide**

Having discussed some of the barriers to help-seeking for mental health problems more generally, the following section reviews literature



addressing barriers to help-seeking that have been identified in those at increased risk of suicide.

There is evidence of an inverse relationship in which adolescents who experience greater suicidal ideation are less likely to seek formal help, particularly from mental health professionals (e.g. Carlton & Deane, 2000; Saunders, Resnick, Hoberman & Blum, 1994). Saunders et al. (1994) found that suicidal ideation is actually a significant barrier to help-seeking in adolescents. This is consistent with evidence that the most in need of help are often the least likely to access it (e.g. Bebbington et al., 2000b; Meltzer et al., 2000) but that times of greater stress can cause an increase in help-seeking behaviour in young people with overall better adjustment (e.g. Offer, Howard, Schonert & Ostrov, 1991).

Jacobson, Richardson, Parry-Langdon and Donovan (2001) found that young people are less likely to feel comfortable with making and attending doctor's appointments and find it more difficult to articulate their feelings when they do. This is of concern because family doctors represent a primary pathway to receiving appropriate support for emotional problems before they become unmanageable and may precipitate a crisis. Both qualitative (e.g. Wilson & Deane, 2001) and quantitative research (e.g. Kuhl et al., 1997) support the notion that avoiding aversive emotions and believing that seeking help will not make a difference are primary help-seeking barriers for young men and adolescent boys. This may be affected by emotional competence; Ciarrochi, Deane, Wilson and Rickwood (2002) suggest that a young

person's level of emotional competence influences their help-seeking. Individuals who find it difficult to identify, understand and manage their emotional states are less willing to recognise or communicate their needs. They may also be inhibited by embarrassment associated with feeling unable to express themselves.

For those young people who do manage to make contact and overcome the initial difficulties associated with approaching health services there are continued difficulties; for example, finding medical consultations too short and diagnostic. Coggan et al. (1997) used qualitative methodology to understand the experiences of young people in relation to suicide risk and help-seeking. They found that participants were often unaware of available services and that participants who had been referred on to psychiatric and psychological services felt they waited too long for an appointment and received an impersonal service. Dissatisfaction with services may be reflected in the high rates of missed appointments and uncompleted treatment in mental health services (Rudd & Joiner, 1998). The participants in Coggan et al.'s (1997) study were not recruited in relation to being at higher risk of suicide, e.g. having attempted suicide, and therefore do not necessarily represent the views of young people at increased risk of suicide.

As an adjunct to the psychological autopsy conducted by Owens et al. (2005) described above, qualitative methodology was used to explore, in greater depth, cases where the individual had not been in contact with mental health services (Owens, Lambert, Donovan & Lloyd, 2005). 66

relatives were interviewed about their experiences in order to further understand what prevented the individual from receiving support. Half of the sample had attended a GP appointment in the month prior to their death. For those who did attend it seems that many were encouraged to do so by their family members and it was apparent that there was increased disclosure of psychological disturbance when relatives accompanied the distressed family member. Some relatives blamed GPs for the outcome and others felt patients were responsible. There were reports of frustration with slow referral pathways when psychological distress was disclosed and in many cases individuals did not disclose emotional distress with consultations focussing on physical problems.

In cases where there had been no consultation prior to death, analysis of participants' reports revealed descriptions of the individual as independent, self-reliant, distrusting of services and unwilling to confide in others regarding their distress. There were also descriptions of participants having become habituated to their relative's psychological disturbance in cases where individuals had on-going difficulties.

However, almost all of the participants were aware that their relative was in distress but found it hard to determine the boundary between normal and abnormal mental states and the appropriate concern to hold. Many described trying to offer practical help and some recognised the need for talking help.

Using relatives' accounts as the primary source in this study enabled the researchers to come close to the subjective experience of the person who

killed themselves. However, family members will inevitably be influenced by their own emotional reaction to their relative's death (Hawton, 2001; Owens et al., 2005). Performing a qualitative analysis with such a large sample (66) also has some pitfalls. Although the large sample provides a potentially greater representativeness for the research, there is a danger of failing to present the richness of the participants' subjective experiences and the range of emotional responses, defences and biases that are likely to have been manifest in their stories.

Wilson and Deane's (2001) qualitative study with young people revealed that previous experience of help was predictive of whether or not individuals were more or less likely to seek help. What was noticeable, however, was that it was any help-seeking experience, regardless of the source, that would influence further help-seeking (Wilson & Deane, 2001). This has implications for the whole structure of health care systems, from reception staff to referrers to specialist help-providers; young people may be deterred from getting help long before they ever have contact with a mental health professional.

### *Tackling barriers to help-seeking and promoting health*

There is the need for raising awareness of mental health problems and using educational strategies to promote use of health services (De Leo et al., 2005; Nada-Raja et al., 2003; Oliver et al. 2005). Oliver et al. (2005) also address the issue of informal support, advocating that health services should encourage peer and family support and educate people to provide support for depressed friends or family members. This is

particularly pertinent for adolescents and younger adults who are more likely to seek help from their parents. Patterson et al. (1994) suggest that fathers are less likely to get emotionally involved than mothers when they are consulted about their children's problems. This may give some indication as to why boys favour speaking to their fathers as it is consistent with reports that males may prefer to receive support that is based on practical problem solving rather than on feelings (Hawton et al., 2001). In addition, mothers are likely to underestimate their children's suicidality and are generally more sensitive in response to their daughters' suicidal thoughts and behaviours than their sons' (Klimes-Dougan, 1998).

Culp and Clyme (1995) suggest that more must be done to learn whom adolescents feel more comfortable to seek help from and what it is that makes an adolescent feel more comfortable to seek help. Using focus groups with young people in an educational setting, Wilson and Deane (2001) found that having a strong positive relationship with the potential help-giver is important in increasing the likelihood of young people to seek help when they need it. The young people described positive aspects of getting help as feeling heard, accepted, valued and treated with dignity. The study was conducted with a convenience sample and therefore reflects the opinions of young people who were more willing and able to articulate their opinions. The sample also valued highly trust and confidentiality and wanted help from someone who had been through experiences like theirs (Wilson & Deane, 2001).

The latter point may have some explanatory power in terms of informal versus formal help-seeking. In the case of informal help-seeking, where there are fewer boundaries, it is more likely that someone in need of help will know whether the person they are seeking help from has had similar experiences or not. Unfortunately, the value of such support is poorly understood and there needs to be a change in the ways services approach peer support if this is going to be successfully harnessed (Owens et al., 2005).

Participants in Wilson and Deane's focus groups suggested that they were often unsure what constituted a problem that warranted seeking help. They were conscious of seeking help for what might be seen as a minor problem which would be embarrassing. Wilson and Deane (2001) suggest that help providers should be clear that no problem is too small if they want to make help accessible for young people. They also suggest that "gate-keepers", for example, teachers and parents, need to change their own attitudes towards getting help if they are to have a positive role-modelling influence on young people.

In response to the reluctance demonstrated by young men to talk about their emotional problems, Hawton et al. (2000) questions whether the traditional notion of a talking therapy is the most appropriate approach for this group. The alternative suggestion is using practical problem solving strategies that may be more beneficial in the short term. This would give young men an opportunity to build a trusting relationship before becoming involved on a more personal level. Offer et al. (1991)

suggest more informal services such as 'drop-in' style clinics would make services more accessible. In addition increasing education for parents and carers and promoting referrals from these and other informal pathways could enhance access to professional services (Smalley et al., 2005). Booth and Owens (2000) advocate partnerships between the health service and voluntary and statutory services, that have reasonable links with young people and other vulnerable groups, so that those who are in need of services but are reluctant to seek help will have better opportunities to access it.

#### *Help-seeking and suicide: summary*

A minority of people who kill themselves are in contact with mental health services at the time of death despite psychological autopsy studies indicating that the majority of these people will have had a mental health problem. About half will have had recent contact with their GP and in the majority of these cases the GP will have recognised the presence of a mental health problem. GPs tended to treat these people within primary care, which does raise concerns about risk management and the treatment of mental health problems in these settings. However, a majority of people do not have even this level of contact with services prior to ending their lives. Young men are consistently the least likely group to access any service regarding their mental health problems.

For those who do not seek help various barriers have been identified. Young people in particular are likely to believe that seeking help will not make a difference and that they should attempt to resolve their problems

on their own. Help-seeking is further hampered by low emotional competence and embarrassment associated with disclosing emotional distress. Help-seeking is more likely when there are positive, non-critical familial relations and where an individual has had positive help-seeking experiences from an early age.

Evidence from qualitative studies suggests that some young people may want to receive support from someone who has experienced similar difficulties in the past. Feeling heard, accepted and valued are seen as crucial aspects of good help. From both qualitative and quantitative studies, several authors suggest that access to help should be made easier by facilitating more informal pathways and promoting partnerships between voluntary and health sectors.

### **Research implications**

One of the problems with research into suicide is that most studies are based on psychological autopsy and third party reports (Eagles et al., 2003; Hawton, 2001); this means that it is impossible to discover factors that could have averted suicide. Understanding the circumstances surrounding a suicide attempt is crucial in delivering a meaningful service to at-risk persons. Whilst autopsy studies give us insight into the factors that expose people to greater risk of suicide they do not necessarily help establish what people need to keep them from taking their own lives. In addition, if services are to be effective in identifying and supporting people who attempt suicide it is essential that there is a greater



understanding of their subjective experience when suicide becomes an option and what help, if any, is meaningful to them at that time.

Williams (1985) suggests that research should move away from asking who is at risk of suicide arguing that we already have good evidence about at risk groups. He suggests that small scale studies should be conducted to help understand what processes are involved in the act of attempting suicide relating to "why now?" Williams argues that it is important to understand why those who were aware of possible sources of help did not make use of it at the time when problems arose (e.g. stress event). He also poses questions about why intellectual knowledge of sources of help may not be enough to help a person access help when they need it. This relates to findings that 72% of attempters knew of the existence of the Samaritans at the time of their attempt but did not get help (Greer & Anderson, 1979). He posits that some will inevitably see getting help as an unacceptable option but that there are others who may not have such views but also fail to get help at the point of crisis.

Future research needs to focus on developing a better understanding of individuals' circumstances in terms of their psychiatric, social, personal and help-seeking characteristics (Booth & Owens, 2000). Qualitative studies are recommended to explore personal motivations and beliefs regarding help-seeking for suicidal behaviour (Oliver et al., 2005). Nadasar et al. (2003) concur, highlighting the link between attempted suicide and ultimate completion of suicide. They suggest identifying barriers to help-seeking in individuals who have attempted suicide as an important

area of research. More research is also needed to determine help-seeking patterns in people who self-harm, in order to aid clinicians in the detection of high-risk individuals in need of intervention (Pirkis & Burgess, 1998).

Both Coggan et al. (1997) and Smalley et al. (2005) also suggest that qualitative research is pertinent to complement the large body of quantitative research regarding suicide. Kuhl et al. (1997) refer to studies, e.g. Offer et al. (1991), where the reasons behind barriers to help-seeking were not targeted. They suggest that research needs to focus on understanding the barriers to seeking help as a means to providing meaningful interventions.

Therefore there is a need for qualitative research to look at the experiences of help-seeking in groups that have been identified as higher risk. As Kuhl et al. (1997) discussed, in-depth qualitative approaches give greater opportunity for the psychological mechanisms that lie behind help-seeking behaviours and barriers to be explored. Such approaches also elicit a fuller understanding of the internal worlds of people in times of distress in a way that most quantitative studies are less able to do. Qualitative methods, such as interpretative phenomenological analysis (IPA), give the reader a vivid picture of the participants' subjective experience by including excerpts of raw data to elucidate interpretations made about the data (e.g. Smith & Osborn, 2003). In addition, studying survivors of 'nearly lethal' suicide attempts is seen as an important area of research (Douglas et al., 2004; Hawton, 2001). Unlike autopsy

studies, which look at the context surrounding a completed suicide attempt, studying attempted suicide may be able to facilitate the understanding and management of suicide by exploring participants' subjective experiences.

### **Clinical Implications**

It is of concern that those who are most in need of help are often the least likely to receive it (e.g. Bebbington et al., 2000a; Wells et al., 1994). In the literature reviewed, young men are consistently identified as the most at risk of suicide and the least likely to seek help for their emotional problems. How closely these two concepts are related is unclear, however, it is recognised that seeking help for emotional distress at an early stage can prevent the development of more serious problems. One of the difficulties is that people, men in particular, who are in distress, may find it hard to understand and articulate their emotional concerns. This may contribute to the failure of services to identify suicide risk when they have the chance; it can be difficult to identify risk, particularly in young men who may not display such classic signs of depression and also find it hard to express themselves in emotional language. Improving training for GPs in risk assessment and referral of psychological problems may help in the identification and management of suicide; however, this will always be difficult considering the pressure that GPs experience in meeting the needs of their communities.

Another problem within Goldberg and Huxley's (1992) second filter is gaining a shared conceptualisation of the problem. Because of the

central role of General Practice in accessing all health care, some people find consultations tend to favour medical explanations and treatment when they are hoping to receive psychological help (Angermeyer & Matschinger, 1997). This can lead to disappointment with services and reluctance to disclose emotional problems. There may be a case for challenging the centrality of GPs as the gatekeepers for all statutory mental health services and promoting alternative pathways to psychological help not requiring a GP referral. This is particularly relevant for those with impulsive tendencies who may be less likely to access support other than in times of crisis. In addition, when referrals are made to specialist services, these pathways are often complicated and may result in long waiting times for services. For many people who already hold beliefs that seeking help will not make a difference, the experience of a long wait for psychiatric or psychological help may indicate a confirmation of these beliefs.

Although the value of informal help is not clear it is associated with accessing formal help (Cornford & Cornford, 1999). As a result, encouraging people to speak about their problems with friends and family is likely to improve mental health either directly or through eventual access of appropriate services (Owens et al., 2005). Talking about mental health problems is affected by perceived stigmatisation of these difficulties. This is perpetuated by media representations and defined within social contexts. More could be done through education and the media to address the negative representations associated with having emotional problems to enhance disclosure and help-seeking. Attitudes

towards help-seeking are defined early in life, therefore, attention should be paid to improving access to help in schools and in other settings for young people.

### **Summary**

There are no distinct criteria than can be used to predict suicide; instead, there are a wide range of pathways that increase risk of suicide, such as psychiatric history and gender. For those who have attempted suicide and/or are at risk of ending their lives, there are a range of psychological and medical treatments that are available, although the evidence for these treatments is inconsistent (Heard, 2000). There is evidence that receiving psychological help can affect the trajectory of a mental health problem at any point in its development; potentially protecting that individual from later suicide risk (Gunnell & Lewis, 2005).

Providing help to the right people at the right time is determined in part by an individual's help-seeking. There are various sources of help for people in times of distress such as peer and family based support, health care from generic services and specialist mental health support, both medical and psychological. Epidemiological surveys (e.g. Bebbington et al., 2000b; Kessler et al., 1994) indicate that about a third of people with mental health problems will seek professional help. Those who do not may access help from their peers or family, which is often experienced as beneficial unless it is in the context of critical relationships. Barriers to seeking help vary across different groups. Young men are least likely to seek help for their problems. Reasons include, believing no one could

help, feelings of shame and embarrassment, believing the problem will resolve itself or feeling unable to articulate their problems. Perceptions of stigma associated with mental ill-health and suicide affect help-seeking in all groups, however, it is more likely to affect males rather than females and younger and older people rather than the middle-aged.

Many people who do attempt to seek help have their mental health problems managed at primary care level. Some of these people will go on to attempt suicide and it is possible that improving training and risk assessment for GPs would improve risk management. Although we have a system that allows for easy initial access to a doctor, the barriers to people disclosing their distress at this level and those in need being referred on to specialist help are not well understood. Several authors advocate the use of qualitative methodology to explore the experiences of psychological help-seeking in people at higher risk of suicide with a view to investigating the internal and external barriers of help-seeking in times of distress. Studying survivors of 'nearly-lethal' attempted suicide may be a particularly important method of suicide research (Douglas et al., 2004; Hawton, 2001).

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## **Part 2**

# **Barriers to psychological help-seeking in young men who have attempted suicide: An Interpretative Phenomenological Analysis**

**Empirical paper**

## **Abstract**

Suicide is the most common cause of death in young men and men are reluctant to seek help in times of emotional distress. This qualitative study uses Interpretative Phenomenological Analysis (IPA) to investigate barriers to psychological help-seeking in young men who have attempted suicide. The participants reported attempting suicide in order to end the overwhelming emotional distress they were experiencing. Identified barriers to help-seeking included being too ashamed to share problems, feeling unable to articulate distress and previous negative experiences of seeking help. The findings suggest that internalised stereotypes of masculinity can prevent young men from disclosing their difficulties and that a lack of empathy and understanding from potential formal and informal help-providers may inhibit distressed young men from accessing necessary support.

## **Introduction**

Suicide is the leading cause of death in men under the age of thirty-five (Brook & Griffiths, 2003) and men are as much as four times more likely to kill themselves than women (Cantor & Neulinger, 2000). In addition, although suicide rates in most demographic groups in the UK have fallen in recent years, rates in young men have continued to rise (e.g. Gunnell, Middleton, Whitley, Dorling & Frankel, 2003). Considerable research has been carried out in an attempt to identify risk factors for suicide; however, there are no definitive clinical models that integrate these factors (Gunnell & Lewis, 2005, Mann, Waternaux & Haas, 1999). For young men, risk is exacerbated by reluctance to seek help for emotional distress (Biddle, Gunnell, Sharp & Donovan, 2004; Hearn et al., 2002) and by disengagement from psychiatric services (Hunt et al., 2006).

Goldberg and Huxley (1992) identified three "filters" in accessing mental health services: (1) consulting the general practitioner (GP), (2) psychological disorder identified by the GP and (3) referral on to specialist services. Only a relative minority, 26-40%, of adults with mental health problems pass the first filter of accessing professional help (Bebbington et al., 2000; Kessler et al.1994) even during periods of serious emotional distress, at times when suicide risk is greater (e.g. De Leo, Cerin, Spathonis & Burgis, 2005). In the UK, it is estimated that between 65% and 86% of people who complete suicide are not in contact with mental health services (Booth & Owens, 2000). However, they are more likely to have had a consultation with their GP in the months prior to ending their lives (Luoma, Martin & Pearson, 2002). In most of these

cases doctors believed that the individuals' difficulties could be managed without referral to specialist services. It is not possible to determine whether or not more could have been done at the primary care level to avert suicide, however, it does raise questions about risk management (Owens, Lloyd & Campbell, 2004). Owens et al. (2004) suggest that risk assessment procedures and guidance and training for GPs should be addressed to tackle any potential gaps on skills and training.

There are other factors that influence primary care consultations. There is evidence that young men are likely to find consultations relating to mental health problems or emotional distress hard to manage. They may experience anxiety during consultations, finding it difficult to express themselves in emotional terms (Ciarrochi, Deane, Wilson & Rickwood, 2002). They also exhibit fewer symptoms of depression than females, even though they may be experiencing a similar degree of depression (Angst, Stassen, Clayton & Angst, 2002). Each of these factors will affect the likelihood of risk being detected during a consultation and inhibit young men from making consultations in the first place.

Most young men do not even have this level of contact with health care services and will not consult any health care professional prior to suicide (Owens et al., 2004). Both quantitative and qualitative research methods have been used to identify potential barriers to seeking help. There is evidence that fears of stigmatisation, associated with suicide and mental health problems, make people more reluctant to seek help. For men in particular, beliefs about seeking help as an indication of failure and weakness are also a factor (Murphy, 1998). Men are more likely to

believe that they should cope on their own and should be able to confront and overcome difficulties without outside help (Addis & Mahalik, 2003). Feeling unable to express themselves emotionally, as well as more practical dilemmas such as not knowing how to access help, can prevent men from disclosing their distress (Coggan, Patterson & Fill, 1997).

Psychological help-seeking refers to disclosing emotional distress to both formal and informal helpers. Although evidence is limited regarding the benefit of informal and peer support, having non-critical relationships with family members is a protective factor against suicide (Cohen, 2004). In addition, individuals are at greater risk of suicide if they live alone and if they have experienced relationship breakdowns (Gunnell, 2000). These findings concur with the classic work of Durkheim (1897) who argued that people are more at risk of suicide if they do not have strong ties to the community. In further support for informal help, there is evidence that adults with long-standing mental health problems find support from friends and relatives as helpful as that provided by mental health professionals (Eagles, Carson, Begg & Naji, 2003). In addition, disclosing distress in informal settings is positively correlated with formal help-seeking, and it is likely that disclosure to friends and family facilitates eventual access to professional help (Cornford & Cornford, 1999; Nataraja, Morrison & Skegg, 2003). This is not surprising, as an individual's 'relationship to help', including their attitude towards and beliefs about seeking help, are influenced by their early experiences and family relationships (Reder & Fredman, 1996).



The role of attitude in influencing health behaviours is acknowledged in Ajzen's (1991) Theory of Planned Behaviour, in which attitude, perceived behavioural control and subjective norms combine to influence intention and eventual health behaviour which includes help-seeking. This model highlights the role of subjective norms in influencing intention to engage in health behaviours such as help-seeking and therefore recognises the role of influences such as gender-role stereotypes discussed above.

Fischer, Winer and Abramowitz (1983) also identified attitude as influencing intention to seek help and considered attitudinal factors to provide the backdrop to a five-stage model of help-seeking, developed through synthesising help-seeking research: Stage (1) involved the perception and identification of a problem, (2) contemplating ways of helping oneself, (3) the decision to seek (or accept) help, (4) a precipitating event to mobilize action and, stage (5), overt seeking behaviour. Discussing experiences of help-seeking in relation to attempted suicide involves all five stages as it explores participants' recognition of their problems, their beliefs about the availability and relevance of potential help, their attitudes towards seeking help and a discussion of their attempts to seek help.

Researching suicide and attempted suicide in young men, particularly in relation to help-seeking is problematic (Douglas et al., 2004). Because men are often less willing, or able, to express themselves emotionally it can be harder to access the experiences of distressed young men. In addition, suicide research is usually restricted to psychological autopsies and third party reports. Psychological autopsy studies have provided a wealth of information about suicide, however, they are obviously unable

to study personal accounts from the distressed individuals to learn what may have averted suicide or prevented them from getting support when they became distressed (Eagles et al., 2003, Hawton, 2001).

Studies exploring the views of non-help-seeking populations using postal surveys have revealed that many young people do not access help even if they know it is available (e.g. Biddle et al., 2004; De Leo et al., 2005). However, these studies often are unable to give insight into the internal worlds of young men who may be at risk of suicide (Oliver, Pearson, Coe & Gunnell, 2005) and there have been calls for qualitative research to complement the quantitative studies that make up the bulk of the literature (e.g. Coggan et al., 1997; Oliver et al., 2005; Smalley, Scourfield & Greenland, 2005; Williams, 1985). Such studies would aim to understand the processes behind help-seeking barriers and to learn what sort of help may seem relevant for young men in times of distress. Improving access to services is important for addressing the mental health needs of young men and in tackling the high suicide rates nationwide (Tylee & Walters, 2004).

Conducting research with people who have attempted suicide is an important but challenging aspect of studying suicide (Hawton, 2001). Douglas et al. (2004) used both quantitative and qualitative methodology to study "near-fatal" deliberate self-harm (NFDSH) in Manchester without discriminating by age or gender. They concluded that studying people who had engaged in NFDSH made a good 'proxy' for studying suicide. The current study used qualitative methods to study the relationship to help of young men who had attempted suicide. It aimed to elicit their

help-seeking experiences and highlight barriers to seeking and accessing support from both formal and informal sources.

The main research questions were:

1. What were young men's attitudes towards seeking help at the time of their suicidal crisis?
2. What experiences had they had of disclosing their distress?
3. What were the barriers to seeking help?
4. What help would be wanted during times of emotional distress?

## **Method**

### **Recruitment**

Participants were recruited from both NHS and non-NHS sources (see Table 1 below). For recruitment via the psychiatry liaison services, staff identified potential participants according to the inclusion criteria (see below). These young men were sent a letter informing them of the study with an opt-in form. Young men who were identified through their involvement with the mental health teams (Crisis teams, CMHTs, Assertive Outreach teams and out-patient psychology) were informed of the project by their key-worker or another member of the team. Those that expressed an interest were then contacted directly by the researcher.

For recruitment via non-NHS sources, the project was advertised by posting flyers in the University Counselling Service and Student Advisory receptions, by email to voluntary organisations and text messages to personal contacts who may have known potential participants. In one instance snowballing took place in which one participant invited a friend to take part in the study.

Ethical approval was given by the Camden and Islington Local Research Ethics Committee and by the UCL Ethics Committee (see Appendix 1 for approval letter).

**Table 1**  
*Recruitment source for participants*

<b>Source</b>	<b>Eligible</b>	<b>Recruited</b>
Liaison Psychiatry	29	3 (10.5%)
Crisis Teams	1	0 (0%)
CMHTs	5	2 (40%)
Assertive Outreach Teams	1	1 (100%)
Out-patient Psychology	1	1 (100%)
Non-NHS sources	5	5 (100%)
Total	42	12 (29.5%)

## **Participants**

The inclusion criteria were young men (18-35 years of age) who had attempted suicide within the past two years. In all cases either the participants themselves, or clinicians involved in their care, described the

index incident as a suicide attempt. This was a subjective judgement of perceived intent of suicide rather than an assessment of potential lethality or medical seriousness. Men who were unable to speak English or those whose severity of mental illness made them unable to take part in the interview, were excluded.

A total of 42 young men were identified as potential participants (see table 1), twelve of whom (29.5%) agreed to take part. The majority of those who were deemed eligible but did not take part did not respond to the opt-in letter that was sent following their contact with liaison psychiatry. Three of the young men who were identified by CMHTs were unable to take part. One participant felt it would be "too personal", another potential participant was readmitted to hospital before the project was discussed and another withdrew prior to discussion. Because participants who were recruited via non-NHS sources responded to posted flyers, emails and text messages, it is not possible to know how many potential eligible participants became aware of the project and decided not to take part. The participation rate of 100% given in Table 1 indicates that all young men who expressed an interest subsequently consented to participate. However, it is clearly not possible to estimate how selective a population this was and therefore the 100% rate does not necessarily suggest that this was a more successful recruitment method.

### ***Demographics***

Participants' ages ranged from 18-37 (median 29). Two men who were over thirty-five were included in the study as the suicide attempt

occurred whilst they were 35 years of age. The ethnic composition of the sample was 8 White British (67%), two British Asian (17%), one Black British (8%) and one Iranian (8%). The methods of attempted suicide were nine overdoses (7 analgesics, 1 antipsychotic medication, 1 methadone), two cutting (1 chest and arms, 1 arms) and one participant had attempted to drive his car into a wall. Participants recruited through non-NHS sources appeared comparable to NHS participants in terms of seriousness of suicide attempt and nature of presentation. The names and details of all participants have been changed to protect their anonymity:

*Participant 1* was a single Black British man in his early twenties. He was unemployed and about to become a student. He took an overdose of antipsychotic medication in the context of a psychotic relapse.

*Participant 2* was a White British man in his late twenties. He took overdoses of paracetamol on two occasions following the loss of his job, partner and home.

*Participant 3* was an Iranian asylum seeker in his early thirties. He was single and unable to work because of his unresolved asylum status. This status had adverse effects on his mental health. He had made a series of suicide attempts over the previous two years, including cutting chest and arms.

*Participant 4* was a single White British man in his mid thirties. He was working as a manual labourer. He cut his wrists two years ago in prison whilst withdrawing from heroin.

*Participant 5* was a White British man in his early twenties. He was in a long-term relationship and took an overdose following difficulties with his partner. He was on incapacity benefit due to depression.

*Participant 6* was a White British man in his late twenties. He worked in manual labour and had recently separated from his girlfriend. He took an overdose of methadone following arguments with his girlfriend and the police.

*Participant 7* was a British Asian man. He attempted to drive into a wall following the collapse of his business in which he was previously successful. He was single at the time of attempting suicide.

*Participant 8* was a White British man in his early thirties. He was on incapacity benefit for depression. He took an overdose of paracetamol.

*Participant 9* was a British Asian man in his early thirties. He was separated from his wife and had two children. He took an overdose of analgesics after being out of work for a prolonged period of time.

*Participant 10* was a White British man in his mid twenties. He was a student and had taken two overdoses of paracetamol in the context of long-standing difficulties with alcohol.

*Participant 11* was a White British man in his late twenties. He was unemployed. He made a series of suicide attempts, including cutting and analgesic overdoses, following the death of his parents.

*Participant 12* was a White British man in his early twenties. He was a student and took an overdose of analgesics following the break-up of a relationship.

## **Interview**

Interviews took place in consulting rooms at an out-patient psychology department and lasted between 45 minutes and an hour. Consent was obtained (see appendix 3 for participant information sheet) for participation and recording of the interview and participants received £10 for their involvement.

The semi-structured interview protocol was constructed using the following framework (see appendix 3 for full interview protocol):

1. The circumstances surrounding the suicide attempt
2. Any help sought at time of crisis
3. Attitudes towards and experiences of help-seeking more generally
4. Specific experiences of seeking or receiving psychological help



## 5. Factors that would make help-seeking more or less likely

Interviews were guided by participants' personal narratives using a flexible "directed conversation" approach (Pidgeon & Henwood, 1996) in order to allow participants to tell their own stories. Although some authors argue that more personal questions should be addressed later in the interview (e.g. Smith & Osborn, 2003), it was felt that participants would be aware of the context of the study and therefore have this event on their mind. As a result, the interview began with questions regarding the participant's suicide attempt. The interview ended with the opportunity to reflect on the interview and to raise any additional issues. For those who expressed the desire to do so, suggestions were made for access to counselling or other help.

### **Data analysis**

The transcripts were analysed using Interpretative Phenomenological Analysis (IPA), following the procedure described by Smith (1995) and Smith and Osborn (2003). This was an iterative analytic process in which transcripts were read and re-read, allowing the researcher to become "immersed in the data" and elicit themes that emerged from the transcripts. This process initially involved reading the individual transcripts in-depth, underlining and summarising parts of the transcript that elucidated the participants' narratives in relation to attempted suicide and help-seeking.

The researcher identified statements that conveyed significant personal meanings in relation to this topic. Re-reading the data allowed the researcher to refine this initial analysis and cluster related statements and themes to produce a master list of themes for each transcript. All the master lists were then reviewed to identify themes that were salient across the transcripts. These were then organised into 'domains' and given a label that reflected salient phenomena. Throughout this process the researcher continually moved between the emerging themes and the raw data to ensure that the themes and domains stayed true to the original text and what was actually said by the participants (see appendices 5-7 for a breakdown of the 3 stages of analysis).

### **Validity**

Following principles outlined by Elliot, Fischer and Rennie (1999), as a validity check on the analysis, a colleague familiar with IPA audited two transcripts, initially analysing the transcripts independently to identify themes and then examining the themes identified by the researcher. She agreed that the themes identified from these two transcripts reflected what the participants said. In addition, a senior researcher, proficient in qualitative research methods, also independently audited several of the transcripts and agreed that the themes and domains reflected the participants' accounts. Respondent validity was not carried out due to difficulties in re-contacting and organising this with participants.

Examples of the analytic process have been included in appendices 5-7 in order to demonstrate the process of drawing themes from the raw data.

Throughout the results excerpts from the transcripts have been included to demonstrate the sensitivity to context and coherence within the interpretative analysis and the importance and impact inherent in the participants' contributions (Yardley, 2000).

### **The researcher's perspective**

Collecting and analysing data using qualitative methodology is inevitably influenced by the subjective perspective of the researcher. It is important to address any prior beliefs that may have influenced data collection and analysis (Elliott et al., 1999). Although I am in the same age group as the men in this study, I have not experienced any of the circumstances that were the primary source of distress for these young people, such as domestic violence, abusive parents, mental ill-health, drug addiction and forced displacement. From working with young people as a trainee psychologist, and through personal relationships, I have become aware of how adversity can affect people's relationship to help (Reder & Fredman, 1996). As a result I expected young men who have attempted suicide to have experienced difficulties in their past that may have affected their ability to trust and rely on others. I also hold the perspective that talking about one's problems is generally a good thing and recognise this belief may have affected my stance in the interviews. However, I attempted to maintain a non-judgmental and curious position throughout.

## Results

Most of the participants spoke articulately about their experiences and engaged well in the interviews. A few participants found it more difficult to express themselves in the interviews but persevered and made valuable contributions. The analysis yielded nine themes which are outlined in Table 2 below. These themes do not necessarily represent the most frequently observed phenomena, and were not necessarily elicited from all transcripts, but were judged to say something significant about these young men's personal experiences and hold on-going personal meaning. They were organised into three domains; (1) Escaping from unbearable feelings, (2) Barriers to help-seeking and (3) Making changes and looking ahead.

**Table 2**

*List of domains and themes*

<b>Domain</b>	<b>Theme</b>
1. Escaping from unbearable feelings	1. The feelings are overwhelming 2. Ending the pain
2. Barriers to help-seeking	3. I don't want to be a burden 4. I'm too ashamed to share problems 5. I can't cope with talking 6. I don't know how to do it 7. I've learnt not to share problems
3. Making changes and looking ahead	8. Help I would have wanted 9. Making sense of what's happened and moving on

## **Domain 1 - Escaping from unbearable feelings**

### ***Theme 1 – The feelings are overwhelming***

Participants consistently reported intense feelings of emotional pain and hopelessness. They described being in psychological distress and not being able to see an end to the pain.

*... and that was the constant theme in my head, replaying over and over again, "what are you doing? What have you done? What have you achieved?" etcetera, etcetera, etcetera and it just was incessant... what future do I really have? And I couldn't see how I could get out of this situation... it got incredibly depressing and dark, where I got the lowest point that I'd ever experienced in my life (P7)*

*...I couldn't see a way of going on having those feelings ... I can't really imagine the intensity of the feelings, looking back, it was just so incredible, and I was quite amazed that I was capable of feeling something so intense like that (P12)*

They had lost any sense of agency regarding their capacity to change their circumstances or cope with the distress, and were unable to see any way of escaping.

*Just felt like there was nowhere to turn. I had nowhere to go, there was nothing in front of me. Everything was just coming in the sides and it was just nowhere, no outcome, there was no finishing line (P5)*

The sense of hopelessness affected their ability to see any possible future that was bearable, feeling that they would be better off dead. The hopelessness also prevented them from finding comfort or reassurance in the support people tried to give.

*I don't know, I lost everything in my life, I just want to die, honestly I don't want a life like that, people say to me you have to think more of the future ... I say what is my future? Every day the same, every day same, every day same, what's a change? Nothing, why have the life? Why have the life? (P3)*

Participants reported using drink and drugs to try and block the pain they were feeling, however, this only provided temporary relief.

*it was really hard to cope with things and the only way I could cope with things at the time was have a bit of gear and that's really what it was to the numb the inside of me (P4)*

*I used to drink and take drugs to block out things, I used to wake up in the morning and start taking drugs just so I wouldn't think about things that were going on in my life. I thought if I was high then I'm happy ... blocking everything out, that's what it was about in my life, blocking everything out (P5)*

P10 found that using alcohol accentuated his feelings rather than helped him manage them, causing him to feel more distressed than before.

*and I drink to try and block it all out but what it actually does is it extends those things ... so if I'm feeling depressed I'll have a drink and then whoomph, straight back down, and there's no depth to how far you can sink (P10)*

## **Theme 2 – Ending the pain**

For all of the participants, attempting suicide represented what Schneidman (1985) labelled an "Aristos", i.e., the best possible solution to the current problem. Attempting suicide was the only perceivable solution to the unmanageable feelings.

*...I just wanted everything to stop then, so that's why I took the overdose (P8)*

*...I was sort of walking around in a day dream most of the time, angry, really really angry er and just well that's why I tried to kill myself I just couldn't see the end to it (P2)*

For those who wanted to die, seeking help was not an option.

*I just had enough, I didn't want to tell anyone anything, I just wanted to get out, get it out of my system and just die (P9)*

However, many participants described being uncertain about wanting to die. In many instances this only became apparent on reflection, following the event, which demonstrates the impulsive nature of some of the attempts.

*Looking back now, I don't think I was in the mindset of wanting to die, of not wanting to wake up again, but the feelings were so strong that I was willing for that to happen... (P12)*

*...quite easily I could have walked into the park, not phoned the police, fell into a corner and just died basically. But I think it was maybe just a cry for help (P6)*

What was clear was that whether or not the intention was to die, there was desperation to put an end to the unbearable feelings and not have to carry on fighting battles that they felt unable to contend with.

*...I don't know whether I wanted to end my life, but I wanted to end those feelings (P12)*

*...it's not that I necessarily wanted to be dead, er I just couldn't really be bothered any more, I'd been a heavy drinker for fifteen years, and I don't want to have to fight it any more ... so I thought, end it (P10)*

## **Domain 2 – Barriers to help-seeking**

Throughout the interviews participants reported a number of barriers to seeking help. The following six themes reflect these barriers. In some instances they prevented initial disclosure of a problem or stopped participants going back for help when their situation worsened, whereas other barriers prevented participants from being able to make use of help that had been sought or become available.

### ***Theme 3 – I don't want to be a burden***

Participants reported a number of ways that the fear of being a burden on others affected their ability to share their problems. In some cases

not seeking help was seen as a way of protecting oneself from the pain of rejection associated with feeling like an unwanted burden on others.

*Like someone said to me last night, why didn't you just ring me why didn't you just call me? And I'm like, because I don't want to push myself on you. You've had a hard day at work, you don't want me ringing up and saying I feel low can I meet up, you know? ... So now I won't contact anyone cos in my mind I'm going to get a response of be on your own; so I'd rather not, you know, push myself and get hurt (P8)*

All of the participants had people in their lives who they could share problems with to some degree at various points in their lives. However, participants were conscious of the negative effect their problems could have on those around them. This was accentuated when their problems worsened and made participants reluctant to seek help.

*... she actually kind of broke down and started crying when, when I told her how I was feeling and that I'd been abused and she found it very hard to deal with and then I had the kind of feeling that I was putting my friends under pressure... and I know the drain it can put on friends and I began to get a bit conscious of that (P12)*

#### **Theme 4 – I'm too ashamed to share problems**

Throughout the interviews participants referred to feelings of shame that affected their self-concept and also their relationship to help. There was often reluctance to let anyone know about their feelings prior to attempting suicide because of fears that they would be seen as "weak".

*They'd think I was weak, that I wasn't able to deal with my problems (P9)*

This became more of an issue when they were at their lowest and most in need of help.

*'cos I didn't want anybody to feel sorry for me, I didn't want them to think I was in the self pity mode ... it would make me look like a weak kind of person, at this time I didn't want to be portrayed as a weak person (P5)*



There were also concerns about what others would think of them if they disclosed their feelings and circumstances; that they would be seen as “mad”, “crazy” or as a “suicidal person”. Concerns about being stigmatised made them feel worse about their problems and less able to seek help.

*Int: ...what was your impression of what people might think of you if you had to end up in hospital?*

*P11: You were crazy, nuts. ... when they hear mental health they think the, the worst scenario of it. They don't see, it can just be, depression doesn't necessarily mean you're off your mind...*

Their perceptions of the stigmatisation of mental illness and suicide related to their pre-morbid beliefs as well as their experiences since the onset of their difficulties.

*It's like, as I say there's a lot of stigma attached to it and in my experience there is, and it's like, you know, in the society if you're a late twenties early thirties male you are meant to be strong enough to cope with things on your own (P8)*

Feelings of shame associated with their difficulties made participants push family and friends away particularly when their situations worsened.

*because of the panics I made myself feel useless you know ... so you start to push your family and friends away from you 'cos you don't want them to see you go into that decline (P2)*

There were distinctions made between people it seemed acceptable or unacceptable to share with. This depended on what responses they felt they would get from others and what judgements they felt others would make.

*...harder with friends 'cos erm, obviously not lots of young people my age know about mental illness and I haven't told them about my health problems; I just don't feel comfortable with them knowing kind of thing (P1)*

**Theme 5 – I can't cope with talking**

Participants reported feeling that talking about their problems would cause more harm than benefit. This prevented disclosure because they felt they did not have the resources to cope with the situation getting worse.

*And then you think ... if I start talking to them about something they're gonna talk about it and it will be like hitting a raw nerve. It's gonna be like playing with a tooth ache in your head 'cos you're thinking, like I can't focus on that because it's too painful for me when I haven't got nothing good to support it with you know? (P2)*

Some participants felt that talking to others would mean that they would have to admit the problem to themselves, which they did not feel able to cope with. This was particularly an issue when they felt a sense of failure. It would have been more bearable if they had something to offer by way of an escape plan, but to admit the problem to friends and family without any idea of how to get out was unacceptable.

*Int: ...what stopped you from talking to your brother or someone else who was close to you?*

*P7: I think just the fear of rejection and failure, you know, because I didn't want to present that to them, and certainly not present that to them without an option, saying, OK, I failed but I'm doing this, you see, because I had nothing, I had lost the ability to really think clearly*

There was a fear of being exposed to painful thoughts, feelings and aspects of themselves that they would then be left to cope with on their own.

*...I'm afraid of being opened up even more, and not being able to cope with it (P8)*

*...if I could be guaranteed to have an on-tap therapist, If I was in some residential place where I could go and chat to someone whenever I wanted to then maybe, but the thought of opening it all up ... when you really start exploring, I haven't got the energy*

*and I'm scared of then having to get on with the rest of my life (P10)*

Keeping problems inside came to represent the final line of defence and was all that participants felt they had control of. Therefore, the thought of disclosing felt like letting down the only protection they had left.

*... if I finally told them then maybe this little bit that I have built up around me would go crashing as well er 'cos I maybe would hand over all my life to them and say "look, this is what shit state I am in" maybe it would even get worse (P2)*

### **Theme 6 – I don't know how to do it**

Throughout the interviews participants described difficulties with being able to articulate their problems and express themselves in emotional terms.

*...how do you go to someone with, where you're literally breaking down you know, literally everything about you, physically, medically, everything about you, mentally, you know, you're just a big ball of mess, and you can't really describe what you feel like, you don't know where you want to be, where you've come from, where you're at, you know, how do you explain that to someone? (P2)*

Being concerned about their ability to communicate what was happening to them made it harder to seek help.

*you could go to your doctors but what might be difficult is explaining how, why you feel in a certain state. Because when I first got ill I didn't know what the hell was going on, I was thinking what's wrong with me? (P1)*

Participants were thoughtful about the possible causes for their perceived difficulty with making sense of their problems and expressing themselves. These often related to their childhood experiences.

*... which is how I was raised, which is half my problem, because I've got no, or I feel like I've got no emotional vernacular, so*

*when these things attack me I don't know what to deal with them (P10)*

Both P12 and P10 felt that their parents' responses to coping with their fathers' difficulties informed their way of coping with emotional problems.

*... when I was thirteen my dad took an overdose , my mum, my brother and I were all there, at the time that he did it and no one ever talked about that so that was kind of when it, it all kind of closed in and there was like a taboo that no one would mention it, so that made other things automatically taboo as well (P12)*

*I mean my dad had been depressed so he should, but he doesn't, like admitting that he has any kind of empathy to it so he doesn't, so he blank walls it, that's what he did in the eighties and he's fine now (P10)*

### **Theme 7 – I've learnt not to share problems**

Problems with trusting others were often given as reasons for not being able to seek help. The participants had experienced rejection, abuse, betrayal and abandonment, which made them wary of sharing their difficulties.

*I can't trust anyone straight off because my trust has been broken so many times that it's just too hard for me now to trust someone straight away (P5)*

In addition, participants had found that when they had shared their problems with people in the past they felt unheard and misunderstood. This made them feel like no one cared for them, adding to their low self-esteem and hopelessness.

*...And it's like, when you're trying to get help and no one seems to be listening or taking notice or helping the situation the only way out at the time is to try and end it, because, you know, no one listens to you, no one wants to care, so what's the point in you being here? (P8)*

For some of the participants, not seeking help was away of keeping control of the situation even though their coping strategies did not seem to help.

*It's just the way I am, I like to sort things out myself, I know that everything's going to get done then (P9)*

Many of the participants reported experiences with their GPs that had made them feel worse and kept them from seeking further help.

*I used to go in there and he used to talk about himself all the way through ... just talk about himself for about ten minutes, how bad he felt, wrote me out a prescription for a beta blocker, said, that's 'cos it's what his friend takes when he has to make major speeches and it makes him feel better, er, write me out them and then sent me on my way [laughs] (P2)*

GPs failed to listen and understand their patients and at times compared the participants situations to their own, diminishing their significance.

*...my GP just sat there and said, "well, I get depression but I don't go on the sick all the time" (P5)*

The result of these negative experiences meant that participants felt cut off from other sources of support.

*... 'cos when you cannae trust your GP who can you trust you know what I mean? ... That's stopped me going to see anybody else (P5)*

### **Domain 3 – Making changes and looking ahead**

Participants reported making positive steps since having attempted suicide. They had been able to share their problems with others and many of them had experienced significant changes in their circumstances. They were now able to reflect on what help they would have wanted at the time of their distress; help they felt may have averted their attempted suicide.

**Theme 8 – Help I would have wanted**

Participants reported, above all, a need to feel understood, reassured and contained. They felt that support from people who had been through similar experiences would provide greater understanding.

*I think a lot of people are trying or try, but they don't actually understand, and because they don't understand I've been in situations where they do patronise ... People who have been through stuff know that someone's not going to just get over it just like that ... that it's a time, it's a process, you know, and no one knows how long it is (P8)*

Participants also found reassurance in knowing that they were not the only people suffering.

*... I think it was because there were other people in the waiting room who were experiencing difficulties as well, just knowing that you are not alone, because I know like from statistics and stuff how many students suffer from different things and I know I'm not alone in it, but it was nice to have, it was kind of like a support group, even though we weren't even talking, it was quite nice (P12)*

As well as receiving reassurance and support from people who have been through difficulties themselves, participants wanted reassurance from people who were experts in mental health. They felt they would be more able to cope if they had help that was "on-tap" (P10); people that they could call when they are experiencing difficulties.

*...somebody who deals specifically with the mind, er, to give you some reassurance that you're not going mad, er, that things are going to turn around ... even a phone line where you can ring someone if you feel that panicky or anxious (P2)*

Some participants changed their GP and noticed a difference in the new doctor's attitude towards them and their problems. This made them feel more hopeful about their future but also made them wonder whether

having a more understanding GP earlier on may have averted the attempted suicide.

*The doctors over that period of time made it harder for me to go back and it's only been my latest doctor that I know I can contact her and talk about it any time, now if my doctors were like this doctor now then I don't think I would have got to the point that I got to... she's more understanding to people with depression, she doesn't just give out the pills, she sits and talks with you, and makes you feel like you're human (P8)*

### **Theme 9 – Making sense of what's happened and moving on**

Participants found that the suicide attempt put down a marker in their lives from which change could come. Although they had feelings of guilt and shame about having made the attempt, it signified a turning point in many of their lives.

*... the overdose just kinda changed my entire life ... I know it's a sad thing it took that to change me, it take me wanting to kill myself to change me ... But er, after that everything in my life I completely changed, everything in my life style (P5)*

For P1, being able to start opening up with a counsellor after having attempted suicide was a significant time for him. He found that the hardest part of getting help was getting over the initial barriers of meeting up and starting to talk, after which, it became easier and he found it helpful.

*It's a bit of an effort to actually go to places and talk about stuff, that's the hardest part, actually getting to a certain place, meeting someone, then setting it all up and talking, that's the hardest thing but when you're actually talking and getting stuff off your chest you feel better afterwards (P1)*

Other participants also found that after they had attempted suicide they were more able to get help and find the benefits of opening up.

*Int: What was it like getting help from [her]?*

*P9: It was good, I didn't mind, 'cos like things were getting on top of me and it was just too stressful for me to deal with so I*

*need help ... Now, I can realise that I need help ... there's people there who care*

Being able to talk and find that other people were able to be containing and supportive was a powerful proponent of change. P7 was convinced that sharing his problems with his mother would harm her. The opposite happened and her strength and containment at the time of disclosure became the turning point in his recovery.

*But that moment with my mother made me come to realise, really it was like a light switch, you know, switching it on and it was just a better understanding of what I needed to pursue to get to where I needed to ... I took it on myself to really just regain my life, to take my life back rather, so I started going to church, started trying to be active, started trying to talk to people and things just picked up very quickly (P7)*

However, there were mixed feelings towards seeking help in the future. About half of the sample maintained that they would be unlikely to seek professional help if another crisis occurred but were more likely to have, and speak to, a confidante. Participants reported learning the value of sharing problems with friends, family and, in some cases, professionals, whom they could trust. Having learned the value of support, many participants reported wanting to be able to help others.

*... if you're gonna take a life, why not do the opposite and try to create a new life for someone? I mean I'm going to try to do charity work for the Red Cross, you know, trying to think of other means try and put your energies into something else (P1)*

*I've started to do that for my friends, I've got to the stage where I feel confident enough inside myself now that I can sit there and listen to somebody else's problems and they can come and confide in me now (P5)*



## **Discussion**

Although each participant had different life circumstances that led to their distress, what was common across their experiences was their overwhelming emotional pain in the perceived absence of escape options. These components are consistent with Williams' (2001) 'Cry of Pain' model of suicide. This model emphasises the diminished self-efficacy and loss of control associated with feelings of hopelessness. Loss of perceived control is disabling for many people but for these young men, who had negative beliefs about seeking help, it was potentially lethal. They were either unable to seek help at the point of crisis or make use of channels that were already open.

A number of factors kept participants from seeking help. They reported negative experiences of sharing problems and difficult past experiences that affected their ability to trust others. Reder and Fredman (1996) discuss how negative expectations of help are formed through early relationships and these experiences are often re-enacted in their help-seeking later in life. They suggest that expectations of maltreatment, such as neglect and abuse, affect people's ability to seek and make use of potential support; for example, expecting to be treated badly may cause an individual to miss appointments and lead to them being 'rejected' by a service following non-attendance. Many participants in this study reported early experiences of abuse and rejection which affected their trust in others but was also re-enacted in later help-seeking experiences. Some described having their confidence broken by help-

providers, mirroring early abuse, or felt they were not taken seriously, which may have re-enacted experiences of neglect.

Participants reported negative experiences with GPs, who were described as not listening, critical, dismissive and compared participants' problems to their own. These experiences made participants reluctant to go back for help or seek referral on to specialist services, as GPs were seen as representing other professionals. In some instances this negligence was accepted as the norm, which may reflect expectations of maltreatment as described above. It was not until some participants encountered a more empathic GP that their expectations changed. Having an on-going relationship with a more understanding GP was attributed to positive changes in participants' circumstances in the current study. This is consistent with previous findings that the patient-doctor relationship is central to patients' experiences of GP consultations when discussing psychological problems. For example, Buszewicz, Pistrang, Barker, Cape and Martin (in press), found that more helpful consultations were characterised by genuine interest and empathy expressed by GPs within a continuing relationship.

Participants expressed feelings of shame associated with being in need. Addis and Mahalik (2003) refer to beliefs about masculinity that are socially constructed and maintained within communities and social groups that can hinder men's help-seeking. They suggest that help-seeking can represent weakness and needing help may be experienced as an assault on men's self-esteem. The description of shame that the present

participants expressed supports these assertions. Participants reported being aware of burdening others and were conscious of being seen as weak and as a failure, both of which have been previously identified as negative aspects of help-seeking (Murphy, 1998). This is likely to have been further exacerbated by shame associated with feeling unable to articulate their problems. Men are more likely to experience problems in expressing themselves in emotional terms (Ciarrochi et al., 2002) which has been shown to inhibit help-seeking (Jacobson, Richardson, Parry-Langdon & Donovan, 2001).

Beliefs that seeking help will not be beneficial have been cited in the literature (e.g. De Leo et al., 2005), however, the current study identified beliefs that seeking help would make problems worse. This phenomenon may also be related to feelings of shame and the 'gender-role conflict' (Addis & Mahalik, 2003) experienced by men seeking help. Help-seeking generates gender-role conflict because the act of seeking help challenges men's self-concept as it conflicts with internalised masculine ideals of independence and self-sufficiency. As a result, young men would need a degree of emotional resource to be able to tolerate this conflict. Because participants were in a state of emotional distress, they would not have had the internal resources to tolerate the conflict inherent in seeking help. Therefore, feelings of shame and the associated gender-role conflict represented a further barrier to help-seeking.

## **Limitations**

The conclusions from this study may be limited by a recruitment bias in those who volunteered. As the analysis indicated, almost all participants reported some improvement following their suicide attempt, which may have contributed to their interest in participating. Therefore, participants in the current study may not represent young men who attempt suicide more generally. Since current mood is known to influence memory (Williams, Teasdale, Segal & Soulsby, 2000), participants' accounts of the past may have been affected by their improved circumstances. In addition, those who volunteered are unlikely to represent young men who are most resistant to seeking help. Those who are most reluctant to talk to others about their problems may also have been less likely to want to talk to a psychologist in the context of research.

Using subjective evaluations of the seriousness of the suicide attempt may also have affected the results. In their study, Douglas et al. (2004), used criteria of "near-fatal" deliberate self harm in order to create a 'proxy' for suicide. They excluded cutting of the wrists and overdoses that did not result in admission to Intensive Care Unit (ICU). The current study only included overdoses that resulted in a hospital admission but did not specify admission to ICU. Therefore, due to the method of recruitment used in this research, it may not represent an accurate proxy for studying suicide. This is further demonstrated by the accounts of participants, many of whom were uncertain whether they definitely wanted to die; stating more clearly that they wanted the emotional pain to end.

## **Research Implications**

The use of in-depth qualitative methods made it possible to elicit phenomena that larger scale studies may have been less likely to do. This is reflected in how many of the participants used the interview to process and reflect on their experiences. Most commented that the interview had been their first experience of talking through their experiences of attempting suicide. As a result, it enabled their views to be explored and processed over the course of the interview. This enabled access to phenomena that other studies, which may assume participants have already processed their experiences, may be unable to do. Therefore, the current study is consistent with recommendations from various authors (e.g. Oliver et al., 2005; Smalley et al., 2005; Williams, 1985) supporting the use of qualitative methodology as a complement to larger scale surveys in the study of people at increased risk of suicide.

The results of this study are consistent with findings elsewhere, that those who are most at risk are often the least likely to access support (Meltzer et al., 2000; Wells et al., 1994). For young men this may be because as their problems worsen they have diminished internal resources with which to cope with the gender-role conflict created by seeking help. However, they may be more likely to seek help if doing so did not carry such negative connotations. As discussed above, attitudes and expectations regarding help are influenced by early experiences and relationships (Reder & Fredman, 1996). It may be beneficial to look at how boys form beliefs about help-seeking and whether it can be reframed as a demonstration of strength rather than weakness.

Future research could focus on how young men come to form ideas about help and use experimental methods to design and evaluate brief school-based interventions aimed at tackling negative perceptions of help-seeking, to study the malleability of negative beliefs about disclosure. For example, Interventions, such as inviting a role model to school to talk about personal experiences of seeking help for emotional problems, could be carried out to study its effect on boys' attitudes to help-seeking.

### **Clinical Implications**

The two major clinical concerns emerging from this study are: (1) the reluctance of suicidal young men to seek help and (2) the inability of helpers to support young men who are in distress. Positive experiences of seeking help can bring relief and alter the trajectory of a problem's development (Gunnell & Lewis, 2005). However, negative experiences can reinforce an individual's sense of hopelessness and make them feel beyond help. Therefore, these two concerns are inter-related:

Individuals may be predisposed to negative beliefs about help due to their early relationships and re-enactments of these relationships in their later help-seeking experiences may perpetuate their difficulties, increasing distress and inhibiting further help-seeking. Thus, a vicious cycle develops in which beliefs that no-one can help them inhibits help-seeking until their problems become more serious, at which point, if they do seek help, those they turn to find it difficult to tolerate their distress and fail to adequately contain their despair. This further reinforces their

negative beliefs about help-seeking and the seriousness of their problems and ultimately leads to attempting suicide.

Being able to seek help before their difficulties had become severe may have led to more favourable responses from people participants sought help from and protected against the development of their problems.

Using role models, as discussed above, may decrease feelings of shame associated with being in distress and increase help-seeking at an earlier stage. It will also reassure some young men that they are not alone in experiencing distress. In addition, encouraging young men to have a confidante, with whom they can share their problems, may aid their emotional development and facilitate future help-seeking where necessary.

In spite of participants' negative appraisals of their ability to express themselves emotionally, most were able to disclose their feelings in interview and found it personally beneficial as a result. However, negotiating internal and external barriers to help-seeking make it hard for young men to have many opportunities to discover the value of talking, and challenge their negative beliefs about help. By tackling stigmatisation and other help-seeking barriers there may be more opportunity for young men to have positive experiences of expressing themselves. However, this needs to be facilitated by improving access to services that can tolerate young men's distress and recognising the need to give young men more time to enable them to express themselves. Unfortunately, time is often in short supply in primary care settings.

Owens et al. (2004) describe GPs as having a key role in suicide management through the identification and management of people at risk. However, in cases where GPs are seen as unapproachable, dismissing and lacking empathy, they become an obstacle rather than a gateway to support. Therefore, one has to consider the possibility of making alternative easy-access pathways to psychological help for young men who feel unable to approach their GPs. Results from the current study support findings that, although GPs often detect the presence of a mental disorder, there may be difficulties in assessing risk and undertaking appropriate interventions (Angst et al., 2002; Owens et al., 2004). More direct access to emotional support and a review of GP consultations to young men may be necessary if their needs are to be effectively addressed.

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## **Part 3**

### **Critical review**

## **Introduction**

Conducting this study was both exciting and challenging. A number of factors make this subject difficult to study and the effects of these on the current research are discussed below. In addition, the background to the study is outlined and the strengths and limitations of the research are discussed.

### *Background to the study*

Choosing this area of research was motivated by my interest in what influences whether or not people disclose distress and where they go to get help if they feel they need it. The decision to study suicide and attempted suicide emerged as a result of becoming aware, through my clinical work and personal experiences, of the scale of the problem in young men, many of whom have little or no contact with services. This was further influenced by conversations with clinicians involved with Camden's 'Sort Out Stress' project ([www.sort-out-stress.com](http://www.sort-out-stress.com)). This is a web-based initiative to promote mental health and well being in at-risk young men. Sort Out Stress uses the Internet to raise awareness of mental health problems, provide accessible self-help resources and guidance for seeking help from a range of sources. This study represented the opportunity to use psychological research to address an important public health issue.

A large amount of research has been conducted to identify risk factors for suicide but little has been done to look at the psychological processes involved in help-seeking in young men who have attempted suicide.



Using qualitative methodology meant taking a close-up position to the phenomena under study. I wonder whether this is rarely done with this particular population because of the difficult feelings that can be evoked. The current research appeared to generate anxiety and resistance in a number of people encountered over the course of the study, including ethics committees and clinicians. In addition, there are fewer young men available because they are more likely than females to complete suicide and those who do survive a suicide attempt are reluctant to attend follow up appointments or seek further help.

### **The problem of engagement**

Recruiting participants for the current study was challenging. Young men who attempt suicide are difficult to reach both in research and clinical contexts. The DOH's (1999) suicide guidance document identified engagement of young men with services as one of the principal aims for tackling suicide in this group. Difficulties in recruiting participants for qualitative suicide research has been noted elsewhere (e.g. Douglas et al., 2004). Heavy demands on clinicians and services can result in research being under-prioritised. This contributed to recruitment difficulties in the current study. However, a principal factor was the scarcity of young men who had attempted suicide being involved with services. Burns and Patton (2000), in a review of the risk factors in youth suicide, identified engagement as a key aspect of managing suicide risk. In their review they cited numerous attempts to tackle self-harm and suicide in young men, all of which experienced low levels of engagement that limited the effectiveness of the interventions (e.g.

Gillham, Reivich, Jaycox & Seligman, 1995). They also indicate from various studies (e.g. Vasillas and Morgan, 1997) that young men and adolescent boys are the least likely to engage or receive help for their suicide risk.

People's fears and anxieties about having anything to do with young men who have been, or continue to be, at risk of suicide was manifest in all aspects of this project. The UCL ethics committee expressed reservations about the project, being concerned that talking about their experiences may make participants more distressed. This reflects a common lay belief that emerged in the data analysis; that young men who are in distress may get worse if they talk about their problems. As the data analysis revealed, negative experiences of help-seeking was associated with increased distress, however, this tended to relate to help-providers being dismissive of participants' distress, lacking empathy and not allowing participants to talk about their problems.

There is little, if any, evidence to indicate that talking about problems with an empathic, trained clinician makes problems worse or increases levels of risk. On the contrary, talking is advocated as a principal mode of support for distressed young people (Roth & Fonagy, 2004). However, the prevalence of beliefs that talking about one's problems can be harmful may explain why so few young men engage with mental health services. Young men are reluctant to talk about their feelings and if they do, help-providers may be reluctant to discuss their difficulties. As a

result young men will have their beliefs about being unhelpable reinforced by people not being able, or willing, to hear their distress.

It is possible that, through such interactions, attitudes held within the health system may be serving to perpetuate beliefs that keep young people from seeking help. Services may reinforce the ideas that talking makes problems worse, that young men should manage on their own and that others cannot support them with their difficulties. This may contribute to the phenomenon in which the people most in need of help are often least likely to access support (Meltzer et al., 2000; Wells et al., 1994). Because services often want to distance themselves from the difficult feelings associated with suicide and attempted suicide they collude with the young men's reluctance to seek help.

This is in part because services lack confidence that they are able to effectively support young distressed men (Michel, 2005) and also because their difficulties may reflect broader issues regarding the fragmentation of society and the loss of community (Durkheim, 1897) that resonate with clinicians and makes them feel unable to help. For example, clinicians may feel that little can be done to change young men's social circumstances and isolation, which may seem to undermine any attempts by clinicians to improve their mental health by other means. The feelings evoked by suicide and attempted suicide can be difficult to manage for the individual, their family and friends and for clinicians working with them. These difficulties are discussed further below.

*The problem of engagement: effects on the research process*

Most participants exhibited anxiety at the start of the interview and also expressed relief when they found the interviews much more manageable than they envisaged. I felt the need to protect them and found myself trying to relieve this anxiety. As a result, some of the interviews may not have been as probing and challenging as they could have been and opportunities to probe some aspects of the interview further may have been overlooked. Inevitably, some of the participants had interpersonal problems that will have influenced their meetings with, and evaluations of, health professionals they encountered. It is possible that greater attention to these parts of the dialogue may have revealed more about how the participants' patterns of relating to others may have affected their judgements of help-providers they spoke to. By design, qualitative work is subjective; however, elucidating these phenomena may have helped gain a clearer perspective of their relationship to help.

In addition, I felt conscious of the language used in the interviews. I needed to determine whether the term 'attempted suicide' was acceptable to participants. I felt that this may have been affected by my own anxiety about using the term which, in turn, affected my capacity for containment. In addition, I had little information about some of the participants prior to our meeting and therefore had to determine the nature of the index event and their evaluation of whether or not it constituted attempted suicide (as oppose to self-harm with non-suicidal motivation) during the course of the interview. In addition, although I

had taken necessary precautions to keep participants safe and received feedback that they found taking part beneficial, I experienced feelings of responsibility for their well-being. The process involved in gaining ethical approval for the study may have influenced this feeling. Because questions were raised regarding the possible negative effects of talking about problems, this reinforced my sense of responsibility for the participants' safety.

In many of the interviews there was a degree of conflict apparent in the participants' emotional states. On one hand there was a sense of their fragility and needing protection, and on the other, feelings of shame related to not being able to manage on their own. I felt this conflict occurred because many participants could not integrate their feelings of being in need with their internalised ideals of being strong, independent and in charge of their emotions. This made me aware of how conflict and poorly contained emotional states may effect young distressed men's clinical contacts. It is unclear how closely the feelings involved in a research interview would reflect a clinical interview, however, this conflict and associated feelings may make it hard for a clinician to successfully identify and negotiate a problem in a clinical setting. As a result, the feelings involved in conducting the interviews reinforced and contributed to the findings from the data. For example, these interpersonal factors may have affected some of the negative experiences of seeking help reported by participants. For stressed and stretched service providers this conflict will have been difficult to tolerate; as a result, it may be easier to minimise problems and rely on 'safer' and more familiar

interventions, such as medication or reassurance, rather than providing emotional support or an exploration of feelings. Help-providers may find themselves being affected by the participants' emotional states causing helpers to feel hopeless and inadequate and participants to feel rejected and abandoned.

I felt that there were times over the course of the research that I was affected by their emotional states. This was particularly during periods when recruitment was more difficult. At times I would feel hopeless. This made me less likely to seek alternative avenues of recruitment and made me reluctant to seek help from others about the study. Although I do tend to be self-sufficient, it was noted by friends and colleagues that I was being unusually resistant to asking for help from supervisors at these times and lacked creativity in looking for alternative solutions.

### **Understanding intention: the function of self-harm**

Every person who ends their life has their own unique reasons for doing so and, to the individual, it represents the best possible solution to the given problem at that moment in time (Schneidman, 1985). People do not attempt suicide if they feel they have other acceptable options. Because of the emotional pain experienced and the lack of perceived escape routes from that pain, ending one's life may seem like the only option. However, what is unclear is the degree to which each participant believed they were going to die. Some of the participants in this study described wanting to do something that would end the pain they were feeling, did not intend to kill themselves but at the same time recognised

the serious risk involved in their actions. This was described as a 'cry for help' by two of the participants and others saw it more by what was being escaped (i.e. emotional pain) rather than by what was being sought (i.e. death or help). For some of the participants there was a sense of the unknown, of wanting the pain to end and therefore doing something to themselves and 'seeing what would happen'.

When reflecting on what had happened, some of the participants were shocked at the seriousness of their actions, whereas, others were subsequently shocked at how minor their actions were in comparison to what they learnt was required to cause death. For example, one participant felt that, in retrospect, he could not have been suicidal as he would have not gone to the lengths to plan and execute a suicide attempt to the degree that he discovered was needed to end his life. However, these narratives indicate how making decisions whilst in distress can lead to potentially life threatening behaviour, and that attempted suicide and self-harm are difficult to clearly differentiate from one another. Because of the difficulty in gaining first hand information when using methods such as psychological autopsy studies, it is unclear how many deaths occur despite individuals experiencing a degree of ambivalence towards dying.

#### *Intent, expectation and severity: defining attempted suicide*

Establishing suicide risk is difficult for clinicians and lay helpers (King et al., 1999). It is also difficult to distinguish between those who deliberately self harm with the intention to die and those who do not. The

current study highlights the difficulty of reliably determining the difference between deliberate self-harm and attempted suicide. This problem has been addressed elsewhere, for example, Hawton (2003) draws attention to the problem of physicians favouring the term attempted suicide in cases of deliberate self-harm even when there is no apparent suicidal motivation. Doing so can be misleading in both research and clinical contexts.

The current study excluded cases in which there appeared to be clear non-suicidal motivation; however, many participants expressed ambivalence towards wanting to die. Although it may seem logical that intention to die should predict lethality of self-harm, there is evidence that this is only the case when an individual has realistic expectations regarding the lethality of their method of attempted suicide (Brown, Henriques, Sosdjan & Beck, 2004). Therefore, those who have unrealistic expectations regarding what is needed to cause their death may survive a suicide attempt despite the intention to kill themselves. This is a serious concern as those with greater intention to die are likely to gain a more realistic expectation regarding what is needed to cause their death following a failed suicide attempt. This demonstrates the need for effective assessment of deliberate self-harm and the provision of appropriate and accessible after-care.

Brown et al. (2004) conclude that assessing both intent to die and severity of attempt provides a good indicator of attempted suicide. However, they also indicate that this is not an infallible procedure, as



lethality will also be affected by availability of various means of suicide. Such complexities make it hard to assess the accuracy of attempted suicide as a proxy for studying suicide (Douglas et al., 2004). Nonetheless, the current study could have been improved by using more stringent exclusion criteria, such as differentiating between participants who had long term medical complications from their overdoses or by using purposive sampling to include a range of suicidal methods. However, using more stringent criteria would have made recruitment more difficult.

### **Beyond barriers to help**

As discussed in the final theme of the analysis, "making sense of what's happened and moving on", I was struck by how almost all the participants used the interview to express painful feelings and found the interview personally beneficial as a result. Some of the participants had previous experience of formal psychological support, with varying reports of its usefulness. However, as discussed, some of the participants held negative attitudes towards talking about their problems. It was the latter group that responded most favourably to the interview. Some of the participants asked if it was possible to meet again and others discussed with me where they could go to receive counselling.

As discussed above, helper-providers can be reluctant to provide emotional support to someone they see as being at risk of suicide. It is understandable that people who are more able to support those at risk of suicide are at the forefront of care provision. However, it is not often

clear who such helpers are or how to access them, and they often represent short-term interventions (e.g. liaison psychiatry, crisis resolution teams) rather than on-going support. In addition, there is often a focus on risk management rather than emotional support. From these interviews it became clear that these young men would benefit from being able to talk to others about their feelings. It is important to manage risk, but this should not diminish attempts to encourage and facilitate emotional support whether professionally or through friends and family. There is a difficult balance to be found between encouraging clinicians and lay helpers to provide a space for people to talk whilst negotiating the complexities of suicide risk management, bearing in mind the challenges in assessing risk.

### **Concluding remarks**

An assumption that has been held throughout the study is that there is help available for young distressed men if only they could be encouraged to seek help. However, as Michel (2005) notes, some clinicians feel that little can be done to help suicidal people. As discussed, it can be challenging to work with the strong emotions related to their experiences. In addition, their difficulties often relate to being isolated and having few supportive ties to the community. In the absence of a supportive environment, clinicians are limited in the services they can provide. It is important that services continue to develop and refine interventions for working with individuals but also that attention is given to community-based interventions. Programs should be aimed meeting the broader needs of communities as well as providing risk management

strategies and symptom management. For example, through empowering and equipping youth workers, churches and voluntary organisations that have contact with young people, particularly those who are isolated or more at-risk. Tackling the stigmatisation of emotional distress in communities, encouraging young people to share their problems with a confidante and making access to self-help resources are all important strategies. Suicide needs to be addressed at these levels as well as through developing interventions for emotional distress and suicidal behaviour.

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## **Appendix 1**

**Favourable ethical approval:  
Camden and Islington MH & SC Trust**

**Camden & Islington Community Local Research Ethics Committee**

Room 3/14  
Third Floor, West Wing  
St Pancras Hospital  
4 St Pancras Way  
London  
NW1 0PE

19 August 2005

Mr Matthew Richardson  
Trainee Clinical Psychologist  
University College London  
Sub-Department Clinical-Health Psychology  
University College London  
Gower Street  
WC1E 6BT

Dear Mr Richardson

**Full title of study:** Experiences of psychological help-seeking in young men who have attempted suicide

**REC reference number:** 05/Q0511/61

Thank you for responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Alternate Vice Chair, I

**Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

The favourable opinion applies to the research sites listed on the attached form.

**Conditions of approval**

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

**Approved documents**

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application	2	10 June 2005
Investigator CV		(None Specified)
Protocol	1 - November 2004	(None Specified)
Covering Letter		(None Specified)

Peer Review	Nancy Pistrang	31 December 2004
Copies of Advertisements	2	31 July 2005
Participant Information Sheet	2	31 July 2005
Participant Consent Form	2	31 July 2005
Participant Consent Form	1 Audio-taping - May 2005	(None Specified)
Response to Request for Further Information		(None Specified)
Letter of support from Psychiatric Liaison Team		02 August 2005
Supervisor CV		(None Specified)

### **Management approval**

The study should not commence at any NHS site until the local Principal Investigator has obtained final management approval from the R&D Department for the relevant NHS care organisation.

### **Membership of the Committee**

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

### **Notification of other bodies**

The Committee Administrator will notify the research sponsor and the R&D Department for NHS care organisation(s) that the study has a favourable ethical opinion.

### **Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

<b>05/Q0511/61</b>
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<b>Please quote this number on all correspondence</b>
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With the Committee's best wishes for the success of this project,

Yours sincerely

**Chair**

Email:

Enclosures:                      Standard approval conditions  
    Site approval form (SF1)



## **Appendix 2**

### **Participant information sheet and consent forms**



supporting partnership in mental health



**Study Title:** Experiences of help-seeking in young men at times of distress.

**Researcher:** Matthew Richardson, Trainee Clinical Psychologist. **Supervisors:** Dr. Chris Barker, Sub-Department of Clinical Health Psychology, University College London and Dr. Jeff Halperin, Clinical Psychology Department, Royal Free Hospital.

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

***What's this study about?***

This study is looking at what people do to cope at difficult times in their lives when harming themselves or trying to end their lives can become an option. It is about whether they try to get help and what sort of help they want from others.

***What does it involve for me?***

The study involves an interview, lasting about 45 minutes, about your thoughts and experiences of seeking help, or not seeking help, in times when you felt low or stressed out to the point of harming yourself.

***Why do you want to know about this?***

We are trying to find out more about what it is like for young men who have been in distress. We hope that learning about these experiences will help improve our services for young people.

***Do I have to take part?***

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time without giving a reason. Deciding not to take part or choosing to withdraw will not affect any services or support you are receiving in any way.

***Will my taking part in this study be kept confidential?***

The interviews will be recorded and later transcribed, with any identifying information removed. The tapes and transcripts will be used by the research team only. When we publish the research, we will use some brief anonymous excerpts

from the interviews. We shall inform your General Practitioner of your involvement in the study. The only time we would break your confidentiality would be if the researcher was seriously concerned about the safety of yourself or someone else. The researcher will refer you on to the appropriate services should you demonstrate intent to hurt yourself or another.

***What are the possible disadvantages and risks of taking part?***

Talking about your experiences may be upsetting. The interviewer is a trainee clinical psychologist and will be able to support you if you feel upset. At the end of the interview the interviewer will be able to suggest ways in which you can get some additional help if you need it.

***What's in it for me?***

Some people find that taking part in this kind of research is a useful opportunity to talk about something important to them. It is also the chance to contribute your unique and valuable perspective to help improve the services we give to people like yourself. If you do decide to take part you will receive £10 payment for the time that you have given up for the interview.

***What if something goes wrong?***

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms should be available to you.

***What will happen to the results of the research study?***

The study will most likely be published in a scientific journal. No identifying details will be used in the publication. We will send a summary of the results to all participants who request it.

***Contact for Further Information***

If you have any questions or concerns regarding the study please contact Matthew Richardson on [redacted] or by email at [redacted]

**Thank you for taking part in this study.**

If you choose to participate in the study you will be given a copy of this information sheet and a copy of the signed consent form to keep.

**Camden and Islington NHS**  
Mental Health and Social Care Trust



Supporting partnership in mental health



Centre Number:  
Study Number:  
Patient Identification Number for this trial:

### CONSENT FORM

**Title of Project:** Experiences of psychological help-seeking in young men who have attempted suicide.

Name of Researcher: Matthew Richardson. Supervised by Dr. Chris Barker and Dr. Jeff Halperin

- 1. I confirm that I have read and understand the information sheet dated July 2005 (version 2) for the above study and have had the opportunity to ask questions.
- 2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.
- 3. I give permission for my General Practitioner to be contacted and notified of my involvement in this study. I understand that sections of any of my medical notes may be looked at by the researcher (Matthew Richardson) where it is relevant to my taking part in research. I give permission for him to have access to my records.
- 4. I agree to take part in the above study.

Please initial box

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Researcher

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

1 for patient; 1 for researcher



Experiences of psychological help-seeking in young men who have attempted suicide.

**Please read carefully the following information about this interview.**

- The interview will be audio-taped.
- The tapes will be destroyed on or before completion of the study.
- Transcripts will be made of the interviews that will be anonymised such that no identifying information will remain in the transcripts.
- Parts of the transcripts may be used in future in publications relating to the research.
- The transcripts themselves will be destroyed within five years of the interview.

1. I have been given an opportunity to discuss any concerns about the audio-taping of the interview, the making of transcripts, or the use in future publications of the transcripts or part of the transcripts **Yes / No**

2. I consent to the audio-taping of the interview, the making of anonymised transcripts based on the interviews and the use in future publications of parts of the transcripts.

\_\_\_\_\_  
Name of Participant      Signature      Date

\_\_\_\_\_  
Name of Researcher      Signature      Date

<b>Researcher's name:</b> <b>Matthew Richardson</b>  Sub-Department of Clinical Health Psychology, University College London, Gower Street, London WC1E 6BT. Email: _____	<b>Supervisors' names:</b> <b>Dr Chris Barker</b> <b>Dr Jeff Halperin</b>
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## **Appendix 3**

### **Interview Protocol**



**Sub-department of Clinical-Health Psychology  
University College London**

**“Experiences of psychological help-seeking in young men  
who have attempted suicide”**

**Semi-structured interview protocol**

**Matthew Richardson  
10.10.05**

Preamble:

“The purpose of this interview is to find out about your views and experiences of getting help when you’ve got a problem. I am interested in finding out what it is like for people when suicide becomes a possibility and what makes people more or less likely to get help when this happens. I will be asking about your own experiences of a time when this was relevant for you, whether you spoke to anyone about how you were feeling and what help you did or didn’t want at the time. The interview will take about an hour and will be recorded. We can stop at any time if you find the interview upsetting or for any other reason. Everything we talk about is confidential and written reports will have your name and other details changed. I will only have to let someone else know about what you say if you are at risk of harm to yourself or someone else, but we can discuss this together should the issue arise.”

**Current Circumstances:**

1. I don't know much about what lead to you being in hospital, could you tell me briefly what happened?

*Alternative for those not recently attending A&E:* Could you tell me briefly about a time when you attempted to end your life; about what was going on for you at the time and what happened?

1.1. What was going on for you that made you think that death was a way out?

1.2. Did you tell anyone about how you are feeling?

-(If no-one) What do you think the reasons are for you not telling anyone?

-(If you did) Who did you speak to? Why did you choose them?

-What was it like talking to them?

-What was helpful/unhelpful?

-What were you hoping to happen from speaking to someone?

1.3. Did you try to get any other help?

-(If none) What prevented you from looking for help?

-What would have made getting help more likely?

-(If so) How would you describe the help you got?

1.4. Looking back, what sort of help would you have liked to have got either at the time or earlier on?



**General questions about help-seeking:**

2. Generally speaking, what are your views about getting help when you've got a problem?

2.1 What do you tend to do when you've got a problem?

2.2 What about if you're stressed or down?

3. Who do you talk to when you've got a problem you want some help with?

-What is it about them that makes you more likely to go to them?

3.1 What do you look for in someone to talk to if you need some help?

-Someone to listen to you, advice, money. . .

3.2 What makes getting help easier for you?

3.3 What makes it harder or less likely?

3.4 Are there people that you would avoid talking to about your problems?

-What is it about them that makes you not want to talk to them?

**Psychological Help-seeking:**

4. Have you had any experiences of getting what some people call psychological help, for example, from a counsellor, psychologist, psychiatrist or psychotherapist?

4.1. Whose idea was it for you to get help?

4.2. What did you think about getting help at the time?

4.3. Could you tell me about how these experiences have been for you?

-How did you end up getting help from . . . ?

-How would you describe the experience?

-What was helpful about seeing this person?

-What was unhelpful?

- What do you think could have been done differently?
- Would you try and get that kind of help again?
- What enabled you or encouraged you to get help?

**More General Questions about the experience of feeling suicidal**

5. In your own words, how would you describe what it feels like to be at the point of attempting suicide?

Prompt: What thoughts go with it?

What images?

- 5.1. What were your options at the time?
  - 5.2. What are some of the things that have kept you going in the past when times have been difficult?
  - 5.3. If you were to have a similar experience in the future what do you think you would do differently?
  - 5.4. What would you say to someone like you who was at the point of committing suicide?
6. What do you think could be done differently by services to help someone in a situation like you were in?
7. Is there anything important that we've missed that would be good to talk about?
8. How has it been today talking about this?

## **Appendix 4**

### **Interview excerpts**

## Excerpt from interview with Participant 2

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Int: And you said you found it hard to go to your parents at that time, could you tell me why, cos it sounds like you have an ok relationship with them?

P2: Well, I've got a really good relationship with them strangely enough, I felt like I didn't want to let them down, I felt like I'd let myself down er and I'd always done very well, although I left school not in a great position but since leaving school I started off at the bottom and sort of worked my way up in jobs, done everything that I said I was going to do, travelled around like I said I was going to do, I spent time in Australia, come back, I worked over there for two years, then got another good job, I just felt, not only had I let myself down, I really let them down, er, and I just, to face them was like another notch in the coffin, it was just like, can I deal with that, to go them was like really putting my hands up to it and saying this is what shit state I'm in really, that's what it would have felt like. Which I should have done before, 'cos literally as soon as I done it, it made me feel better, it wasn't as bad as I thought it was going to be, they were very supportive and stuff like that, so that has been the best side of it you know, that I know that I've got terrific parents. The problem is that I just didn't want to let them down. So, if I would have told them, it would have been like owning it up to myself, I think I couldn't accept any more that I, I, . . . because of the panics I made myself feel useless you know, 'cos I say, 'cos of the travelling around the world I got to the point where I couldn't even travel on the tube, so you think "how on earth am I in this position now?" you know from how I was six months ago. And you don't think, "oh, I can get back there, you just see like well if I've got in this state within that amount of time, where am I going to be in that amount of time? so you start to push your family and friends away from you 'cos you don't want them to see you go into that decline. That's what I thought I was going into.

Int: So, there was a sense of keeping them at bay, so you didn't have to own up to them but also to yourself [yourself]

P2: Most definitely, yeah.

Int: What would you have been owning up to?

P2: Er, I dunno, I really dunno, losing it really, and I think because I was treating myself with alcohol, because that's the only way I could deal with the panic attacks er was when you had a drink it seemed to pass which is the wrong thing, because the next day they come back with a vengeance but for example, I was self-medicating myself really er so not only did I think it was the panic attacks I thought oh I've lost all this because I'm a piss head, you know what I mean er when that wasn't the fact you know, it was just that that was the only way I could treat myself at the time when no one would see ya. You know, when you couldn't even get a doctor I was [inaudible] had to have a drink. I just felt like I failed myself in that way as well, I should have seeked help long before and maybe erm I wouldn't have got in the position I was in.

## Excerpt from interview with participant 5

---

Int: Right, so what do you think was happening that made, to the point that you felt like you had to end it all?

P5: Just felt like there was no where to turn. I had nowhere to go, there was nothing in front of me. [mm] everything was just coming in the sides and it was just no where, no outcome, there was no finishing line.

Int: Mm, sure, so there was no where else to go, so you just felt like you needed to end it?

P5: Mm

Int: And did you let anybody know how you were feeling at that time?

P5: No, I'm not a, I don't really show my emotions,

Int: Yeah, so, erm, you don't really show your emotions, so that's one reason why you didn't let other people know, what other reasons do you think stopped you from telling anybody what was happening?

P5: 'cos I didn't want anybody to feel sorry for me, I didn't want them to think I was in the self pity mode or something like that, you know what I mean?

Int: Mm

P5: I just, I don't, I don't really know

Int: Yeah, so you really didn't want people to show sympathy, I think and to see you as being self-pitying basically

P5: Yeah

Int: What would be so bad about people thinking that about you? Why would that seem so bad, for people to see that you were having a rough time?

P5: It would make me look weak; it would make me look like a weak kind of person, at this time I didn't want to be portrayed as a weak person

Int: Mm, Mm

P5: But now I realise this, you cannae, you cannot go on like that, you know what I mean

## **Appendix 5**

### **Data analysis stage 1**

**IPA analysis stage 1****Extract from P2**

- 
- |   |  |
|---|--|
| <ul style="list-style-type: none"><li>• <b>Let myself down</b></li><li>• <b>Let others down</b></li><li>• <b>I can't cope with letting people down</b></li><li>• <b>Owning up to the shit state I'm in</b></li><li>• <b>Disclosing not as bad as I thought it would be</b></li><li>• <b>I've got good parents</b></li><li>• <b>I didn't want parents to know</b></li><li>• <b>Didn't want to let people down</b></li><br/><li>• <b>Owning up to others means owning up to self</b></li><li>• <b>Feeling useless</b></li></ul> | <p>P2: ...I just felt, not only had I let myself down, I really let them down, er, and I just, to face them was like another notch in the coffin, it was just like, can I deal with that, to go them was like really putting my hands up to it and saying this is what shit state I'm in really, that's what it would have felt like. Which I should have done before, 'cos literally as soon as I done it, it made me feel better, it wasn't as bad as I thought it was going to be, they were very supportive and stuff like that, so that has been the best side of it you know, that I know that I've got terrific parents. The problem is that I just didn't want to let them down. So, if I would have told them, it would have been like owning it up to myself, I think I couldn't accept any more that I, I, ... because of the panics I made myself feel useless you know...</p> |
|---|--|

**Extract from P5**

- 
- |  |  |
|--|--|
| <ul style="list-style-type: none"><li>• <b>I felt trapped, with nowhere to go and no end in sight</b></li></ul>  | <p>P5: Just felt like there was no where to turn. I had nowhere to go, there was nothing in front of me. [mm] everything was just coming in the sides and it was just no where, no outcome, there was no finishing line.</p> <p>Int: Mm, sure, so there was no where else to go, so you just felt like you needed to end it?</p> <p>P5: Mm</p> <p>Int: And did you let anybody know how you were feeling at that time?</p> |
| <ul style="list-style-type: none"><li>• <b>I don't really show my emotions</b></li></ul>   | <p>P5: No, I'm not a, I don't really show my emotions,</p> <p>Int: Yeah, so, erm, you don't really show your emotions, so that's one reason why you didn't let other people know, what other reasons do you think stopped you from telling anybody what was happening?</p>   |
| <ul style="list-style-type: none"><li>• <b>I don't want anyone to feel sorry for me</b></li><li>• <b>I don't want to be seen in self pity mode</b></li></ul> | <p>P5: 'cos I didn't want anybody to feel sorry for me, I didn't want them to think I was in the self pity mode or something like that, you know what I mean?</p>  |

## **Appendix 6**

### **Data analysis stage 2**



## IPA analysis stage 2

### Extract from P2

P2: ...I just felt, not only had I let myself down, I really let them down, er, and I just, to face them was like another notch in the coffin, it was just like, can I deal with that, to go them was like really putting my hands up to it and saying this is what shit state I'm in reality, that's what it would have felt like. Which I should have done before, 'cos literally as soon as I done it, it made me feel better, it wasn't as bad as I thought it was going to be, they were very supportive and stuff like that, so that has been the best side of it you know, that I know that I've got terrific parents. The problem is that I just didn't want to let them down. So, if I would have told them, it would have been like owning it up to myself, I think I couldn't accept any more that I, I, ... because of the panics I made myself feel useless you know...

- **Ashamed of letting myself and others down**
- **I can't cope with being seen as a failure**
- **Learning to open up**
- **Supportive parents**
- **Ashamed of letting people down**
- **Owning up to others meant owning up to myself**
- **Feeling ashamed**

### Extract from P5

P5: Just felt like there was no where to turn. I had nowhere to go, there was nothing in front of me. [mm] everything was just coming in the sides and it was just no where, no outcome, there was no finishing line.

Int: Mm, sure, so there was no where else to go, so you just felt like you needed to end it?

P5: Mm

Int: And did you let anybody know how you were feeling at that time?

P5: No, I'm not a, I don't really show my emotions,

Int: Yeah, so, erm, you don't really show your emotions, so that's one reason why you didn't let other people know, what other reasons do you think stopped you from telling anybody what was happening?

P5: 'cos I didn't want anybody to feel sorry for me, I didn't want them to think I was in the self pity mode or something like that, you know what I mean?

- **Feeling trapped and hopeless**
- **I don't show my emotions**
- **I don't want people to feel sorry for me**
- **Ashamed of being in need**

## **Appendix 7**

### **Data analysis stage 3**

**IPA analysis stage 3****Extract from P2**

P2: ...I just felt, not only had I let myself down, I really let them down, er, and I just, to face them was like another notch in the coffin, it was just like, can I deal with that, to go them was like really putting my hands up to it and saying this is what shit state I'm in reality, that's what it would have felt like. Which I should have done before, 'cos literally as soon as I done it, it made me feel better, it wasn't as bad as I thought it was going to be, they were very supportive and stuff like that, so that has been the best side of it you know, that I know that I've got terrific parents. The problem is that I just didn't want to let them down. So, if I would have told them, it would have been like owning it up to myself, I think I couldn't accept any more that I, I, ... because of the panics I made myself feel useless you know...

**Theme 4: I'm too ashamed to share problems**

**Theme 9: making sense of what's happened and moving on**

**Theme 4: I'm too ashamed to share problems**

**Extract from P5**

P5: Just felt like there was no where to turn. I had nowhere to go, there was nothing in front of me. [mm] everything was just coming in the sides and it was just no where, no outcome, there was no finishing line.

**Theme 1: the feelings are overwhelming**

Int: Mm, sure, so there was no where else to go, so you just felt like you needed to end it?

P5: Mm

Int: And did you let anybody know how you were feeling at that time?

P5: No, I'm not a, I don't really show my emotions,

Int: Yeah, so, erm, you don't really show your emotions, so that's one reason why you didn't let other people know, what other reasons do you think stopped you from telling anybody what was happening?

**Theme 4: I'm too ashamed to share problems**

P5: 'cos I didn't want anybody to feel sorry for me, I didn't want them to think I was in the self pity mode or something like that, you know what I mean?

### Stage 3 Cont.

#### Some excerpts coded under theme 4: "I'm too ashamed to share problems"

##### P1

P1: More family for me, which is not so bad but erm, harder with friends 'cos erm, obviously not lots of young people my age know about mental illness and I haven't told them about my health problems I just don't feel comfortable with them knowing kind of thing. And I think they might look at me in a different light, so that's been difficult as I've always been a bit secretive and it doesn't really help because erm, it kind of like makes me look at myself and think am I alright today, do they notice anything and I'm constantly a bit paranoid, not now but erm, over the four years that's how I've been, I've been a bit paranoid.

##### P2

I really really thought I was going mad, I really thought I was schizophrenic or something, thought that something's not right. And then obviously you don't want to talk to people about that you know, you don't want to say to people I have these terrible... where I don't even know me own name and I've you know, these terrible thoughts in my head, I've you know, you feel like you've murdered someone do you know what I mean, the kind of terror, you feel that you've done something so bad when really you haven't [mm] you know what I mean?

...

I just felt, not only had I let myself down, I really let them down, er, and I just, to face them was like another notch in the coffin, it was just like, can I deal with that, to go them was like really putting my hands up to it and saying this is what shit state I'm in really, that's what it would have felt like.

...

. The problem is that I just didn't want to let them down. So, if I would have told them, it would have been like owning it up to myself, I think I couldn't accept any more that I, I, . . . because of the panics I made myself feel useless you know, 'cos I say, 'cos of the travelling around the world I got to the point where I couldn't even travel on the tube, so you think "how on earth am I in this position now?" you know from how I was six months ago. And you don't think, "oh, I can get back there, you just see like well if I've got in this state within that amount of time, where am I going to be in that amount of time? so you start to push your family and friends away from you 'cos you don't want them to see you go into that decline. That's what I thought I was going into.

##### P5

P5: 'cos I didn't want anybody to feel sorry for me, I didn't want them to think I was in the self pity mode or something like that, you know what I mean?

...

P5: It would make me look weak; it would make me look like a weak kind of person, at this time I didn't want to be portrayed as a weak person

...

P5: Aye, I've got a wee paranoia bugging me, I get paranoid with people. I think I'll tell them something and they'll go and laugh at me, that's the way it goes sometimes. That's the part I need to get rid of in my head, need to get rid of the paranoia, but I don't know how.

##### P7

P7: ... I would just briefly tell them what was going on and even people closer to me again, just briefly tell them what was going on but not really give them an insight in to what was going on, because it was again, about I wouldn't say ego

as such, well perhaps at was, maybe it was not false pride, because I hate to think that I'm superficial but in terms of my self-worth I didn't want to be seen as being a failure then it would just further confirm my lack of success in my own mind, if I'm actually talking about, you know, this deal has failed, this hasn't gone through, to where it should do it was further acknowledgement I my own mind, you know, I didn't want to be negative, you know, I wanted to be optimistic about the situation, erm, but what I found that as more doors started closing my own doors to people in my life

...

MR: Obviously it was hard to tell your mum up until when you did but, what stopped you from talking to your brother or someone else who was close to you?

P7: I think just the fear of rejection and failure, you know, because I didn't want to present that to them, and certainly not present that to them without an option, saying, OK, I failed but I'm doing this, you see, because I had nothing, I had lost the ability to really think clearly

**P8**

MR: What was it that stopped you from being around people when things started to get tougher?

P8: Erm, are they gonna judge you the way that the doctors judged you, the way that er, the way that the social services have judged you in the past, the way that other people have judged you and it's like hard really.

MR: Yeah, yeah, what sort of judgements did you imagine they might be making?

P8: Erm, like, like from the doctor, is it just in my imagination? Am I just thinking this or do I really feel it? Everything's just going round and round in my head, and, you know, I suppose, I didn't want to go near anyone because of the sense of guilt and stuff

...

P8: ...when you are a male in your mid-twenties, late twenties, you're meant to get on with it and that's the stigma of society, you're meant to just get on with it and face reality but you don't get the help, you don't get the help you want, and at the time you don't know really what help you want, apart from people being real and maybe wanting to listen, you know, that 's a step isn't it, people wanting to listen

**P9**

MR: How did you imagine people would have reacted if you had told am that you had really got to the end of it all?

P9: They'd think I was weak, that I wasn't able to deal with my problems, (14-9)

**P12**

he asked how I was, I said oh, not feeling that great and I think he just thought like because it was a rainy day or something and he said , well at least you're not kind of, sort of joked, at least you're not suicidal or something, I thought well, I didn't tell him because I didn't feel able to tell him, but I was actually feeling suicidal, but just because he'd made that joke I wasn't able to tell him