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MAJOR RESEARCH PROJECT

Chloe Isbister BSc

YOUNG PEOPLE, SELF-HARM AND HELP-SEEKING

Section A:

Section A: What are the attitudes and beliefs that serve to enhance or inhibit the help-seeking behaviour of young people who self-harm and have thoughts of suicide? (Word count: 5436)

Section B:

Young men's experiences of accessing and receiving help from child and adolescent mental health services following self-harm.
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Section C:

Critical Appraisal. (Word count: 1981)

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A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology
July 19th 2013

DEPARTMENT OF APPLIED PSYCHOLOGY CANTERBURY CHRIST CHURCH UNIVERSITY

CANTERBURY CHRIST CHURCH UNIVERSITY
Doctorate in Clinical Psychology (D.Clin.Psychol.)

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Firstly, I would like to thank the young men who participated in this study. The opportunity to share in their experiences has been fascinating and inspirational.

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Summary of portfolio

This work considers help-seeking for self-harm in young people.

Section A evaluates the literature into young people's attitudes about help-seeking for self-harm and suicidal ideation. Young people predominately expressed barriers to help-seeking including poor perception of need, lack of faith in sources of help, cost to self and fear of consequences (i.e. stigma). A limited number of factors that facilitate help-seeking were expressed. Limitations of the literature are identified and areas for further developments within the field of help-seeking by young people who self-harm are identified.

Section B presents a qualitative study that considers how young men, who have self-harmed, experience help-seeking from child and adolescent mental health services. Following semi-structured interviews, five dominant themes were identified that described factors that facilitated initial help-seeking and on-going engagement in services. This provided the framework for the development of a model of help-seeking by young people that considers the influence of intra-personal and inter-personal influences on help-seeking within a two-stage process (initial access and on-going engagement). Clinical implications, ideas for future research, and limitations of the study are discussed.

Section C provides a critical reflection on the process of conducting this research. This section considers the development of skills, possibilities for approaching the work differently, clinical applications of the research and future directions for conducting research.

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Section A:

Section A: What are the attitudes and beliefs that serve to enhance or inhibit the help-seeking behaviour of young people who self-harm and have thoughts of suicide?

Word Count: 5436

Abstract

Aim: The rising rate of self-harm and suicidal ideation amongst young people is concerning, particularly in the context of low help-seeking. This has raised considerable interest into researching the factors that prevent help-seeking in young people. Despite this, there has been a preponderance for studies to privilege measurable demographic characteristics of help-seekers. This has led to a dearth of information about more dynamic factors associated with help-seeking including attitudes and beliefs. This review evaluates the literature which addresses young people's beliefs about seeking help for self-harm.

Method: A systematic search of electronic data-bases was carried out to identify studies that considered beliefs, attitudes and values of young people about help-seeking for self-harm and suicidal ideation. References and citations of relevant articles were also inspected for additional studies.

Results: Nine studies were identified as relevant to the review based on inclusion and exclusion criteria. This included two qualitative studies, four quantitative studies and three mixed method studies. Young people predominately endorsed barriers to help-seeking including poor perception of need; independent coping and self-reliance; lack of confidence in others' ability to help; fear of the consequences and cost to self and social status.

Research implications: Since barriers into help-seeking dominate this field of research, future research is indicated to explore the factors that facilitate help-seeking. Additionally, young men were highlighted as an important group to research further given their high risk of suicide but lower likelihood of seeking help. Finally, further studies that utilise a qualitative design were indicated given the rich information this affords for learning about lived experiences.

Introduction

Research over the past decade has explicated the magnitude of self-harm and suicidal ideation amongst our younger generation. In their meta-analysis of population-based studies of self-reported suicidal phenomena, Evans, Hawton, Rodham and Deeks (2005) found that of half a million young people, 29.9% had a prevalence of suicidal ideation. Similarly, results from a large scale study of self-harm across 41 UK schools indicate a prevalence of self-harm in 13.2% of 15-16 year olds (Hawton, Rodnham, Evans & Weatherall, 2002). These data are concerning given the negative consequences on psychosocial behaviour (Fergusson & Woodward, 2002; Gratz, 2006). Raising most concern is that suicide is believed to be 30-40 times more likely in people who self-harm than in the general population (International Association for Suicide Prevention, 2012).

Despite the risks associated with self-harm and suicidal ideation, research indicates that young people experiencing these difficulties demonstrate lower intentions to seek help than for other emotional difficulties such as anxiety or depression (Costello, Burns, Angold & Leaf, 1993; Biddle, Gunnell, Sharp & Donovan, 2004). This paradox has resulted in a surge of interest into understanding the perceived barriers to help-seeking for self-harm and suicidal ideation in order to appropriately identify and treat those in need (NICE, 2011; National Suicide Prevention Strategy, DH, 2012

Within the field of help-seeking, there has been a focus on measuring demographic characteristics (age, gender, family support) in order to predict likely help-seeking or non-help seeking behaviours. Whist this approach is valuable in that it produces data that can be translated into targets for policy development (Biddle, Donovan & Gunnell, 2007), it

overlooks the dynamic, internal processes that are involved in help-seeking including personal beliefs and attitudes.

This review will be the first to explore the intrapersonal factors (attitudes and beliefs) that influence help-seeking for self-harm and suicidal ideation. Firstly, descriptions of self-harm, suicidal ideation and help-seeking will be given. This will be followed by a review of two models of help-seeking, identified via a comprehensive literature search, as specific to young people or self-harm. Empirical literature concerning young people's beliefs regarding help-seeking for self-harm and suicidal ideation will then be reviewed. Finally, consideration will be paid to the clinical and research implications of the findings of this review.

Defining self-harm and suicidal behaviour

Recent guidelines for the long-term management of self-harm, developed by NICE (2011) adopt a broad definition of self-harm “self-poisoning or self-injury, irrespective of the apparent purpose of the act” (p. 16). A definition of suicidal ideation has not been formally developed, but commonly refers to thoughts of ending one's life.

Defining help-seeking:

In the context on mental health difficulties, help-seeking refers to “the process of using informal and professional networks to gain support in coping with mental health problems” (Michaelmore & Hindley, 2012). It is believed to be a coping behaviour in response to a problem or distressing experience that relies on social interaction with another person in order to obtain advice, information, treatment and support (Rickwood, Deane, Wilson & Ciarrochi, 2005). Help can be sought from informal sources including family, peers and the internet and from formal sources such as trained healthcare professionals, teachers and youth

workers. There is no literature that conclusively reveals that seeking help from one source is more helpful than another. Despite the wide range of pathways to seeking help for emotional difficulties, research exploring this behaviour has predominately focused on formal pathways.

Formal help seeking by young people for self-harm

Epidemiological data consistently concludes that the majority of self-harming behaviours do not reach the attention of professional services (Hawton et al, 2006; Meltzer 2001). Whilst data from UK hospitals suggests that around 25,000 young people present to Accident and Emergency (A&E) each year following self-harm (Hawton, et al., 2006), findings from population-based studies indicate that hospital data represents only 10-20% of the actual cases occurring in the general population of young people (Ystgaard, et al., 2009) and that self-harm might be between 20 to 50 times higher than suggested by hospital admission rates (Rossow & Wichstrom, 2009).

Whilst young people may seek help from various places (General Practitioners, School Counsellors, voluntary services), only 60% of young people in the UK, who experience severe mental health problems, are believed to receive support from specialist services (CAMHS National Service Framework, 2004). One may assume, therefore, that a large proportion of young people who self-harm or who experience suicidal ideation do not receive appropriate support. This highlights a discrepancy between need for help and help received.

Characteristics associated with help-seeking for self-harm

A recent meta-analysis by Michaelmore and Hindley (2012) has provided a thorough review of the characteristics commonly associated with successful help-seeking for self-harm by young people. This includes; the presence of suicidal ideation, being female, alcohol use in

females and drug use in males, parental detection of self-harm, greater service provision, not being from an ethnic minority group, older age and negative life events (i.e. bullying). Whilst this review provides a very concise synthesis of the demographic determinants of help-seeking for self-harm, it considers only quantitative, demographic-based studies. This may overlook the rich information that can be gained from exploring dynamic variables associated with help-seeking, for example, by asking specifically about beliefs, values and attitudes.

Theoretical models of help-seeking

A wide range of theoretical models have been proposed to understand the complex process of help-seeking. Historically, the most influential models used for informing empirical research were developed by Anderson and colleagues (Aday & Anderson, 1974; Anderson, 1968; Anderson & Newman, 1973; Anderson, 1995). These models have tended to be deterministic and have relied on identifying measureable characteristics of service users in order to predict service use (Costello, Pescosolido, Angold & Burns, 1998). Characteristics include 1) predisposition to using services (age, gender, education, ethnicity); 2) enabling factors (availability of services, income, travel); and 3) need (lay person and professional perception of need) (Anderson, 1995). This deterministic approach has been criticised for being static focusing only on if help is sought and by whom, and failing to explain the processes involved in help-seeking from a social and phenomenological perspective.

Dynamic approaches have been developed to address the criticisms of the traditional models and describe help-seeking as a process of progressing through different stages (Murray, 2005). In contrast to the deterministic models, many of the dynamic approaches consider how experiences of illness are understood and acted on by individuals and their wider social context, which, according to Young (2004) is crucial, since the social environment can act as

a means of facilitating or inhibiting the interaction between individuals and formal help providers. A particularly influential “dynamic” model developed by Pescosolido (1992) is the Network Episode Model, a stage-process model which seeks to explore the process of how help is sought.

Models for young people

A common critique of help-seeking models is that they are predominately developed based on adult samples (Murray, 2005). The traditional models, therefore, do not take into consideration the systems that surround a child and the impact that this may have on the help-seeking journey of a young person, compared to an adult (Murray, 2005). Nor do they adequately consider how age related cognitive and emotional development may impact on the process of identifying the need for help and acting on this need.

In this next section, two models of help-seeking are described. These models have been chosen for discussion given that one is adapted specifically for young people and based on a highly influential adult model and the other is specific to help-seeking for self-harm. Both models consider the social context of help-seeking.

Costello et al (1998) ‘*Network Episode Model - Revised*’

The highly influential Network Episode Model (Pescosolido, 1992) emphasises that help-seeking is a socially constructed decision determined by the beliefs, assumptions and values of the social network (family, friends and organisations). Interaction with the network leads to beliefs about what causes mental illness, acquisition of information (where can one obtain help) and the development of subsequent action scripts (whether or not to seek professional

help). The network, therefore, influences identification of a problem as well as what can be done about it (Pescosolido, 1992).

In the revised model, (Network Episode Model-Revised; NEM-R) Costello et al (1998) made a number of critical modifications to account for the complex network that surrounds a young person (Fig. 1. items in bold). Costello et al (1998) highlighted the difference in autonomy and agency that children and adults have over their health care. For example, in comparison to adults who are likely to draw support from their network, but be an active agent in their help-seeking journey, young people are likely to have agents acting on their behalf (Costello et al, 1998). The fundamental modification to account for this difference is therefore incorporation of the family and the school at the centre of the help-seeking pathway.

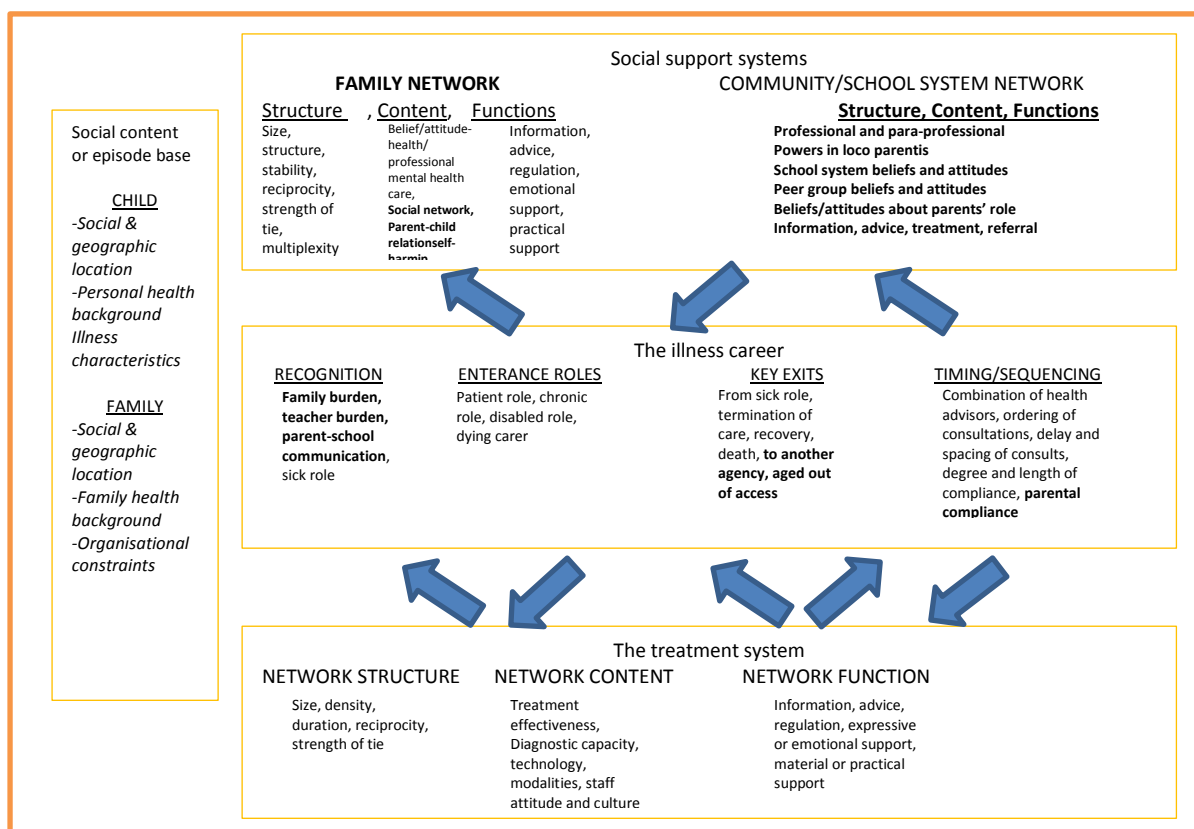


Figure 1. Network-Episode Model - Revised

A criticism of this model may lie in its generalisation to all young people and, therefore, the potential to ignore the variance that might be observed between the developmental stages of childhood and adolescence. For example, a key task during the developmental stage of adolescence is to develop independence so as to reduce reliance on parents (Allen & Land, 1999). This is supported by research that indicates that peer support is the most common form of help sought by adolescents, with up to 90% reporting that they would access their peers rather than a professional or parent when in times of distress (Kalafat & Elias, 1995; Offer, Howard, Schonert & Ostrov, 1991). This brings into question the primary focus of the model on the influence of parents and the school.

Biddle et al (2007) 'Cycle of Avoidance'

In contrast to the NEM-R, in which inter-personal experiences are central to facilitating help-seeking, Biddle et al (2007) developed a model that describes the intra-personal influence on non/help-seeking (i.e. attitudes and beliefs). Whilst this model was developed to describe the process of non-help-seeking for young people with general emotional distress, it was developed based on interviews with young people aged 16-24, who had experienced self-harm and suicidal ideation. This, therefore, offers a crucial insight into the field of help-seeking for self-harm.

The Cycle of Avoidance (COV) (Figure 2.) presented help-seeking as a circular process, which is dependent on four main concepts; 1) Lay diagnosis which involved working out whether their distress was 'normal' and required no intervention, or 'real' and required action.; 2) Normalising and coping; 3) Defining and redefining need and 4) Considering the social meanings attached to distress and help-seeking (i.e. stigma).

Through focusing exclusively on the intra-personal world of young people in distress, the COV advanced on the traditional stage process models of help-seeking by placing value in individual experience and by explicitly exploring the cognitive processes that are influential in help-seeking.

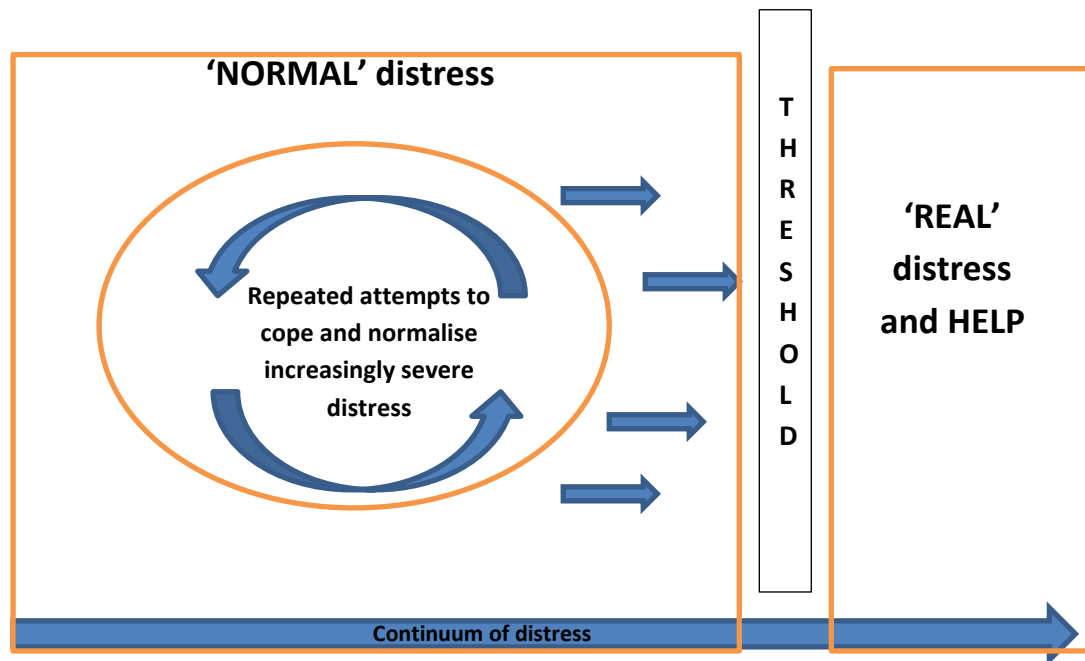


Figure 2. The Cycle of Avoidance

Summary

Research indicates that self-harm may be associated with eventual suicide and that intentions to seek help are lower in young people who self-harm compared to their peers with emotional problems alone. Whilst a range of theoretical models have been developed to explain help-seeking by young people for self-harm, deterministic approaches appear to have been privileged, which attempt to profile help-seekers based on measurable demographic characteristics (see Michaelmore & Hindley, 2012). A need was, therefore, identified to explore the influence of dynamic, intrapersonal factors (values, beliefs and attitudes) on the journey of help-seeking for self-harm in young people.

Aim

This paper aims to comprehensively review the limited literature base that seeks to establish the process by which young people reach services following self-harm and suicidal-ideation, by exploring the beliefs, values and attitudes that appear to influence whether formal help is sought or not.

Method

A systematic literature search was conducted using Ovid, Psych-info and Science Direct.

The following search terms were used:

- Young people OR Adolescents
- AND Self-harm OR self-injury OR non suicidal self-injury (NSSI) OR NSSI OR suicidal ideation
- AND Help-seeking

Results were inspected for their suitability against the following inclusion criteria (Appendix. B):

- Sample aged between 14-24 must indicate a mean age that is between 16-18
- Asked specifically about attitudes and beliefs regarding seeking help for self-harm or suicidal-ideation
- Written in English Language
- Research study only (not systematic review or meta-analysis)

The search returned nine studies that met criteria for inclusion to the review (see Appendix. A for search strategy).

Review

The first section of this review explores the attitudes and beliefs of young people about help-seeking for self-harm or suicidal ideation. This begins with an in-depth exploration of the barriers to help-seeking, structured according to themes, and ends with a brief consideration of the facilitators. The extent to which the themes reflect the NEM-R and COA models of help-seeking is considered throughout. Throughout this section, help-seeking refers to all help sources and does not differentiate between formal and informal help-seeking unless specified. Following this, a methodological critique of the papers will ensue, which will be followed by a discussion of pertinent issues and implications, including clinical recommendations.

Attitudes and beliefs that influence help-seeking

Perception of the episode of self-harm or suicidal ideation

Many studies have demonstrated that a key variable in deciding whether to seek help, or not, is the perception of need (Mojtabai, Olfson & Mechanic, 2002). A person may perceive their experience to be a legitimate problem that requires outside intervention, or as an insignificant issue with which they believe they can cope. A number of studies reported attitudes pertaining to the latter.

Freedenthal and Stiffman (2007) recruited young people from a longitudinal study ‘American Indian Multi-Sector Help Inquiry’ (AIM-HI), who had reported in their yearly interview (2003) that they had thought about or attempted suicide in their lifetime. Participants were asked “what stopped you from seeking-help” and were offered the opportunity to express, in their own words, their beliefs about barriers to seeking help. A thematic analysis of the

qualitative data revealed “did not perceive the need for help” as the most common barrier to help-seeking.

Also using open ended questioning, Fortune, Sinclair & Hawton (2008) sought to find out what young people, who had previously engaged in self-harm, perceived as the barriers to their help-seeking. Over five thousand young people between the ages of 15-16 from 41 secondary schools in the UK took part in this study, of which 10.3% had a lifetime history of self-harm. Participants who denied seeking help for suicidal ideation were asked “Why didn’t you try to get help?” A grounded theory analysis of the responses to this open ended question revealed three beliefs “Spur of the moment”, “Not that serious or important” and “My choice”. These beliefs were more frequently expressed by boys, which may reflect the difficulty that males experience in recognising their own experiences of distress (Jordan et al., 2012) and their tendency to perceive their difficulties as less severe than females (Biddle et al., 2004).

Gould et al. (2009) sought to investigate the barriers to help-seeking of school pupils who had refused uptake of a referral to services after expressing suicidal ideation. Participants were secondary school children involved in a Randomised Control Trial to investigate whether asking about suicide increases distress in young people. A follow up questionnaire about barriers to help-seeking was administered to 24. Results revealed beliefs including “Do not have a problem”, “Problem is not serious enough”, “Thought it would get better”.

Perception of need is reflected in both models of help-seeking (NEM-R and COA). Costello et al (1998) emphasised that young people are not proficient at recognising their own problems and that a parent or influential adult is crucial in the recognition of the young

person's need for help. Biddle et al (2007), explain that difficulties with problem recognition results from polarised norms about distress as either 'real' and therefore requiring help or 'normal' and therefore not in need of help. They indicated that young people lack a benchmark for where 'normal' distress ends and 'real' distress begins.

Coping/self-reliance

As may be expected, given what we know about the stage of adolescence being one of a growing need for independence (Erikson, 1963) a number of studies identified attitudes and beliefs about the importance of coping independently.

Gould et al. (2004) aimed to identify youth's attitudes about coping and help-seeking for suicidal ideation. Over two thousand school pupils were asked "What would you do if a friend tells you he/she is thinking about killing themselves?". Participants were asked to rate statements about help-seeking with either 'Yes' or 'No'. A factor analysis was carried out on the responses and yielded three factors "Maladaptive coping strategies", "Help-seeking strategies" and "Suicidal normalization". Results revealed support for attitudes pertaining to self-reliance "Should be able to handle problems on your own" and "Good idea to keep feelings to yourself". Boys were significantly more likely to endorse these views.

Cigularov, Chen, Thurber & Stallones (2008) aimed to identify the barriers to help-seeking by school children who had attended a school-based suicide prevention programme. All attendees were asked to complete an evaluation questionnaire, which asked "If I was suicidal or depressed, I would not seek help because..." and offered an option of 26 potential barriers to help-seeking. A number of 'self-reliance' statements were endorsed including "I believe I can handle my problems on my own".

Self-reliance was also a recurrent theme reported by participants in Curtis (2010). This study aimed to investigate university students' attitudes and experiences about seeking help for personal problems including suicidal ideation. An email-based survey and one-to-one interviews yielded attitudes pertaining to self-reliance such as 'You must remain strong'.

A number of beliefs pertaining to coping independently, were specifically endorsed by boys; "I can or should be able to cope on my own" (Fortune et al, 2008) and "[We] can solve it ourselves" (Gould et al., 2009). This may reflect traditional gender role expectations that influence the development of beliefs about the man's need for autonomy such as the need to solve problems alone, to be independent and in control of their emotions (Vogel, Heimerdinger-Edwards, Hammer & Hubbard, 2011).

Neither Costello et al (1998) in their NEM-R model nor Biddle et al. (2007) in their COA model explicitly identified self-reliance or coping as a mechanism in determining help-seeking. Evidence from this review indicates that inclusion of self-reliance and coping may be an integral part of a frame work of help-seeking in adolescence. Therefore absence of its reference in the two models, developed for young people in general, may reflect their poor sensitivity to developmental and gender differences in help-seeking.

Confidence in the emotional availability and skills of potential helpers

Gilchrist and Sullivan (2006) invited young people aged 16-24 to engage in semi-structured interviews to discuss their beliefs and attitudes in response to hypothetical scenarios about suicide and non-help-seeking. Barriers relating to perception of the availability or skills of potential helpers were reported including "Parents might ignore them", "Parents might not understand them" and "Parents might make a big deal".

Molock et al. (2007) conducted focus groups with young American churchgoers to explore the aspects of the church and wider networks that may support or hinder help-seeking for suicidal ideation in young people. Using a vignette to elicit attitudes and beliefs, they identified that lack of confidence in adults' ability to help as a key theme, "Adults might minimise the problem", "Adults might give unsolicited advice", "Adults might over react". Cigularov et al. (2008), found similar results.

In the NEM-R Costello et al (1998) highlighted the role of the network (parents and school) in influencing help-seeking behaviour. Nevertheless, according to this review, whilst the network structures may be in place to facilitate help-seeking, if the young people do not believe in the ability of the networks to help them, they will not access the network.

Fear of the consequences

The impact that seeking-help might have on one's sense of self or social standing is consistently indicated throughout research. This was recognised by Fortune et al (2008) who stated, in their model of help-seeking, that "the individual's motivation to act is influenced by their estimation of the cost benefit ratio of taking action" (p. 8). The cost of seeking help for self-harm or suicidal ideation was demonstrated throughout all but one paper reviewed here.

Cost to self

A mixed methods approach was utilized by Wadman (2010) in an effort to explore attitudes about suicide and help-seeking behaviours. 195 young people who were recruited from community services in Wales took part in workshops designed to elicit awareness of and attitudes about sources of support and completed questionnaires assessing attitudes and barriers to help-seeking. Responses included "Peers might find out". Concerns about stigma

were endorsed in Freedenthal and Stiffman's (2007); Fortune et al (2008); Curtis (2010) and Cigularov et al. (2008). Gilchrist and Sullivan (2006) similarly reported concerns about "Being found out", appearing "Inadequate" or "Inferior". Attitudes about appearing "Weak" were particularly described by young men, which might reflect their desire to uphold the dominant stereotyped characteristics of masculinity (Pederson & Vogel, 2007; Jordan et al., 2012).

Young people's concerns about the way in which help-seeking is perceived by others accurately reflects the process of non-help-seeking identified in the COA (Biddle et al., 2007). Support was not found, however for the process of non/help-seeking outlined in the NEM (Costello et al., 1998) which noted that the beliefs and attitudes of others impacted on the parent, rather than on the young person themselves. This perhaps reflects the developmental sensitivity of the two models, with the COA most accurately representing help-seeking for older and older aged and independent 'young people' and the NEM more appropriately reflecting help-seeking for younger aged more dependent 'young people'.

Facilitators

Whilst help-seeking literature has predominately focused on the attitudinal barriers of young people towards help-seeking, three studies asked young people specifically what would facilitate help-seeking for self-harm and suicidal ideation. Participants identified "Asking others who have been through it but who have had enough experience to help" (Molock et al., 2007), "One to one support", "Better advertising of services", "Break down stigma", "Set up confidential support groups" (Wadman, 2010), "Buddy systems" and "Support groups" (Curtis, 2010).

Neither the NEM-R (Costello et al., 1998) nor the COA (Biddle et al., 2007) specifically considered factors that facilitated help-seeking in young people.

Methodological critique

Caldwell, Henshaw and Taylor (2005) reviewed a range of published frameworks for critiquing quantitative (Sajiwandani, 1996; Polgar & Thompson, 2000) and qualitative (Hammersley, 1992; Mays and Pope, 2000) methodologies and developed a combined framework for assessing both approaches. This framework was used to guide the assessment of the quality of studies included in this review.

Study design and data collection

The majority of studies utilised a questionnaire design, four of which (Cigularov et al., 2008; Gould, 2004; Gould, 2009; Wadman, 2010) used closed questions, yielding quantitative data and three of which (Curtis, 2010; Fortune et al., 2008; Freedenthal & Stiffman, 2007) used open ended questionnaires producing some qualitative data. The four quantitative studies aimed to investigate participants' 'perceptions' and 'attitudes', by employing a closed-question design. Their results reflected the extent to which their sample agreed with preconceived ideas and did not account for subjective meaning. This may therefore contradict the aim of exploring 'attitudes' and 'perceptions'.

Whilst maintaining a questionnaire design, three studies (Freedenthal & Stiffman, 2007; Fortune et al., 2008; Curtis, 2010), captured the subjective attitudes and perceptions of participants by integrating open-ended questions. Although this approach more adequately achieved the aims of the studies, only brief responses were generated and data analysis relied

solely on the researchers' interpretation of participants' responses with no opportunity to check the validity of their interpretations with participants.

Reflexivity

Two studies utilised one-to-one interviews (Curtis, 2010; Gilchrist & Sullivan, 2006) and one (Molock et al., 2007) employed focus groups to gather data. Whilst these approaches offered more in-depth exploration of the phenomena of help-seeking in comparison to the majority of self-report studies, both studies would have benefited from increased reflexivity through considering the ways in which the researcher and the research process could have impacted on the collected data. For example, firstly, given that issues of stigma and the pressure to be perceived as independent and able to cope is consistently reported in this area of research, utilising a focus group design may have encouraged more socially acceptable responses rather than accurate representations of attitudes and beliefs. In this case, the sensitivity of the method might be considered inappropriately matched to the research question. Secondly, the relationship between researchers and participants and the potential impact on responses in both studies was not considered. For example, the first author in Molock et al. (2007) was affiliated with the church from which the sample was recruited and Cigularov et al. (2008) administered their questionnaire as an evaluation of their programme and by the programme trainer. Both of these approaches may have potentially influenced participation and biased attitudes.

Selection of participants

Only four of the 9 studies recruited young people with actual experience of help-seeking for suicidal ideation or self-harm (Gould, 2009; Freedenthal & Stiffman, 2007; Curtis, 2010; Fortune et al, 2008), the remainder asked about intentions to seek help for self or others and

used hypothetical scenarios. Since it is well known that attitudes are not accurately related to behaviour (Gould, 2004) and that there is a disparity between individuals' expressed desire to seek help and their actual willingness to seek help (Raviv, Ravi, Vago-Gefen & Schachter-Fink, 2000), it is possible that basing data collection on non-clinical participants reduces the validity of the data.

Three qualitative studies (Gilchrist & Sullivan, 2006; Molock et al, 2007; Curtis, 2010) recruited participants through posters, leaflets and announcements. Since this approach necessitates that participants actively seek out the researcher to express their interest in the study, a self-selection bias may have existed. As a consequence, the sample may represent young people who are more active in seeking help and may not have been representative of young people in general.

An additional consideration of sampling is the country in which each study was conducted. For example, only two studies were British, five American, one Australian and one New Zealand. Since America, Australia and New Zealand do not offer free health-care, it is possible that this structural barrier may have implicitly impacted on the attitudes and beliefs reported in these studies.

Analysis of data

Whilst the majority of studies utilising a qualitative approach provided adequate explanation of the process by which themes, categories and concepts were derived from the data, a clear exposition of the methods of data analysis was not apparent in a number of studies (Gilchrist & Sullivan, 2006; Wadman, 2010; Freedenthal & Stiffman, 2007; Molock et al., 2007).

Consideration of the reliability and validity of qualitative data was considered to some extent in four studies. Multiple coders, a blind or independent checker and statistical test of inter-rater reliability were used by three studies (Freedenthal & Stiffman, 2007; Molock et al., 2007 and Fortune et al., 2008). Whilst only one rater analysed the data in Curtis (2010), this study used a mixed method approach, which allowed for triangulation of the data, thus bolstering the robustness of the findings.

The quality of the presentation of results was variable amongst studies. The analysis of quantitative data by Wadman (2010), produced only percentages and efforts to carry out any further statistical analysis were not apparent. In addition, whilst it is expected that qualitative studies should satisfy the reader of the relationship between the evidence and the conclusions by presenting examples of discursive data, this same study presented only bullet points of themes.

Discussion

Clinical and research implications

Clinically, the utility of knowledge about the factors that inhibit and facilitate help-seeking for self-harm is vast and can be drawn upon to mobilise the development of new structures for reaching out to those who are not accessing services. In terms of the stigma surrounding help-seeking, education campaigns that detail the prevalence of mental illness and the options for seeking help should be developed and aimed at young people as early as primary school (NICE, 2008). This has most recently been reflected in a campaign by youth charity 'Mindful' (www.mindfulcharity.ca).

Education campaigns should aim to utilise pictures and real-life stories of those who have sought help covering all age ranges and sexes in order to normalise the experience of needing and seeking help (www.time-to-change.org.uk). Where there is an indicated need for specialist mental health services, clinicians might consider offering outreach into schools, GP centres or youth centres in addition to the typical clinic setting. This approach has already been recognised as a successful way of promoting mental health and reducing stigma within the government's primary care 'Targeted Mental Health in Schools' initiative (Barrow, 2011).

The indication that poor perception of need is a barrier to young people's help-seeking, points to the crucial role of other sources of support in enabling recognition of need and facilitating access to services. Clinicians are in a position to consult on the development of public health campaigns that aim to raise awareness of the warning signs of self-harm, provide suggestions about developmentally appropriate ways in which to approach and support a young person who demonstrates self-harm and signpost clear routes for seeking further information and formal help.

Future research

The method by which help-seeking has been researched may have resulted in a propensity to focus on barriers to help-seeking and may have reduced the opportunity for studies to ask young people about what facilitated their help-seeking. For example studies have predominately recruited non-clinical samples and have measured hypothetical help-seeking beliefs through self-report questionnaires. Further qualitative research may be of value that considers the lived experiences of young people who have actually sought, accessed and

received help for self-harm or suicidal ideation as this may offer the opportunity to explore how their story differs.

This review explicated specific gender differences in perceived barriers towards help-seeking and, in line with previous research, highlighted gender norms associated with masculinity as a common attitudinal barrier. This, considered in combination with research that indicates that young men select more lethal methods of self-harm, raises their profile as a particularly risky group of young people. This review therefore, supports the recent development of a number of campaigns, news reports and official documents (NICE, 2011) that have outlined the vital importance of learning about the experiences of young men at risk of self-harm and suicide in order to begin to offer services that may be more suitably equipped to meet their needs. Attempts have already begun in this area by Jordan et al. (2012) who asked adult men about their experiences of seeking help for self-harm and suicide. Extending this research specifically to young men, however, is of value given that developmental influences may impact help-seeking differentially.

Conclusion

There is now a substantial body of research investigating how help-seeking for mental health difficulties is influenced by attitudes, beliefs and values. This paper reviewed nine empirical research articles that have sought to examine the beliefs and attitudes of young people about seeking help for self-harm and suicidal ideation. This review indicated that there is a preponderance for studies to focus almost exclusively barriers, with only three of the nine studies specifically considering factors that may facilitate help-seeking. Future qualitative research is indicated that considers how young people experience seeking help, to add to the abundance of data on hypothetical help-seeking. Developing an awareness of what facilitates

successful help-seeking, specifically for young men, is crucial given their high levels of risk taking but decreased levels of help-seeking.

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Section B

Young men's experiences of accessing and receiving help from child and adolescent mental health services following self-harm.

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Abstract

Objective

Given the high rates of completed suicide and poor help-seeking among young men, this research explored how young men, who had successfully sought help from a Child and Adolescent Mental Health Service (CAMHS), experienced help-seeking. This study focused on the factors that facilitated initial access and on-going engagement in services.

Method

Eight young men between the ages of 16-18, who had entered CAMHS following self-harm or suicidal ideation, and who were engaged in on-going therapy, were recruited. Each young man was interviewed to elicit his personal experiences of help-seeking and help-receiving. Interviews were transcribed and subjected to Interpretative Phenomenological Analysis.

Results

Five dominant themes, that overarched participant's individual experiences, emerged from the data: Role of external adult in recognising, normalising and initiating help seeking; Challenging and renegotiating perception of need for help and meaning behind this need; Maintaining an independent self; Mechanisms of engagement and Shared experience. Help-seeking was described as a journey of two stages; 1) initial access and 2) on-going engagement, during which the presence and timing of external influences (parents, teachers) and internal influences (personal beliefs and attitudes) were crucial. A model of help-seeking is presented.

Conclusions

This study is the first of its kind to consider factors that facilitate the help-seeking journey of young men aged 16-18 following self-harm. It highlights the need for provision of information to parents and teachers about how to identify need and ways to facilitate access to services. Information and guidelines on how to adapt services to meet the complex

developmental needs of young men, is highlighted for service developers, commissioners and clinicians.

Introduction

The magnitude of self-harm and suicidal ideation amongst young people has become a global health concern. Raising most concern is the significant association between self-harm, suicidal ideation and an increased risk of completed suicide (Andover & Gibb, 2010; Muehlenkamp, Claes, Havertape & Plener, 2012). This is reflected in the National Suicide Prevention Strategy (DH, 2012) which highlights ‘people with a history of self-harm’ (p.5) as a particularly high risk group. An additional group highlighted are ‘young men’ (p.5) in light of the alarming increases in suicide in men aged 15-44 over the past decade. This trend has been accounted for by increased lethality of self-harm methods by men (Garland & Zigler, 1993) and poorer help-seeking intentions (Cusack, Deane, Wilson & Ciarrochi, 2006).

Defining help-seeking

In the context of mental health difficulties, help-seeking refers to ‘using informal and professional networks to gain support in coping with mental health problems’ (Michaelmore & Hindley, 2012, p. 507). Informal sources refer to family, peers and the internet and formal sources includes trained healthcare professionals, teachers and youth workers.

Theoretical models of help-seeking

A wide range of theoretical models have been proposed to understand the complex process of help-seeking including deterministic models (Anderson & Newman, 1973) and dynamic models (Pescosolido, 1992). A common criticism across the literature, however, is its adult-oriented focus, resulting in limited direct relevance for young people (Murray, 2005).

Incorporating consideration of the differential impact of life stages within help-seeking

models is important, particularly for young people given that the unique tasks associated with adolescence (increased autonomy and independent decision making), have been highlighted as potentially obstructive to the help-seeking process (Rickwood, Deane & Wilson, 2007). Costello, Pescosolido, Angold, & Burns (1998) attempted to do just that in their adaptation of the Network Episode Model (Pescosolido, 1992). The Network Episode Model- Revised (NEM-R Costello et al., 1998), highlighted the difference in autonomy and agency that children and adults have over their health care and focused on the influence of external agencies (family, school) on facilitating help-seeking.

In contrast to the focus on external influences, Biddle, Donovan, Sharp, & Gunnell (2007), developed a model of help-seeking based on intra-personal influences (attitudes and beliefs) and obtained this data through interviewing young adults who had self-harmed. The Cycle of Avoidance (COV; Biddle et al., 2007) explored the way in which young adults interpret their internal distress and how this impacts on their decision not to seek-help (barriers). The COV explained that help-seeking for self-harm was dependent on; 1) Lay diagnosis (‘normal’ requiring no intervention, or ‘real’ requiring action); 2) Normalising and coping; 3) A movable threshold of need and 4) Social meanings attached to distress and help-seeking.

Despite the numerous models proposed to predict and describe help-seeking, there remains a discrepancy between the need for accessing professional help and the actual seeking of professional help, particularly for self-harm and suicidal behaviours (Hawton, Rodham, Evans & Harris, 2006; Meltzer, Harrington, Goodman, & Jenkins, 2001). This has resulted in increased research into factors that inhibit (barrier) and enable (facilitate) help-seeking.

Barriers to help-seeking for self-harm

Barriers to help-seeking have been extensively researched. In terms of stable, demographic barriers, gender has been highlighted as one of the most consistent predictors of non-help-seeking for self-harm by young people (Michaelmore & Hindley; 2012; Mariu, Merry, Robinson & Watson, 2012). In terms of more dynamic barriers, a number of studies have explored how young people's attitudes and beliefs about help-seeking for self-harm negatively influence their behaviour. These studies have found that men, in particular, exhibit more anti-help-seeking attitudes.

Male-sensitive attitudes are characterised by the desire to uphold the dominant stereotyped characteristics of masculinity (Pederson & Vogel, 2007; Jordan et al., 2012) and include beliefs that they should handle problems themselves (Wilson, Deane & Ciarrochi, 2005), cope independently (Gould et al., 2004; Cigularov, Chen, Thurber & Stallones, 2008; Curtis, 2010) and that seeking-help might impact negatively on their sense of self or social standing (Wadman, 2010; Gilchrist & Sullivan, 2006; Freedenthal & Stiffman, 2007; Fortune, Sinclair, & Hawton, 2008; Curtis, 2010; Cigularov, et al., 2008). Additionally, beliefs regarding 'no perceived need for help' were also endorsed by young men, which might suggest difficulties with recognising their own experiences of distress (Rickwood et al., 2007). One particularly gender-salient variable that is endorsed by males and replicated throughout studies is self-stigma (Vogel, Wade, & Hackler, 2007), whereby negative societal views on help-seeking by men are internalised and enacted (Jordan et al., 2012).

Rationale for research

In comparison to the wealth of data pertaining to unmet need and barriers to help-seeking for self-harm by young people, very little is known about met need and the factors that facilitate help-seeking (Rothi & Leavey, 2006; Gulliver, Griffiths & Christensen, 2010). A number of

reports have acknowledged this imbalance and have recommended that research priorities should shift to explore where and how young people seek help (Barker, 2007), focusing on what enabled help-seeking rather than what obstructed it.

Whilst help-seeking research has traditionally focused on understanding the process of access to services, there is now growing interest into researching the factors that enable (facilitate) on-going engagement once help is sought, particularly since poor treatment engagement is a marker for adverse outcomes (Pillay & Wassenaar, 1995). Given the high rates of treatment drop-out by young people who self-harm (Ougrin, & Latif, 2011), research into the factors that facilitate on-going engagement is crucial in this area. Most importantly, this research should focus on young men given that they are underrepresented in support services, but overrepresented in mortality figures following completed suicide.

The aim of this research was to explore how young men, who have successfully accessed formal help for self-harm, understand their journey of help-seeking and how their experiences led them to continue to seek help after initial access.

Research questions

- a. How do young men make meaning of their decision to seek-help from formal sources for self-harm and what sense do they make of the factors that facilitated this decision?

- b. How do young men make meaning of their experience of engaging in help from CAMHS following self-harm?

Method

Research design and methodology

A non-experimental, descriptive design was selected for this study to enable exploration of the nature and defining features of young men's experiences of seeking help. A qualitative methodology was chosen to expand upon the existing quantitative 'self-report' approaches, which have previously dominated the help-seeking literature. This study utilised in-depth semi-structured interviews and sought to explore the lived experience of formal help-seeking for self-harm by young men.

Interpretative Phenomenological Analysis (IPA; Smith, 1996) was selected as the analytic paradigm for this study. IPA's commitment to phenomenological enquiry allows the researcher to explore the meanings people make from the experiences they have lived through (Smith et al., 2009). It attempts to gain insights into how a given person, in a given context, makes sense of a given phenomenon. In the current study, IPA allowed for an exploration of how young men make sense of their experiences of help-seeking. By utilising an analytic approach that focused on subjective meaning making, this study offered a valuable contribution to the field of help-seeking research which has previously attempted to measure if and why help is achieved, rather than considering the complex, individual processes of how help is sought.

Participants

Criteria for inclusion to the project was: male; 16-18 years; engaged with CAMHS for therapeutic intervention at time of recruitment and interview; self-harm (cutting, overdose, scratching, burning, strangulation, head banging, punching walls) is a key feature of referral to CAMHS; two or more episodes of self-harm in past 12 months. Exclusion criteria

included: severe anorexia; current acute episode of psychosis and a learning disability that would impede capacity to comply with research requirements.

Participants were eight young men currently receiving care from CAMHS (Table. 1). The sample size selected for this project was within recommended guidelines for IPA studies, which utilise a concentrated focus on a small number of cases (Smith, Flowers & Larkin, 2009) in order to allow for carrying out depth interviews and analysis.

Procedure

Ethical approval

A local NHS Research Ethics Committee granted full ethical approval for this study to take place (Appendix. D). Research and Development approval was also granted by the four NHS trusts that were involved in recruitment (Appendix.E). The study was conducted in line with the code of ethics and conduct outlined by the (British Psychological Society, 2006; Health Professionals Council, 2009).

Recruitment

Participants were recruited from four National Health Service (NHS) CAMHS clinics across the south of England. Participants who met the inclusion criteria were identified by a named clinician at the recruitment site and the participant information sheet was discussed with the young person at the end of their usual session. If the young person expressed an interest in the study and demonstrated that they clearly understood what their participation would involve, verbal consent to be contacted by the researcher was gained. Initial contact between researcher and young person took place via telephone where the purpose of the study and requirements for involvement were discussed once again. Once the young person

demonstrated enough knowledge of the study to make an informed decision a date for the interview was agreed at which point the consent form was filled out.

Interviews

Semi-structured interviews were the chosen method of data collection for this project allowing for a discursive interaction between the participant and researcher. Interview schedules were developed to provide a loose framework for eliciting the rich accounts of how young men made sense of their journey of seeking help for self-harm. The preparation of a schedule was particularly helpful in this context given that the area of discussion (self-harm) was emotionally laden and thus needed to be sequenced and approached in a sensitive way. The questions were reviewed by two clinical psychologists experienced at working with young people who self-harm and a youth consultation group. This process was invaluable for considering ways to word questions. The interviews lasted between 40-60 minutes and were digitally recorded, transcribed and anonymised for analysis. Interviews took place over a period of 14 months.

Analysis

Once collected, data were subjected to Interpretative Phenomenological Analysis (Smith, 1996) following published guidelines in Smith et al (2009). The authors suggest that, given the idiographic commitment, analysis should take place on a case by case basis and should progress through six stages:

- 1) Reading and re-reading: Repeated reading of the transcripts, whilst simultaneously listening to the audio-recording, took place to enable the researcher to become immersed in the data. Attention was paid to the most striking observations of the data and these

observations were noted down as a process of bracketing in an effort to suspend judgement and to enable focus on the participant's idiographic account.

2) Initial noting: The researcher examined semantic content and language use, similarities, differences, echoes, amplifications and contradictions in the participant's narratives.

Comments were made on a left hand side column of the transcript (Appendix.F) with different colours to represent different aspects of the analysis. For example, exploratory commenting took place in three parallel stages; descriptive comments (blue) had a clear phenomenological focus and focused on the participant's' explicit meaning, linguistic comments (green) focused on exploring the use of language by the participant and finally, more interpretative noting, which involved engaging with the data at a more interrogative and conceptual level (red) took place.

3) Developing emergent themes: The hermeneutic cycle was particularly evident in this stage during which the dataset of notes made during stage 2 became the focus of analysis. The researcher attempted to identify emergent themes by mapping interrelationships, connections and patterns. This involved focusing on discrete chunks of data, whilst remaining cognizant of what was learnt from the process of whole transcript coding. Emergent themes were noted in the left-hand column (Appendix. F).

4) Searching for connections across themes: A list of all themes made on the transcript was printed out (Appendix. G). Themes were then cut out and spread on a floor in order to move themes around (Appendix. H). This provided a spatial representation of how themes relate to each other. The process of abstraction was used to aid identification of patterns and involved

scanning each individual theme and identifying like with like. Similar themes were clustered together and were given a new theme title to represent a 'super-ordinate theme' (Appendix.I).

5) Moving to the next case: Given the idiographic commitment of IPA, in order to retain individuality, it was crucial to treat each case on an individual basis and therefore, bracketing was employed to suspend presuppositions and judgements made from the previously analysed transcript. Here, a reflexive diary was used to record details of any prior observations and judgements, in order for these to be retained for later consideration but postponed for the immediate analysis of the next transcript.

6) Looking for patterns: The final stage involved looking for patterns across cases. Each super-ordinate theme for each participant was cut out and spread on the floor in order to move around and consider links and similarities to establish 'Higher-order concepts'. Higher-order concepts were then then listed (Appendix. J) and example quotes were provided for each concept (Appendix. K). Finally, recurrence of higher-order concepts was considered (Appendix. L) and, in line with recommendations from Smith et al (2009), themes endorsed by half of the sample or more were retained as 'Over-arching themes' (Appendix. M) and included in the research write up.

Quality assurance

The process of data analysis was subjected to quality assurance practices recommended in Mays and Pope (2000).

Reflexivity: IPA relies on a 'double hermeneutic' in which "the researcher is trying to make sense of the participants trying to make sense of their world" (Smith & Osborn, 2008, p. 53).

This complex, inter-subjective relationship is influenced, therefore, by the researchers' and participant's assumptions and prior experiences. This has implications both at the stages of data collection and analysis and is therefore examined throughout the process. In the current

study, particular consideration was given to the gender difference between the researcher, who was female and the participants who were male and the potential for this to influence the data.

The impact of the researchers' gender on the participants:

It was possible that experiences expressed within the interviews by the young men might be influenced by the gender of the researcher and consideration was paid to whether this might have been enacted in the interviews. For example, the researcher was mindful that, in the context of talking to a female, the young men might have felt compelled towards promoting the more stereotypically dominant characteristics of masculinity (i.e. coping independently, not appearing weak).

The impact of the participant's gender on the researcher:

The researcher approached this project with assumptions about, but not direct experience of, being a young man. These assumptions were, therefore, informed by personal and clinical experiences of interacting with young men and reading of literature within this area.

Assumptions included that young men would have difficulty expressing their experience using spoken words and that they would be reluctant to share their intra-personal world.

Bracketing: With the possibility that gender differences might impact upon the interview and interpretation process, 'Bracketing' was therefore employed. This involved the researcher engaging in discussion with a male supervisor prior to and during data collection to identify any personal or intellectual biases on the part of the researcher. This supervisor also read and coded three of the original transcripts, which offered the opportunity for discussion about any likely biases within the young men's narratives about their experience. A research diary was used during the process of data collection and analysis to note down any assumptions or observations that may have biased the data.

Triangulation: Investigator triangulation involved two researchers (research supervisors), independently analysing the same transcripts (for three cases), in order to assess the reliability of the data analysis. Their analysed transcripts were then compared with the original transcript, analysed by the main researcher, in order to check for selective attention and interpreter bias and to explore alternative explorations. On all six occasions (three transcripts each), themes and overarching-themes were satisfactorily similar.

Deviant case analysis: In an effort to refine, broaden and confirm the patterns that were emerging from the on-going data analysis, the process of deviant case analysis was employed. This process involved inspecting transcripts for elements in the data that contradicted or did not appear to reflect patterns or accounts previously emerging from the data analysis.

Results

Whilst the journey of help-seeking was unique for each participant, five dominant themes, that overarched participants' individual experiences, emerged from the data: Role of external adult in recognising, normalising and initiating help seeking; Challenging and renegotiating perception of need for help and meaning behind this need; Maintaining an independent self; Mechanisms of engagement and Shared experience. In order to capture the commonality and individuality in participants' experiences, Table. 1 provides a representation of the dominant themes for each participant.

Table. 1
Study participants and their dominant themes

Participant	Age	Entry to CAMHS	Dominant Themes	Example extract
1. Jack	17	(GP)	<ul style="list-style-type: none"> • Role of external adult in recognising, normalising and initiating help seeking • Maintaining independent self 	<i>“It might have just been banging my head and that but my mum saw it as more serious”</i>
2. David	17	(GP)	<ul style="list-style-type: none"> • Challenging and renegotiating perception of need for help and meaning behind this need • Maintaining independent self 	<i>“I thought about the stereotype around it like mental people go to it it was a like nerve wracking thing but like if it’s going to help me, I’m gonna go to it”</i>
3. Jamie	16	Previous referrals Current: (A&E)	<ul style="list-style-type: none"> • Role of external adult in recognising, normalising and initiating help seeking. • Mechanism of engagement 	<i>“They were just like if you need to talk in the night just go to the desk and call over and I will chat to you doesn’t matter what time it is”</i>
4. Simon	16	(A&E)	<ul style="list-style-type: none"> • Maintaining independent self • Shared experience 	<i>“Just told her because she’s the one who goes to CAMHS and it really helped her so we always talk about this kind of thing”</i>
5. Chris	17	Previous referrals Current: (Paediatrician)	<ul style="list-style-type: none"> • Role of external adult in recognising, normalising and initiating help seeking • Mechanisms of engagement 	<i>“They were quite relaxing, they weren’t pressuring me, kind of relaxed, quite, the mood that they gave off was quite gentle”</i>
6. Adam	18	Previous referrals Various pathways	<ul style="list-style-type: none"> • Mechanisms of engagement 	<i>“Just where they treat you like an adult they don’t talk down to you, they talk to you as if they were talking to your parents almost”</i>
7. Ben	16	(School)	<ul style="list-style-type: none"> • Role of external adult in recognising, normalising and initiating help seeking • Maintaining independent self 	<i>“If I’m being honest I kind of agreed and thought I’d just go and sit in silence”</i>
8. Ed	17	(A&E)	<ul style="list-style-type: none"> • Maintaining independent self • Mechanism of engagement 	<i>“Instead of you doing all the work as such they give you stuff to do you know, try and suggest ways to help out”</i>

Theme 1: Role of external adult in recognising, normalising and initiating help seeking

Recognising and voicing a need for help

In all cases, initial recognition of need for help came from external sources such as parents, friends or school teachers. It was evident that there was considerable confusion about whether their experiences of self-harm reflected “normal” behaviour or “real” distress as Adam illustrates;

Umm yeah I couldn't put a label on it umm yeah it didn't seem abnormal to me all of these suicidal thoughts, they didn't seem like I'm going crazy, it just seemed like a natural things at the time and to be honest the amount of worry it caused in other people and the fact that I immediately needed to be referred to an inpatient unit confused me.

This confusion reflects the movable threshold of need as identified in the COV (Biddle et al., 2007) in which young people believe their distress to be “normal” until eventually recognising their distress to be “real” via the occurrence of a crisis (e.g. inpatient admission) or through the influence of an external agency. For example, in the current study, all of the young men relied on other people (external sources) to act as a barometer for determining “real” need as Ben reports, “I told her that I thought about it (suicide) but that it was ok and that I wasn't that bad but she did and told mum”. Equally, Jack's appraisal of his behaviour as “. . . just banging my head” contrasted with his mothers' appraisal “. . . [she] saw it as more serious”

Gender-typical beliefs surrounding masculinity (the need to be self-sufficient and cope independently) seemed to result in the young men developing a higher threshold for perceived need for help. It is possible, therefore, that for young men in the current study, the

influence of having external sources model concern and initiate help-seeking, eased the internal pressure of maintaining this stereotype.

In addition to failure to recognise need, comments made by three participants spoke to the difficulty in translating need into words and indicated that other people initiating conversations about their difficulties was a “relief”. For example, Jamie, who had taken multiple overdoses, offered an insight his difficulty in vocalising his troubles and the influence of others on making it possible:

Like at first I wasn't going to tell my friends and I was always saying I was upset. . . I thought if they walk away they are not my true friends and if they stay they will not think they are any different. They helped by asking if something's wrong.

Initiating help-seeking

Striving for independence and autonomy, a characteristic of the developmental stage of adolescence (Erikson, 1963), was strongly reflected in the interviews and was characterised by dominant themes of wanting to cope independently; “I like to sort things out for myself”; “I needed to do things myself and not rely so much on other people”. Nevertheless, these beliefs were contradicted in the young men's actual help-seeking behaviours, which relied on external adult help to initiate help-seeking. The extract below draws our attention to this conflict and demonstrates Jack's acknowledgement of the importance of his mother in helping him to access help, which starkly contrasts with his dominant narrative around wanting to “solve [problems] myself” and his suggestion that relying on others for help is considered to be “weak”.

Even if I'd known [about CAMHS] I wouldn't have given it a second thought so you know yeah I think parents should be made more aware of it . . . Maybe it should be more parents should be made more aware of it rather than kids themselves.

Whilst the majority of young men described an external influence for accessing help (parent or other influential adult), Ed's narrative contrasted with the other young men in that his help-seeking was more internally motivated,

Well at the time I was in employment and it was effecting how I was working the way I was working and the way I was working died down quite a bit so I thought I want to continue working I got to sort myself out otherwise I will lose my job.

In addition to his different help-seeking practices, Ed was the only young person in the sample who was in full-time employment and not in education. It is possible that, whilst the education environment maintains a need for adult guidance and direction, the workplace environment fosters responsibility and autonomy. This observation might indicate that different life style choices interact with developmental stages and changes the way that help may or may not be sought.

Normalising help-seeking

The normalising approach taken by external sources was particularly powerful. This sub-theme spoke to concerns about stigma and illustrated the power of increasing awareness of the prevalence of suffering of young people, as Ben noted, "My form tutor told me more about how common mental problems were and umm he even said he had seen loads of boys go to CAMHS from school so like yeah."

Normalising from a gender perspective was endorsed by many of the participants and reduced the sense of social isolation. For example; David, like the majority of participants, made inaccurate assumptions about the wellbeing of other young men in his school “Yeah because everyone in my school was like that big kind of guy.” For David, when his GP provided an insight into the prevalence of help-seeking by young men, this offered an alternative perspective:

Q: “Ok so it sounds like you spoken to your mum and she spoke to the Doctor, what was it like going to see the Doctor?”

David: “It was fine really because you saw there was light like you can get through it”

Q: “Ok, so what helped about that process. Where did the light come from?”

David: “Just like knowing you were not the only one who went through it and that there were other people who had gone through it . . . they started talking about I’m not the only male.”

Normalising the experience of emotional difficulties from a gender perspective enabled David and the majority of participants to shift from holding a generalised and accepted image of young men as “tough” and able to “cope independently” towards the development of a multifaceted identity whereby masculinity can be coupled with emotional vulnerability and difficulty.

Adam, who had over five years of inpatient and outpatient CAMHS experiences and who did not share the group concerns of stigma about accessing services for mental illness offered a different insight into how his experiences had been normalised:

Adam: “I mean I’ve never told anyone that I’m here but I wouldn’t have any problem I wouldn’t be embarrassed about it if it came up . . . there’s not much of a stigma anymore”

Q: “Why do you think that it, why do you think that’s changed?”

Adam: “Umm I mean the news is always telling us how sort of like depression is a really valid illness which you know is to be treated as seriously as a physical ailment umm yeah . . . my age group we have grown up learning how depression is such a serious thing and that all mental illness is a serious thing like mood disorders and schizophrenia and yeah so I don’t think if it did tell someone I don’t think there would be any sort of judgement or any sort of shame whatsoever.”

Adam’s reference to the influence of the media in decreasing stigma has been highlighted in the ‘Tackling Stigma Framework’, which highlights “The role of the media as allies” as one of the 8 priority areas (National CAMHS Support Service, 2010, p. 38).

Gender of the influential other

Whilst only three participants had a male therapist, five young men indicated that their journey of help-seeking was positively influenced by having contact with a male in some way. Jack, who had been against accessing help when encouraged by his mother, changed

his mind following an informal discussion with a male family friend; “I was probably, in hindsight, looking for some kind of male perspective”. Despite its dominant reference, gender was not, on its own, as crucial as anticipated. Instead participants’ narratives highlighted that gender was only considered influential when coupled with respect. Jack went on to say; “because he was a good friend of my dad’s I trusted him, his opinion”. Similarly, Ed’s description of his older friend highlights the respect he felt, “I looked up to him . . . Yeah well he kinda had his life sorted you know he’s got a good job, good family good friends etc so it was something almost I could aspire to be like.”

David further endorsed this notion of being influenced by someone who he looked up to, although speaking hypothetically; “Like have a male model who has gone through it like at the other side, like a successful guy who has been through it”. Utilisation of male identification figures has been highlighted in the delivery of public health messages. For example, Frank Bruno, who many people assume to typify masculine norms, fronts the ‘Time to Change’ campaign (www.time-to-change.org.uk). Similarly, male film stars such as Russell Brand and Jonny Depp have publicly shared their experiences with self-harm.

Theme 2: Challenging and renegotiating perception of need for help and the meaning behind this need.

In addition to the influence of external sources, there was evidence that the young man’s own internal influences played a crucial role. For example, each young man appeared to engage in an on-going process of negotiating and renegotiating their need for help and the meaning behind this need. This process may reflect the adolescent developmental tasks of experimenting with different roles, beliefs and behaviours in an effort to establish a more coherent sense of self (Erikson, 1963).

Recognition of need for help

Illustrated in the three extracts below are participants' dominant beliefs about being able to "handle" and "control" problems, which contrasted with eventual realisation of the limits to their coping styles. This is highlighted by Ben,

I was angry at my mum whenever she mentioned the appointment first of all, but then it was ok and I started to think that maybe I can't handle it on my own 'coz I hadn't been doing so well really.

Similarly, David reported; "I didn't really think . . . I needed it, I thought I could control my emotions [but] my emotions are strong so it's not always easy to control them". Chris also demonstrated a shift in his perception of need "I was a bit reluctant, then I thought that yeah, in this time I've tried to do it by myself I've not got any answers or got anywhere so clearly I do need some help"

Challenging gender norms

Through the process of accessing and receiving help, participants' displayed a shift away from the polarised position of 'help-seeking is weak' to a more balanced position and in some cases a position of increased feelings of masculinity. For example, Chris, who explained that he would have preferred to tell his friends he had been mugged rather than own up to having self-harmed, for fear of this information compromising his "image" and "social acceptance", changed his mind and noted:

It is services that can change your life literally and that can actually help you to stop and actually help you to realise what you are doing is causing a lot of harm to you and people around you.

This extract draws our attention to the way in which Chris, like a number of the participants, reframes help-seeking as a responsibility he has to others. This method of reframing reflects research by O'Brien, Hunt & Hart (2005), who found that men legitimised their need for help by emphasising that receiving help promotes the most salient aspects of masculinity (i.e. taking responsibility).

Theme 3: Maintaining an independent self

Inherent in participants' narratives was a resistance to committing fully to the process of help-seeking. This was illustrated by participants employing strategies to establish some distance between them and the help-seeking process, possibly in an effort to avoid the associations with "patient" or "client" and to maintain their pre-therapy sense of developing self.

Choice and control

A number of participants exhibited internal processing strategies to maintain some level of choice and control, as Jack illustrated,

I just thought well alright, fair enough, if nothing else it's an experience. That's what made me feel a bit more comfortable with it I think because there was also that option of always getting out of just saying this isn't for me, I've tried it.

Ed drew on his experience of others' help-seeking to reassure himself that he could escape if he wanted to,

My friend was fed-up with the way the CAMHS worker was treating her and decided to leave, it is a voluntary service and if you don't want to come here it's completely up to you, they are not going to force you.

In addition to internal strategies for maintaining control, there was evidence that external sources also acknowledged the importance of handing back control to the young man to support his engagement. For example, Simon, who disclosed his overdose to a friend, was asked "is there anything you would not like me to mention?" by his friend's mum prior to her disclosing his overdose to his parents. In this situation, in which Simon's personal experiences faced exposure, he was given the opportunity to grasp some control over the process. This was possibly reflected in his later comment, "I know what will happen now, no one is going to try and lock you up because I told them that I am feeling like that"

For a number of participants, non-face-to-face methods of communication such as social networking or text messaging were used as a vehicle for maintaining some control over their communication of distress both in terms of accessing help and engaging in services. Simon, who was concerned that his disclosure would come as a shock as he believed that others perceived him to be "happy" and "fine", highlighted the usefulness of a social network for enabling him to communicate his difficulties, "Erm it's just easier you know yeah it's just a lot easier to say you know you are just typing something out and you can think about it before you have to send the message."

This non-face-to-face approach, which enabled Simon to maintain some choice and control over his disclosure, was similarly recognised by Adam who noted,

The texting service that this place offers is useful . . . I recommend that I think it's really helpful and it doesn't have to be used it's good to have that kind of safety net."

This reflects the recent development of a set of guidelines for promoting the use of technologies safely and effectively to promote young people's wellbeing, highlighting the benefits of an anonymous face-to-face service for engaging young people (Campbell & Roberts, 2013).

Theme 4: Mechanisms of engagement

Given that none of the participants entered CAMHS entirely of their own volition and were therefore, not the main stakeholders in the referral process, this might imply that their motivation to seek help and continue to engage with help was low. Having maintained their engagement in services, however, all participants offered an insight into what helped to keep them engaged.

Developmentally sensitive approach taken by clinician

All participants highlighted an appreciation for the relationship that developed between them and their clinician. In most instances participants reported that the approach of their clinician was developmentally sensitive, scaffolding the development of a respectful and egalitarian partnership, possibly further breaking down the stigma associated with asking for help. For example, Chris, likened his clinician to a "football coach" and noted,

His whole personality was, he's like a 55 year old man who comes to your house on a bicycle and he's all energetic and he says it to you straight and he's just speaks to you bluntly and the way he was was kind of like almost like a coach to a football player come on you got to come and do it, you need to do this yourself, it was like that and that not like ah are you ok, if it had been like that I probably wouldn't have really participated.

Similarly, Adam, who had experienced a number of different CAMHS teams due to having moved areas frequently, reflected on his diverse experiences of clinicians' approaches,

Just where they treat you like an adult they don't talk down to you, they talk to you as if they were talking to your parents – umm that's been the most useful, I don't know just no bullshit basically.

The appreciation of “no bullshit” was similarly reflected by Ed who summarised his clinician as; “He's quite a sound guy, he's very straight forward”. This somewhat reflects recent research that young people's highest rated preference for therapy was that “the therapist would be genuine or a ‘real’ person and that they would be honest and respect them” (Watsford & Rickwood, 2012, p. 361).

In-session techniques:

Reviews of treatment effectiveness have been unable to conclude that any one particular psychological therapy is most effective in alleviating self-harming behaviour (NICE, 2011; Royal College of Psychiatrists, 2010). This may reflect that self-harm has different meanings in different context (NICE, 2011) and may indicate that interventions should be tailored to

young people on an individual basis. Young people in this study provided an insight into what they had found useful about their therapeutic experience.

Two young men, who had previously accessed school and voluntary counselling services compared these experiences with their experience of CAMHS.

Ed noted,

“I did kind of have an idea in my head that it was just gonna be ah how does this make you feel... and upon going for my meeting it did turn out to be like that so I didn't think that was particularly the best option for me so er a lot of the questions he was asking me I already knew the answers to myself and I didn't see it progressing anywhere”

Q: “So is the approach of CAMHS did it feel different to [counselling] or does it feel quite similar?”

Ed: “Um It's similar in the way they ask you about how you're feeling, what the circumstances are etc but instead of you doing all the work as such they give you stuff to do you know, try and suggest ways to help out in different circumstances so I find it personally a lot more helpful.”

There was a tendency for participants to privilege a practical, skill learning approach in therapy, opposed to reflection on their experiences. From a developmental perspective, this tendency may reflect their familiarity with goal-focused approaches inherent in the education system, a context within which they have all spent the majority of their formative years.

Adam similarly endorsed an approach that had a practical focus in comparison to his experience of counselling which he described as “flimsy” and “no direction”, “. . . I just wanted to work as it were and that’s why I like this service as well, because there are clear, firm objectives to work towards, set topics before each session and that.”

Theme 5: Shared experience:

Experiencing emotional distress, in the context of beliefs about stigma and difficulty in vocalising their experiences, can result in feelings of isolation. This was reflected by a number of young men who were unaware of how common it is to experience self-harm or how typical it is to need some external help. The extract below was typical of the beliefs of young men. Chris noted,

[it is] like really shocking to learn that that was something that was common but I don’t think there’s not many males that self-harm. It just doesn’t I don’t get it, they all seem, when you are in a group of boys, it’s almost like emotion doesn’t exist and then you can’t envision what they are doing in their private time, you think, well they must be like that all of the time so I think that is probably why.

Similarly to results found in Jordan et al (2012), in which men were interviewed about their experiences of suicide, there was an acknowledgement of the therapeutic value of having a shared experience, both in terms of disclosure and engagement.

Ed noted that talking to other people with similar experiences “slowly takes the bricks out of the wall [the] mental block you put up then eventually it wears away.” He indicated that shared experience was much more than simply helpful for normalising experiences and made

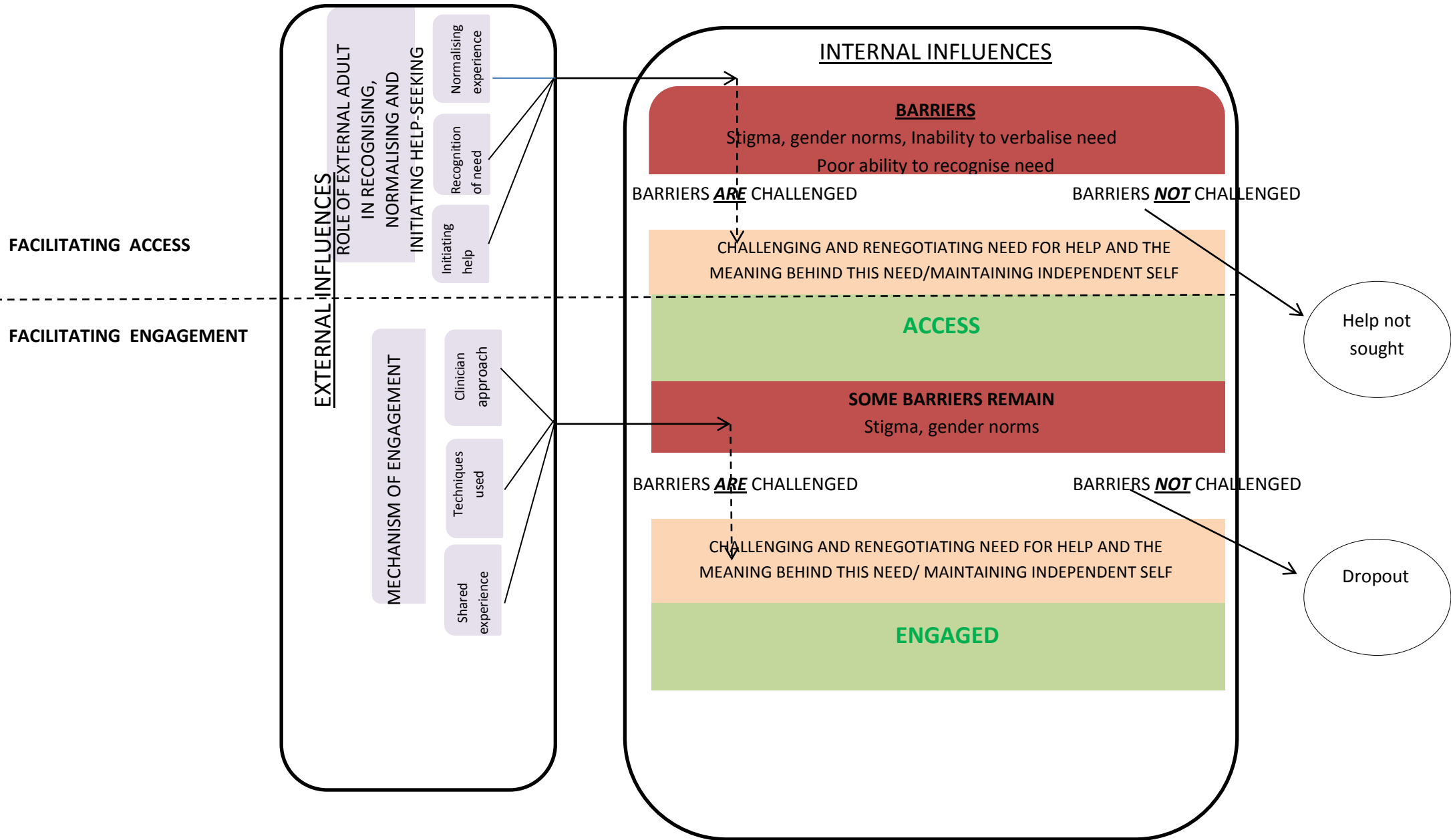
reference to “the bigger picture”. Chris similarly spoke to this theme and proposed that the usefulness of shared experience is learning not only about others experiences of self-harm, but also about hearing their journey of recovery and gaining some hope and strength from this,

I think being able to speak to someone who has had the same experience as you would have been even more helpful . . . so it’s like if I have self-harmed and if you’re speaking to someone who has been through it that can be inspirational and he will understand where I am coming from.

Preliminary model of help-seeking by young men who self-harm

The experiences of help-seeking expressed by the young men in this study are synthesised into a graphical representation within figure. 1. This model depicts help-seeking as a complex process that takes place within two stages and is dependent on the presence and timing of specific influences.

Figure. 1
Model of adolescent male help-seeking for self-harm



Discussion

This study explored how young men make meaning of their decision to seek help from CAMHS, including the factors that facilitated their decision, and how they experienced the help they received. Help-seeking was described as a journey of two stages; 1) initial access and 2) on-going engagement. This, therefore, builds on traditional models that assume help-seeking is achieved once entry into services has occurred. Help-seeking was also described as determined by the presence and timing of specific external and internal influences, (fig.1). Again, this builds on traditional models of help-seeking that privilege either external or internal influences.

Links to previous research and theory

Previous models of help-seeking

The current study both supports and extends previous conceptualisations of help-seeking. Similarly to the NEM-R (Costello et al., 1998), which emphasises external influences in help-seeking, the current study highlights the influence of the young persons' network (parents, peers and school) in identifying need, deciding a plan of action and supporting access to services. Furthermore, similarly to the COA (Biddle et al., 2007), in which the cognitive processes (attitudes and beliefs) of the individual help-seeker is central to determining help-seeking, the current model highlights the impact of 'internal influences' in accessing and engaging in help.

The current study goes on to extend this work and demonstrates that, for a cohort of young men who self-harm, help-seeking was predicated on integrating both "external influences" and "individual influences" and finding a balance between the two. For example, whilst young men relied on gentle guidance from external sources, they simultaneously engaged in

strategies to maintain a sense of independence (i.e. acknowledging that their participation in services is voluntary). This consequently resulted in them changing their perspective and renegotiating their need for help and the meaning of help-seeking (“I probably wanted for someone to help me a little bit in the end.”). This process is typical of the developmental stage of adolescence, during which a young person oscillates between striving for independence and autonomy in order to explore new roles and identities and a continued need for guidance and support from influential others (Erikson, 1963).

Promoting engagement

This study acknowledged the fundamental need to learn about factors that help to retain young people who self-harm in services given their high rates of drop-out (Ougrin & Latif 2011). Participants identified influential factors including their clinician fostering a developmentally sensitive relationship with them; being treated as equal and being given control and choice. These findings support recommendations made in a recent study by Green et al. (2012), which considered strategies for engaging youths in treatment and also support recommendations from a literature review into factors that motivate and engage suicidal youth in therapeutic interventions (Daniel & Goldstron, 2009).

The CAMHS Review (DCSF & DH, 2008) also acknowledges the importance of paying consideration to the developmental stage of those entering services and, similarly to the current study, recommended that services should enable the young person to feel in control. This review, however, highlighted a number of recommendations aimed at fostering a sense of control that were not recognised directly by participants in the current study, including; involving young people in their own treatment and care planning. This is further reflected in

the Department of Health's "You're Welcome" quality criteria (DH, 2011) that set out principles to help health services become young people friendly.

Stigma

In the current study, participants indicated that help-seeking presented a challenge to the gender ideal of masculinity and demonstrated evidence of self-stigma (i.e. "relying on others for help is weak"). Whilst this supports an abundance of literature in the area of adult male help-seeking and stigma (Vogel, Heimerdinger-Edwards, Hammer & Hubbard, 2011; Shepherd & Rickard, 2012), the current study adds to the limited research considering late adolescent male's accounts of stigma and help-seeking. This is important since there may be qualitative differences between the experience of stigma for adults and for adolescents given their different developmental stages. Kranke, Floersch, Kranke and Munson (2011) suggest that, whilst adults are most concerned by the impact of stigma on social status, jobs and significant relationships, adolescents, who are in the thralls of the complex task of identity development, wish to protect their developing sense of self and may feel increasingly threatened by the possibility that who they are could become defined by their current experiences of distress and need for external help.

The factors that helped to challenge barriers for young men in the current study included, having their experiences normalised by external sources and being offered practical, skills-building approaches with clear objectives. This might reflect recommendations by Hammer and Vogel (2010) who developed a male-sensitive brochure to promote therapy by highlighting approaches that are considered more compatible with traditional gender roles such as "strategy for attacking", "solution-focused", "cost-effective" and "client-directed team effort" (p. 301).

Implications

Educating external sources (parents, teachers and other young people) in identifying self-harm and determining need for help is crucial. This could be achieved through wide dissemination of available protocols and guidelines for schools in dealing with self-harm strategically (i.e. Walsh, 2006). The media could be a useful and accessible platform from which to educate parents about best-practice procedures for managing self-harm. This may include highlighting warning signs, providing guidelines for effectively supporting young people who self-harm and signposting appropriate services.

Normalising participants' experiences of distress and need for help was highlighted as a crucial factor in reducing stigma and enabling access in this study and, in some instances, resulted in participants re-formulating their help-seeking as a sign of increased masculinity. This highlights the need to educate young men from an early age about the incidence of mental health difficulties, and for help-seeking to be talked about in keeping with gender norms. This may be achievable through school-based emotional wellbeing programmes and positive media coverage as described in the 'Tackling Stigma Framework' (National CAMHS Support Service, 2010). Similarly, providing an anonymous platform for young men to help others in a similar situation would speak to participants' desire for a 'shared experience'. This has recently been recognised by youth charity 'Mindful' (www.mindfulcharity.ca) who, in July 2013, launched a professional and peer-led web-support service.

The emphasis this study has placed on the importance of providing developmentally appropriate services to young people who self-harm points to implications both at a therapeutic level and at the level of service development and commissioning. Firstly, given

that the quality of the therapeutic relationship is frequently highlighted as counting for the largest variance in subsequent treatment engagement (Oruche, Downs, Holloway, Draucker, & Aalsma, 2013), supporting clinicians to achieve the inter-personal characteristics that are regularly highlighted as crucial to engagement should be a priority. Secondly, service developers and commissioners should ensure they consult guidelines for providing developmentally sensitive CAMHS services and make appropriate adaptations. Guidelines may include the “You’re Welcome” criteria (DH, 2011) and the CAMHS Review (2010).

Limitations and future directions:

Sampling

Consideration should be paid to the sampling procedure selected for this study.

Firstly, the small sample size in this study was necessary to enable an in-depth exploration of participants’ experiences of help-seeking for self-harm. Nevertheless, this limits the ability to generalise these findings to a wider population and we cannot assume that the experiences of the young men in this study are representative of young men who self-harm and seek-help in general. For example, this study only recruited participants who were attending CAMHS settings and, therefore, limited consideration of whether the help-seeking experiences expressed in this study reflect experiences of help-seeking from other sources including voluntary counselling services. Future research in this area would be beneficial to ascertain whether the journey of help-seeking by young men who self-harm differs depending on where help is sought. In addition to this, recruiting young men aged 16-18 limited consideration of potential differences in help-seeking across the stages of adolescence. Future research may consider whether adolescence, although classified as one distinct developmental stage, impacts help-seeking differentially depending on where young people fall, i.e. “young adolescence” (13-15) or “old adolescence” (16-19).

Finally, whilst the model of help-seeking described in this study is developed based on the experiences of young men who self-harm, it is unclear whether this model is specific to self-harm or whether it describes a process of help-seeking by young men more generally. Future research might consider replicating this study with non-self-harming young men to determine its specificity to self-harm.

Data collection and analysis

Whilst steps were taken in this study to ensure reliability of the Interpretive Phenomenological Analytic approach, a number of possible limitations of this methodology should be highlighted.

Firstly, data collection took place via semi-structured interviews. This strategy may have reduced the opportunity to gather accurate and detailed accounts of participants' experiences given the evidence that young men may have difficulty with verbalising their experiences (Jordan et al, 2012). Additionally, given that participants were considered to be in the adolescent stage of identity development, the experiences they chose to verbalise may have been biased towards accounts that they perceived to be more socially acceptable.

Finally, given that the researchers' interpretation is central to the IPA process, steps were taken to acknowledge and control for the potential impact on data collection and analysis (see method section). Despite this, however, there may have been a tendency for results to be biased towards reflecting the researchers' beliefs and may have resulted in missing out key features of the participants narratives.

To account for these limitations, this study may, have benefited from returning to participants to check out their agreement with interpretations made.

Conclusion

This study is the first of its kind to consider how young men aged 16-18 experience the journey of help-seeking following self-harm. It is also the first of its kind to conceptualise help-seeking as a process of two stages involving access and engagement. Despite its limitations, this study has demonstrated that young men's help-seeking for self-harm is facilitated by a balance of external influences (parents, teachers, peers and mental health clinicians) and internal influences (the young person's own cognitive processes). This has important implications and points to the need for the provision of education in the area of self-harm and help-seeking. For parents, peers and teachers this may include provision of information about how to identify need for help (in young people) and ways to facilitate access to services. For commissioners, service developers and clinicians, this may include provision of guidelines to help adapt services to meet the complex developmental needs of young men, necessary for facilitating continued engagement in services.

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Section C

Critical Appraisal

Word count: 1981

1. What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?

Other than carrying out a small research project as an undergraduate, I embarked upon the MRP as somewhat of a research novice. Although this filled me with some amount of dread, from the very first mention of ‘research’ at Salomons, my familiarity with quantitative methodologies began to flood back and I instantly felt at ease. That was, until I attended the research fair and became aware of the number of qualitative studies being proposed. This confused me somewhat, which I believe was a reflection of my beliefs about quantitative methodologies representing the gold-standard in research and qualitative methodologies being used as a precursor or adjunct to quantitative approaches. My biases also appeared to be reflected in the results of my preliminary literature search into help-seeking, which was saturated with quantitative research studies each aiming to measure help-seeking.

After some consideration, I realised that this bias measured only agreement with pre-defined characteristics of help-seeking and prevented any exploration of how individuals themselves experience this behaviour. I therefore, went about revisiting the lecture notes from qualitative teaching at Salomons and carried out some independent reading to familiarise myself with qualitative approaches. I soon developed an appreciation of their strengths and their pivotal place in research, particularly within the field of help-seeking. My loyalty towards quantitative methodology, thus, somewhat shifted. This shift in thinking was an exciting learning opportunity for me and through discussions with my supervisors I developed a better understanding of the unique contributions that each qualitative approach can make. I believe that by suspending my biases and engaging my curiosity, my skills as a researcher significantly developed. I believe that this has not only helped to develop skills for designing and critiquing quantitative and qualitative research studies but also, allowing this process to

occur organically will have a lasting influence on my appreciation of the equal value of the different methodologies.

Whilst the process of completing an ethics application was somewhat challenging, immersing myself in the process helped to develop and consolidate my skills. I particularly valued the structure of the ethics application form, which helped to scaffold my thinking around the endless ethical considerations. Most striking for me was the process of designing a procedure to safeguard against issues related to risk that might have arisen during the interview process given that the topic of study was self-harm. I believe that my clinical experience of working with young people, my familiarity and skills for completing assessment of risk and my experience of acting on concerns about risk were crucial in designing this procedure. Having gone through this process, my awareness of ethical and risk related issues within my clinical practice also increased. I observed a renewed curiosity about risk related issues when meeting with clients for the first time and I began to feel more at ease when discussing with clients any concerns I had. I also recognised a shift within supervision, towards an increased reflection on how clinical risk issues impact on me personally.

Beginning the Interpretative Phenomenological Analysis (IPA) process was an interesting learning curve for me. I had initially planned to use a computer software programme (Nvivo) to help with developing my codes. However as I progressed with Nvivo, I felt as though it acted as a barrier, preventing me from connecting with the personal experiences of the participant and also preventing me from developing a personal experience of the data for myself, both of which are fundamental principles of IPA (Smith et al., 2009). On reflection, I am mindful that my initial decision to use computer software to aid my analysis may have reflected my familiarity and felt safety with quantitative methodologies. I subsequently aborted this process and reverted to the recommended pen and paper method endorsed by the developers of IPA themselves. I believe that the disconnect I felt in the early stages of

analysis, as a result of using Nvivo, was a beneficial process. This process enabled me to engage more closely with the participant, their experiences and the analytic paradigm.

2. If you were able to do this project again, what would you do differently and why?

Given that one of the most significant findings in this study was the role that other people played in influencing young men's help-seeking, I felt that the results may have been strengthened, had I used a different sampling procedure. For example, I considered the potential benefit of also interviewing the key influential figure in the young man's help-seeking journey both at the stage of access (parent, carer or teacher) and engagement (clinician). I believe that having adopted this approach would have enabled triangulation of the data which would have helped to validate themes and increase the credibility of the results (Jonsen & Jehn, 2009).

Throughout this process, I have learnt a great deal about the difficulties associated with recruitment for a research project and the approaches that can be taken to maximise recruitment opportunities. For example, I was aware from the outset that recruitment may be a particular challenge for my project, given that part of the reason for carrying out this research was because help-seeking in young men is very low. I subsequently made efforts to broaden my recruitment net as wide as possible and made links with over 16 different CAMHS teams, yet recruitment remained a challenge. Nevertheless, there were a number of barriers to recruitment that I could have anticipated earlier, had I made contact with the potential recruitment sites prior to developing a proposal. For example, a large scale research trial, also investigating self-harm, was taking place within two of my three recruitment sites. This trial directly benefitted the CAMHS teams since it provided an intervention, reducing their waitlist. Thus, this study was given priority and reduced the number of potential

participants for my study. Furthermore, I was unaware of significant service reconfiguration that was taking place within one trust and the impact this may have on clinician's ability to remain mindful of my study. This presented a significant learning experience for any research I undertake in the future, highlighting the importance of carrying out initial investigations into service demands and their priorities prior to designing the study.

My data collection method involved carrying out only one interview with each participant, which was possibly influenced by my stereotyped beliefs about young men not being very willing to talk. I was, however, delighted that that the young men proved me wrong and rather than attending begrudgingly, they each expressed their gratitude for being able to tell their story and for being asked to contribute to a project that might help others. On reflection, the study might have benefitted from carrying out a follow-up interview to assess the credibility of my interpretations and to ask for elaboration on comments that I had been particularly interested in when transcribing the data.

3. As a consequence of doing this study, would you do anything different in regard to making clinical recommendations and changing clinical practice and why?

I believe that my clinical practice has been, and will continue to be impacted by this research, both directly and in-directly. For example, as Clinical Psychologists working in young people's settings, I believe that we have a responsibility to educate adults about appropriate ways to facilitate access and engagement in help-seeking. For example, this may involve providing teaching or consultation to school staff as a routine part of our role. As an early intervention strategy, this might involve educating parents of younger children about how to adapt their approach to supporting their child when faced with emotional difficulties as they grow into adolescents.

In terms of my clinical work, I have already recognised my growing awareness of the impact that the developmental stage of adolescence has on engagement with the traditional weekly, clinic-based therapeutic sessions. I have used the knowledge learnt from conducting this research to inform my practice accordingly including offering outreach in schools, homes and coffee shops, where possible. I have also attempted to provide my young clients with more choice and control around the format and direction that therapy may take. I am, however, aware of the potential barriers to achieving this. For example, within my current team, service constrictions such as offering time-limited therapy and clinicians holding large caseloads, impacts on their ability to work flexibly.

Finally, believe that this research has highlighted the difficulty that young men experience in terms of recognising and vocalising need for help and that self-harm may be hidden behind more visible problems such as drug abuse or aggression. This points to the fundamental need for clinicians to ask about experiences of self-harm in initial assessment stages, regardless of whether it is referenced in a referral or is discussed by the young person or their carer. This reflects research recommendations by Royal College of Psychiatrists (2010) that risk assessment tools should be used as part of a routine psychiatric intake assessment and not as a separate exercise. This research has made me very aware that, as clinicians, we need to ask the correct questions to facilitate expression of need and experiences and we should not rely on the young person to disclose without some offering some scaffolding.

4. If you were to undertake further research in this area, what would that research project seek to answer and how would you go about doing it?

This research is the first to consider help-seeking of young men for self-harm and highlights a number of interesting avenues that warrant further exploration. Firstly, my decision to recruit

only males between ages 16-18 who had self-harmed somewhat restricts consideration of the applicability of the findings to a wider audience. For example, by replicating the study to include young men in early adolescence, this may inform us about the differential impact that stages of development has on help-seeking. This is important given that self-harm is believed to begin around age 13-14 (Hawton & Harris, 2008) and, thus developing a good understanding of ways to facilitate access as an early intervention strategy would be beneficial.

Whilst I did not embark on this research with the intention to develop a new model of help-seeking, I was very excited by the opportunity to represent young men's very complex experiences of help-seeking diagrammatically. I believe that this is a unique contribution to the field of help-seeking research, given that it may be developmentally sensitive and it may have direct relevance to self-harm. Nevertheless, I am mindful that this is purely conjecture and further research is warranted to assess the specificity of this model. This may include replicating the current study and assessing the applicability of the model in other samples including a mixed age range, both males and females and also in non- self-harming young people. This is an exciting piece of future research within a field that is rapidly growing both in terms of academic interest and clinical need.

Finally, this research highlighted that young men placed value in shared experience and highlighted this as helpful for facilitating initial access and on-going engagement in services. Towards the latter part of my research write-up, I became more familiar with the range of on-line mental health peer support services that are in operation (www.mindfulcharity.ca). With this in mind, and in the context of shared experience being highlighted in the current study, I believe that this research points to the need to evaluate peer-support provision, both in terms

of the impact on the person receiving support and the impact on the person providing the support. I believe that this information could make a very valuable contribution to the way in which services offer help to young men and the way in which formal services can use more informal networks to supplement their work.

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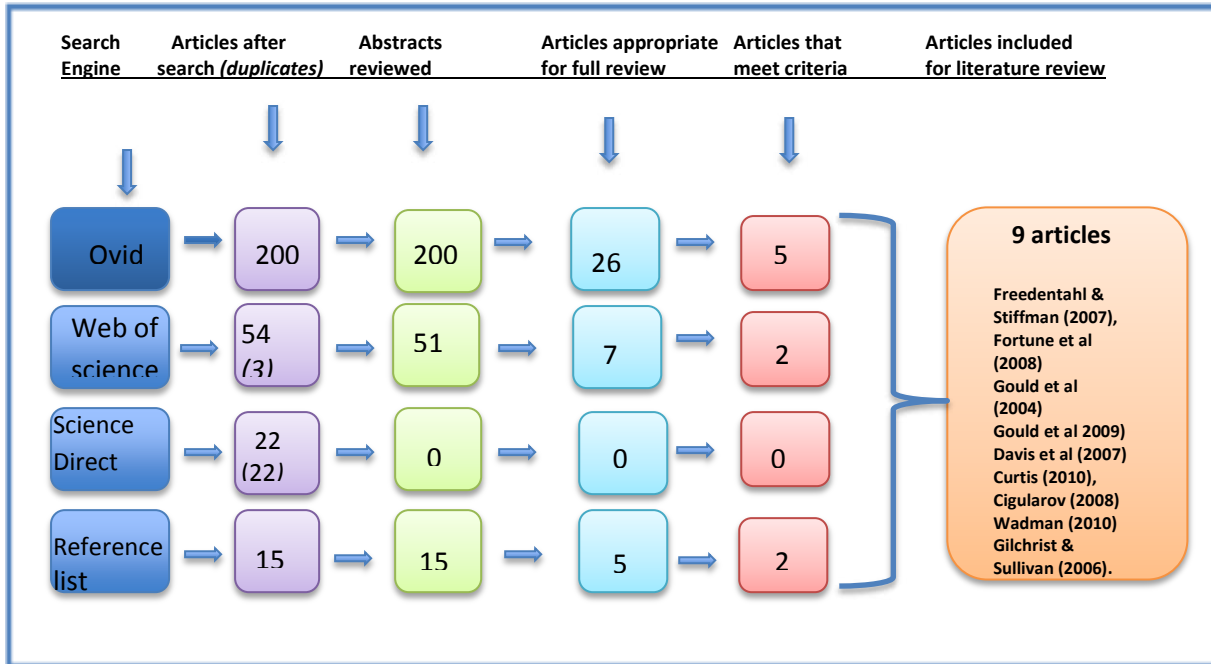
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Appendix. A:

Search strategy

Search completed in November 2012



Appendix. B:

Abstracts reviewed

Authors	SH specific	Male/Female	Location	Qualitative	Quantitative	Barriers/Facilitators	Clinical/ non-clinical population	Child/Adult	Comment
Mariu et al (2012)	NO	M/F	NEW ZEALAND		YES	BARRIER	NON	C	
Gilchrist et al (2006)	YES	M/F	AUSTRALIA	YES		BARRIER	NON	16-24	
Bruin et al (2010)	NO	M/F	NEW ZEALAND		YES	BARRIER		C	
Gulliver et al (2010)	NO	M/F	?	YES	YES	BOTH	NON	C	
Cusack et al (2004)	NO	M	AUSTRALIA		YES		CLIN	A	
Gould et al (2004)	YES	M/F	USA		YES	BOTH	NON	C	
Cleary et al (2004)	NOT A STUDY	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NOT A STUDY
Jordan et al (2012)	YES	M	N.IRELAND	YES		BOTH	BOTH	?	
Evans et al (2005)	YES	M/F	UK		YES		NON		PREVALANCE
Fortune et al (2008)	YES	M/F	UK	YES	YES	BARRIER (MAINLY)	NON	C	
Biddle et al (2004)	NO	M/F	?		YES		NON	16-24	
Wu et al (2012)	YES	M/F	TAIWAN	YES			CLIN	A	
Coe et al (2005)	NO	M/F	?		YES			16-64	
Rothi et al (2006)	NO	M/F	?		YES				REVIEW
Murray	NO	M/F	UK	YES			NON	C	104

(2005)									
Gould et al (2009)	YES	M/F	USA		YES	BARRIER	CLIN	C	
Michaelmore et al (2012)	YES	M/F	?						REVIEW
Curtis et al (2010)	YES	M/F	NEW ZEALAND	YES	YES	BOTH	NON	16-24	
Leavey et al (2011)	NO	M/F	?	YES	YES	BARRIER	NON	C	
Ravi et al (2009)	NO	M/F	ISRAEL		YES	BARRIER	NON	C	
Baetens et al (2011)	NO	M/F	?		YES	BARRIER	NON	A	
Nada-Raja et al (2003)	YES	M/F	NEW ZEALAND	YES	YES	BARRIER	NON	A	
Cigularov et al (2008)	YES	M/F	USA		YES	BARRIER	NON	C	
Rossow et al (2010)	YES	M/F	NORWAY		YES		NON	C	PREVALANCE
Wadman (2010)	YES	M/F	WALES		YES	BOTH	NON		NOT HELP-SEEKING
Rickwood et al (2007)	NO	M/F	?	YES				C	
Ystgaard et al (2009)	YES	F	EURO REGIONS		YES		NON	C	PREVALANCE
Rickwood et al (2005)	NO	M/F	AUSTRALIA		YES	BOTH	NON	C	
Hawton et al (2009)	YES	M/F	UK		YES		NON	C	
Vogel et al (2011)	NO	M	?		YES	BOTH	NON	A	
Wislon et al	NO	M/F	AUSTRALIA		YES		NON	C	

(2012)									
Freedenthal et al (2007)	NO	M/F	AMERICA		YES	BARRIER	NON	C	NOT SH FOCUS
Sawyer et al (2012)	NO	M/F	?				NON	C	
Wilson et al (2001)	NO	M/F	AUSTRALIA	YES	YES	BOTH	NON	C	
McDonald et al (1995)	NO	M/F	?		YES	BOTH	NON	C	
Wilson et al (2005)	NO	M/F	?		YES	BARRIER	NON	C	
Molock et al (2007)	YES	M/F	USA	YES		BOTH	NON	C	

Key

Met inclusion criteria:

- Sample aged between 14-24 must indicate a mean age that is between 16-18
- Asked specifically about attitudes and beliefs regarding seeking help for self-harm or suicidal-ideation
- Written in English Language
- Research study only (not systematic review or meta-analysis)

Appendix. C

Manuscript guidelines

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Appendix. D

Letter of ethical approval

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Appendix. E:

Research & Development Study approval

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Appendix. F
Coded transcript

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Appendix. G:

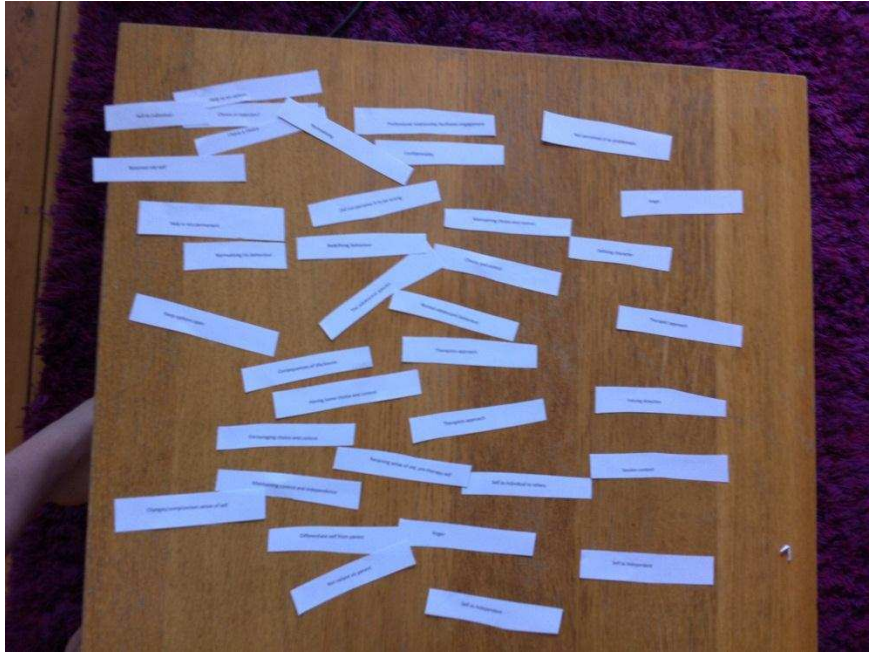
List of emergent themes participant. 1

Absent male
Parent as influential
Difference in defining 'problems'
Articulating feelings
Not reliant on parent
Parent as driving force
Self-harm comes second
Which problems are more acceptable?
Bringing it up
It's not severe enough
Is it severe enough?
Consequences of disclosure
Denial of need
Belief in ability to cope independently
Self as individual
Expectations of self-harm
Negative associations
Expectations of self-harm
Self as individual to others
Anger
Normal adolescent behaviour
Cost to others
Redefining behaviour
Parent's concern
Different perspectives on the normality or the behaviour
Defining character
Normalising his behaviour
Not perceived of as problematic
Regrets
Normalising
Anger
Self as independent
Can sort own problems out
Deny need for help
Retaining sense of old, pre-therapy self
Self as independent
Does not perceive need
Choice or coercion?
Normalising help-seeking
De-pathologising
I have a choice
Help is not permanent
Keep options open
In denial
Pathologising behaviour is frightening
What defines a problem?
Self as independent
Generalising the ability to cope independently
Quick fix
Recognising struggles
Gender of helper
Help as sign of weakness
Retained old self
Challenging perception of weakness
Gender of helper
Normalising
Having some choice and control
Need implying weakness
Help as an option
Session content
Professional relationship facilitates engagement
Friends not aware
Personal to interpersonal challenge
Alcohol
Minimising
Embarrassment
Cost to others
Confidentiality
Anxiety
Did not perceive a need
Did not perceive it to be wrong
Not a cry for help
Others who seeking help and gender
Differentiate self from parent
Maintaining choice and control
Gender of therapist
Encouraging choice and control
Non-intrusive and easy way out
Seeing the benefits
Therapist approach
Choice and control
Parent's on-going influence
Parent's ongoing influence
Maintaining control and independence
Therapists approach
Therapists approach
The adolescent species
Valuing direction
Gender of therapist
Gender and engagement
Prior perceptions of clinicians
Self as independent
Lack of awareness of peers
Future help-seeking
Denial of need
The invisible disease
Accessibility
School interventions
Self as independent
Educating parents
Influence of parents
Educating parents
Gender- masculinity
Masculinity
Changes/compromises sense of self
Losses
Gender of helper

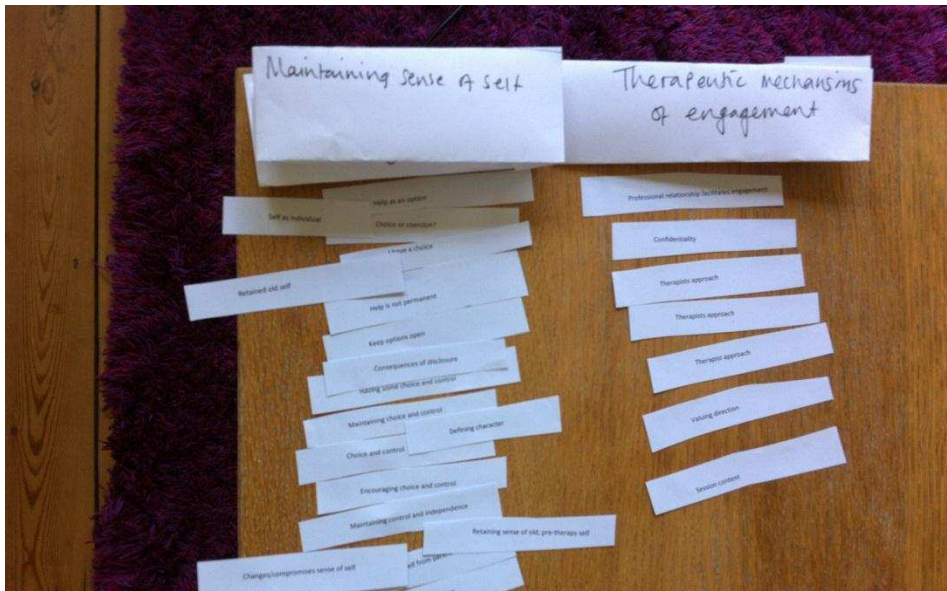
Unconsciously looking for male perspective

Appendix. H

Arranging emergent themes



Arranging higher-order themes



Appendix. I:

Super-ordinate themes

'Super-ordinate' themes participant.1

Maintaining some control

Maintaining control and independence ('I would say to ? I think I'm just going to stop')

Choice and control

Encouraging choice and control ('Just see if you want to do this')

Maintaining choice and control ('I imagined that I wouldn't come')

Keep options open

Help is not permanent

I have a choice (it's worth trying ... it's an experience ... I just thought I'd give it, I'd decided to go')

Choice or coercion?

Having some choice and control ('option of ... getting out of just saying this isn't for me')

Help as an option

No perceived need for help

Deny need for help ('...and I often deny that I need help I don't like help I and I was very in denial')

In denial ('I was really in denial of the fact that there was anything wrong with me')

Denial of need

Self as independent

Self as independent

Did not perceive a need ('I didn't think I was doing anything wrong or anything was wrong')

Denial of need

Self as independent ('most things I can solve myself')

Does not perceive need

Belief in ability to cope independently ('Yeah I hadn't thought I'd been coming for so long')

Can sort own problems out ('... someone who likes to do things myself')

Normalising help-seeking

Future help-seeking ('I might after this even look for more, seek other help')

Normalising help-seeking ('it's something that everyone can benefit from in some way')

De-pathologising

Normalising

Gender of 'The other'

Gender of therapist

Challenging perception of weakness

Gender of therapist ('Probably I reckon it was nice having a guy that was a good thing obviously')

Gender and engagement ('Definitely made a difference at the beginning which is kind of the crucial part I guess')

Unconsciously looking for male perspective

Gender of the helper ('I was probably looking for some kind of male perspective')

Gender of the helper ('I was looking for a male perspective')

Gender of the helper

Therapeutic mechanism of engagement

Session content ('don't talk about my problems I just .. about my day and that's alright')

Therapist approach

Therapist approach

Therapist approach ('I think sometimes people need a push because people of my age are lazy')

Confidentiality

Professional relationship

Problem blindness

Generalising the ability to cope independently ('I can sort it myself, everyone does')

Lack of awareness of peers needs/problems

Compromising masculinity

Help as a sign of weakness ('because I didn't want to seem weak')

Need implying weakness

Embarrassment

Negative associations

Masculinity ('I found a bit kind of weak')

Gender-masculinity ('it just didn't feel manly')

Maintaining sense of self

Not reliant on parent

Retained old self

Changes/compromise sense of self

Retaining sense of old, pre-therapy self ('I was very I am quite independent')

Defining character ('I'd always been a fairly happy person')

Consequences of disclosure

Self as independent

Self as independent ('I've always been someone and I still am who likes to do things myself')

Self as individual to others

Self as individual

Differentiate self from parent

Defining problems

Which problems are more acceptable?

Self-harm comes second

Expectations of self-harm

Expectations of self-harm ('they weren't sure if I really needed to be here')

It's not severe enough
Is it severe enough?
Difference in defining problems ('well she seems to think (it's a problem) I don't but I think')
The invisible disease
Different perspective on normality of behaviour ('and it might have just been banging my head and that but my mum saw it as more serious')
What defines a problem? ('well I am going through a hard time but I can sort it myself')

Normalising behaviour as obstacle

Did not perceive it to be wrong ('I didn't feel like I was doing anything wrong or harming myself particularly')
Normalising his behaviour ('I just see it as being angry')
Normal adolescent behaviour ('people of my age are lazy')
Anger
Redefining behaviour ('it might have just been banging my head')
The adolescent species
Anger
Normalising
Not perceived as problematic ('I didn't really see it as a problem')

Role of parent

Educating parents ('Parents should be made more aware of it rather than kids [of CAMHS]')
Influence of parents
Educating parents
Pathologising behaviour is frightening
Parents' on-going influence ('I didn't have that push from my mum I probably wouldn't come I probably wouldn't still be coming')
Parents' on-going influence
Parent as influential ('Mum thought I should get some help')
Parent's concern
Parent as driving force ('she thought like it would help, benefit to maybe talk to someone')
Valuing direction ('You need that push')

The role of self-harm

Not a cry for help

Cost to others

Cost to others ('she was sometimes crying')

Themes not included:

Personal to interpersonal challenge
Anxiety

Regrets
Losses
Minimising
Alcohol
Articulating feelings
Bringing it up
Parent v's equiviliant
Recognising struggles
Quick fix
Prior perceptions of clinicians
Friends not aware
Absent male
Accessibility
School interventions
Other who seeking help and gender
Non-intrusive way out

Appendix. J:

List of 'Higher-order concepts'

Influence of others and normalising

Changes in perspectives

Gender of the other

In-session techniques

Approach of the helper

Prior help-seeking experience

Shared experience

Self-harm as secondary

Influence of others

Maintaining choice and control

Appendix. K:

Higher-order concepts with example quote

Example used: Influence of others

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Included in results write-up

Not included in results write-up

Appendix.L Higher-order theme 'Recurrence Table'

Higher-order concepts	Jack	David	Jamie	Simon	Chris	Adam	Ben	Ed	Present in over half of sample?	
Influence of others and normalising	YES	YES	YES	YES	YES	YES	YES	YES	√	Combined
Gender of the other	YES	YES	NO	NO	YES	NO	YES	YES	√	
Change in perspective	YES	YES	NO	NO	YES	NO	YES	YES	√	
In-session techniques	NO	YES	YES	NO	NO	YES	YES	YES	√	Combined
Approach of the helper	YES	NO	YES	YES	YES	YES	YES	YES	√	
Prior help-seeking experiences	NO	NO	YES	NO	YES	YES	YES	NO	X	
Shared experience	NO	YES	NO	YES	YES	NO	YES	YES	√	
Maintaining choice and control	YES	YES	NO	YES	YES	YES	YES	YES	√	
Self-harm as secondary	YES	NO	NO	NO	YES	NO	YES	NO	X	

<u>'Over-arching' Themes</u>
Influence of other
Change in perspective
Mechanisms of engagement
Shared experience
Maintaining independent self

Appendix. M

'Over-arching' themes

Final list of 'over-arching themes'. Each theme was endorsed by half of the sample or more

Influence of another 1, 2, 3, 4, 5, 6, 7, 8

- Normalising
- Influence of others
- Gender of the other

Mechanisms of engagement 3, 6, 2, 7, 1, 5, 4

- In-session techniques
- Approach of the helper

Change in perspective 5, 7, 1, 2

- Prior help-seeking experience

Shared experience 5, 2, 4, 7

Maintaining choice and control 5, 2, 7, 4,

- 1. Jack**
- 2. David**
- 3. Jamie**
- 4. Simon**
- 5. Chris**
- 6. Adam**
- 7. Ben**
- 8. Ed**

Appendix. N

Abridged Research Diary

February 2011: First meeting with internal supervisor: having spent a lot of time recently conducting literature searches into my area of interest 'self-harm' I have begun to identify a particular area that appears to warrant more interest - male self-harm. It seems clear that young men do not receive help as frequently as young women even though they are at increased risk for suicide. I discussed this area with Alex, and expressed my interest into learning about what prevents or enables young men to seek help. Alex was in agreement.

March 2011: First meeting with external (clinical) supervisor: She was in agreement with my research idea. This meeting also helped me to consider the potential difficulties with focusing on young men. For example, we began to think that the reason for me wanting to conduct research into young men who self-harm (i.e. the fact that we see very few in services) and the impact that this might have on recruiting only young men who have sought help. I left this meeting planning to look into prospective help-seeking by focusing on non-clinical populations.

March 2011: After conducting some searches of the literature into young people and help-seeking for self-harm, it is becoming clear that there is a preponderance for studies to recruit non-clinical populations. I feel that I am justified in focusing on clinical groups of young people as this would present a different story about 'actual' help-seeking rather than 'prospective' help-seeking.

April 2011: Meeting jointly with internal and external supervisors: Having thoroughly considered the area of focus for my research, this meeting has focused on the methodology. I shared my knowledge from having carried out a provisional literature review, that the majority of studies used a quantitative methodology to assess beliefs about accessing help for self-harm. Both of my supervisors and I were in agreement that the research base lacked consideration of personal experiences. Given this, and the concerns about ability to recruit young men, it appeared clear that utilising a qualitative approach to explore personal experiences of

help-seeking by young men, would be both a useful contribution to the field and also, practically, more feasible for recruitment.

May 2011: Following agreement for my study to utilise a qualitative methodology, I have begun to investigate the various different methodologies. Having read a number of studies using an Interpretative Phenomenological Analytic paradigm, it has become evident to me that IPA's focus on making mean of personal experiences was an appropriate stance for my project given its striking comparison to the majority of research in this field - with focus on measuring agreement with pre-conceived ideas about help-seeking.

May - August 2011: making links with CAMHS services: Given the potential difficulty with recruiting young men who were accessing services, I have spent a number of weeks making phone calls and sending emails to clinical psychologists within three different NHS trusts where there were links with the Salomons course. This part of the process is both challenging and rewarding. Getting the attention of very busy psychologists is difficult, however once contact is made, the responses I receive are very motivating. In general, I receive a very positive response and clinicians agree to support the research in their team if it goes ahead. This resulted in 16 contacts.

October 2011: MRP proposal review panel: I attended the Salomons review panel to discuss the rationale for my study and any potential difficulties I may encounter. The panel were positive about my study, but concerned about my ability to recruit enough participants. During this panel, there was discussion about potential ways for helping with recruitment. This included changing the lens of the study by recruiting young people, parents and clinicians to triangulate. This also included extending my age range from 16-18 to 14-18. Whilst I appreciated the recommendations and understood the reasons for them, I felt slightly uncomfortable. For example, given that I am hoping use IPA, a homogenous sample is necessary. I did not think this would be achievable if I extended my age range since the help-seeking behaviours of 14 year olds was likely to differ (i.e rely on more parental guidance) to an 18 year olds (who would be more independent).

The panel understood my counter-argument and agreed that, should manage to recruit from all three trusts as planned, recruitment might be possible.

January 2012: Meeting with both supervisors (separately) to discuss ethics application. This meeting was particularly helpful to consider the steps that were necessary for ensuring the safeguarding of young men when interviews were taking place. This is a particularly important consideration given the levels of risk posed by participants.

February 2012: Ethics panel: Overall, the members of the ethics panel with interested in the study and only had a few queries. Whilst I had been worried about the panel, my experience was very positive and encouraging.

March 2012: Ethics favourable opinion with conditions: The panel requested that I add a line to the consent form to acknowledge possible sharing of information with parents, carers and therapists, should issues of risk arise.

April 2012: Ethics/R&D applications approved

April- June 2012: literature review: The process of conducting the systematic literature review was a helpful process for refining my rationale for the study.

May - December:

Following receiving approval from three R&D trusts, I have begun to once again make contact with clinicians in CAMHS teams to remind them of the study. I have also attended a team meeting of seven of the recruitment sites in order to disseminate information about the study and to answer any questions that clinicians may have. This process has been encouraging as clinicians have frequently expressed their concern about young men who self-harm and the need to learn more about how to help them.

I am feeling concerned, however that there have not been any potential participants identified. I am also a bit concerned that, given the reconfiguration of many of the CAMHS services within one of the trusts, that my project will be forgotten or put to one side. I carry on sending email reminders however.

December 2012: Meeting with both supervisors: I asked to meet with both supervisors to share my concerns that recruitment is

very slow. Both supervisors are keen for the project lens to remain the same, however they suggest that I consider also recruiting from the voluntary sector in addition to CAMHS. I decide to make amendments to my ethics application to include recruitment from voluntary sector counselling services.

December 2012: Service user consultation group: I had arranged to meet with a young people's service user consultation group to gather their opinions on my interview schedule. I was rather nervous entering the focus group and had concerns that they may have strong objections to the questions I was hoping to ask. However I was pleasantly surprised. Seven young people opted to attend and shared some very useful insights including: changing around the order of questions in order to ease participants into the interview and rewording two questions to make them clearer. The group appeared to really enjoy this consultation process and it gave me renewed enthusiasm to re-engage with my project. I am hoping that the young men I recruit will be as forth coming when they meet me in interview.

December 2012: Amendment is approved and I begin to contact local counselling services for young people. I am encouraged by the responses by the counsellors that I speak to.

December 2012: First participant interview: To my delight I was contacted by a clinician who had shared the participant information sheet with a young man and who had agreed for me to contact him.

December 2012: I am due to meet my first participant today. I am feeling rather nervous about the interview because my experience of engaging young men in discussions about their difficulties, to date, has been rather challenging. I am hopeful that these young men might be more forth coming and reflective about their experiences however.

On meeting my first participant, I was happily surprised as he was very thoughtful, reflective and insightful. He was grateful for the opportunity to talk about his experiences and noted that he thought this research would help other young men. Perhaps his willingness to talk reflects the fact that he self-selected for involvement in the study?

January 2013: I have submitted section A to my supervisors to review. Their responses are very encouraging. It is becoming

clear that I need to revisit the theory of help-seeking since this aspect of my review is less clear. I believe this reflects the field of help-seeking which is criticised for poor development of theoretical models.

January 2013: I have been working on section A and am beginning to feel more comfortable with the theory surrounding help-seeking. I initially realised that there were so many different models of help-seeking and had some difficulty deciding on their relevance for my study and therefore, which to include in my review. I subsequently conducted a systematic search of the evidence and decided to include one model that is influential and developed just for young people and one model that is developed for adults but specific to self-harm. I thought that this might provide a good sense of models in general given that I am limited in terms of writing space.

February 2013: more participants: Despite continuing to be concerned about recruitment, I am contacted by three clinicians who have potential participants. I have a similar experience to the first participant, that they young men are very reflective and insightful.

I am transcribing interviews as they are completed and I am beginning the first stages of the IPA process; 1) reading and reading the transcript 2) initial coding 3) developing emergent themes and searching for connections across themes.

March-April 2013: My second draft of section A is approved and I am feeling really motivated about my project. Four more participants recruited and interviewed. Being able to meet the young men and actually recognising how their experiences are vital learning points for how we facilitate access to and engagement in help is brilliant.

May 2013: to my surprise, I have completed data collection, with eight participants. I continue with the transcription and analysis process. I can now appreciate why it is helpful to keep a reflective diary in order to aid bracketing as I try to ensure that my preconceived ideas do not interfere with the analytic process. I am hesitant to make interpretations at first; however, as I progress through the transcripts and become more immersed in the data, I develop more confidence.

May-June 2013: I have been writing my section B. This has been a slight challenge as I have been very cautious to link

section B with section A, but not replicate material. I send my first draft of section B to both supervisors and quickly receive very encouraging feedback. I am very grateful to my supervisors at this stage for balancing critical and encouraging feedback. Writing up the results section has given me a valuable overview of help-seeking by young men. It has become very clear about the important factors for facilitating their help-seeking

Developing a model: Whilst I had not set out to develop a model as part of this research, I am becoming aware that my analysis has highlighted processes that are not clearly evidenced in any existing models of help-seeking. I have been enjoying the process of trying to represent my research findings diagrammatically and believe that the model I have developed might be considered a unique contribution to the field of help-seeking by young men.

July 2013: I have completed my write-up of section B and I have sent this to my supervisors for review. I have begun work on section C, which I have found a helpful process for consolidating my thoughts and reviewing the journey that I have taken to achieve this project. I have been surprised that over the course of conducting this project, I have been thinking about ways to continue to develop on this piece of research.

Appendix. O

Participant information sheet



A research project looking at young men's experience of self-harm and their journey of seeking help

INFORMATION SHEET FOR YOUNG PEOPLE AND THEIR PARENTS/CARERS

Hello my name is [REDACTED], I am a doctoral student studying clinical psychology at Canterbury Christchurch University. I am carrying out some research and I would like to offer you the opportunity to take part in a research project. The project aims to find out about the experiences of young men who have received help for their self-harm.

Before you decide if you want to join in it is important to understand why we are doing this research and how you could be involved. So please think about the information provided in this leaflet carefully and talk about it with your family, friends or therapist if you want to.

What is the study and what will happen?

Why are we doing this research?

We know that although self-harm is common among young people only a very small number of adolescents receive help from services. We also know that young men are less likely than young women to ask for help when they might need it. Some other research has been carried out to consider the reasons why young men find it difficult to ask for help, but there is very little information about what actually helps. I would like to learn from young men

themselves and find out about their individual journey of asking for and receiving help.

Why have I been invited to take part?

You have been chosen because this research project is looking at young men, like you, who have managed to ask for help from services for their self-harm. I will be asking other young people to take part too – 8-10 young people in all from around the south of England.

Do I have to take part?

No, it is up to you. If you do take part, I will ask you to sign a form saying that you agree to take part (a consent form). You can stop taking part at any time during the research without giving a reason. If you choose to stop, this will not affect the help that you receive in any way.

What will happen to me if I take part?

If you are interested in taking part your clinician/therapist/worker will ask you if they can give me your contact details. If you agree to this, I will contact you by telephone to discuss the study and to tell you about how you could be involved. I will then send you some information through the post to read. I will contact you 2 weeks later to check whether you would still like to be involved. If you would, I will arrange a time to meet with you at your usual clinic. This meeting will last roughly one hour and it will involve me asking about your experience of self-harm and about your journey of help-seeking such as 'Did you have help from those around you?' Or 'What helped you to come to the service?' There are no right or wrong answers. I am interested in your experience and this will be different for each and every person I meet.

The meeting will be recorded using a voice recorder as I will need to listen back to the discussion we had. After the interview I will listen to the recording and write it up on a computer and saved on to a CD that is protected by a password so only I can use it. All information such as names and places will be changed so that you will not be identifiable in any way.

How many times will I have to meet with the researcher?

You will only have to meet once: to discuss your experiences.

What are the possible benefits of taking part?

This research will help us to learn more about how young men, who self-harm, access help and we think that this is a really important area to learn more about. The experiences that you share will be anonymously fed back to services. This will help services to consider how they might adapt the way that they offer and provide services to young men like you, making it more accessible to ask for help when needed. This might even lead to more research in the future.

When this project is completed I will send you a summary of the findings so that you can see how your interview has been used in the research.

Will anyone else know I am doing this?

Your therapist will know that you are involved in the research project.

This research will be supervised by a Clinical Psychologist and also a Clinical Psychologist who works for Canterbury Christchurch University. It is possible that these two people might look at some of the recorded information just to check that the project is being carried out properly. If this happens, all of your personal details such as your name will NOT be shared.

If I am worried about you after your interview, I might discuss this with your therapist. It might also be necessary for some information to be shared with your parent or carer. This would only take place if I had concerns about your safety or the safety of others.

I would discuss this with you before consulting with your therapist or parent/carer.

Who is organising this research?

This research is carried out for a doctoral training programme in clinical psychology at Canterbury Christchurch University in collaboration with [REDACTED] NHS Foundation Trust.

Who can I contact for more details?

Details about this project:

You are very welcome to contact [REDACTED] (Trainee Clinical Psychologist) on [REDACTED]. You will reach a 24 hour voicemail service. Please state your name and who the message is for ([REDACTED]). This telephone number should only be used for research purposes and all other contact should be made directly with your service.

You will be given £10 cash to reimburse any travel expenses you may have incurred coming to take part in the study. This will be given to you once the interview has been completed.

General details about taking part in research:

Please ask your clinician if you have any questions generally about taking part in research. Hopefully they will be able to answer your questions. If they are unable to help, they will arrange for you to meet with someone who can help.

Appendix. P

Consent form



Consent form

Identification Number:

Title of Project: How do young men who self-harm understand their help-seeking journey and their experience of the help they received?

Name of Researcher [REDACTED]

Please tick to confirm

YOUNG PERSON:

?

- ?

 I confirm that I have read and understand the information sheet for the above study.
- ?

 I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- ?

 I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and that this will not affect the care that I receive in any way.
- ?

 I understand that relevant sections of the recorded interview may be looked at by another member of the research team. I give permission for these individuals to have access to the recorded data.
- ?

 I understand that if necessary some information will be shared with my parent or carer.
- ?

 I agree to my therapist being informed of my participation in the study.
- ?

 I agree to take part in the above research study.
- ?

 I agree for quotes from my interview to be used in the write up of the study.

Name of participant

Date

Signature _____
Name of Person taking consent
(if different from researcher)

Date

Signature

Researcher _____

Date _____

Signature When complete, 1 copy for patient: 1 copy for researcher

Appendix. Q

Interview schedule:



Introduction:

- Explain who I am
- Reminder what the research is about (aim to normalise the process)
- Explain that I will be asking some questions that are about self-harm and ask how they refer to self-harm (cutting, self-injury etc) – say that I would rather use their words.

A. Help-seeking journey

1. Could you tell me about when you first came to CAMHS?
 - *Prompt: when was this, what was it like, who did you come with?*
2. Could you please tell me a brief history of your self-harm?
 - *Prompt: when it began, occurrence, frequency,*
3. Could you tell me about the time when you realised that you needed help for your self-harm?
 - *Prompt: What did you notice? What did you do? Who did you go to? What did people advise you to do? Who did you ask for help from (formal or informal)? Was seeking help for SH different from other problems?*
4. Could you describe any things that helped you to ask for help from informal sources (such as school, friends, parents etc)?
 - *Prompt: People, staff, attitudes, prior experience, expectations*
5. Could you describe any things that helped you to ask for help from formal sources (such as CAMHS, Counselling service, A&E)
 - *Prompt: People, staff, attitudes, prior experience, expectations*
6. What things got in the way of you asking for or receiving help?

➤ *Prompt: People, staff, attitudes, prior experience, expectations*

B. Experience of seeking help from CAMHS

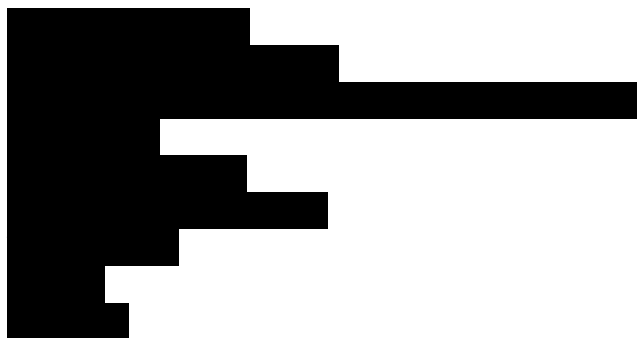
1. Could you tell me your experience of CAMHS?

Prompt: Was it as you expected?, How was it different? What could have been better? What did and did not work for you? Any advice they could give to others asking for help?

Appendix. S:

Letter outlining end of study

Chloe Isbister
Trainee Clinical Psychologist
Canterbury Christ Church University
Department of Applied Psychology
Salomons Campus
David Salomons Estate
Broomhill Road
Tunbridge Wells
TN3 0TG



11th July 2013

Re: End of study

Dear [REDACTED],

I am writing to thank you for your time taken to carefully review the ethical considerations of my research project, for which you granted approval in February 2012. I am also writing to inform you that this project has now reached completion.

Empirical Study Title: A journey of help-seeking: Young men's experiences of accessing
and receiving help from CAMHS following self-harm

REC reference: [REDACTED]

I have thoroughly enjoyed carrying out this piece of research and I believe that it makes a valuable contribution to the field of young people's mental health.

I am enclosing a brief report as an overview of the research undertaken, which I hope you find both interesting and informative.

Thank you once again for your time and to the other members of the ethics panel who gave up their time to review my project.

Yours Sincerely

Chloe Isbister (nee Richmond)

Cc: 

Appendix. T:

End of study report to Ethics and R&D

End of study: Brief Report

Empirical Study Title: A journey of help-seeking: Young men's experiences of accessing and receiving help from CAMHS following self-harm

Researcher: Chloe Richmond

REC reference: 12/LO/0266

Commenced: September 2012

Concluded: July 2013

Participants recruited: 8

Introduction

The rising rates of self-harm and suicidal ideation amongst young people is concerning, particularly given the low rates of help-seeking that are evident amongst this population. This has raised considerable interest into researching the factors that prevent help-seeking in young people over the past decade. One area in particular that has been highlighted as 'in need' of further investigation is the help-seeking behaviours of young men, given that they present the greatest risk for completed suicide but the poorest help-seeking intentions.

This research aimed to explore how young men, who had successfully sought help from a Child and Adolescent Mental Health Service (CAMHS), experienced help-seeking. This

study focused on the factors that facilitated initial access and on-going engagement in services.

Method

Eight young men between the ages of 16-18, who had entered CAMHS following self-harm or suicidal ideation, and who were engaged in on-going therapy, were recruited. Each young man was interviewed to elicit his personal experiences of help-seeking and help-receiving. Interviews were transcribed and subjected to Interpretative Phenomenological Analysis, a qualitative analytic method.

Results

Five dominant themes, that overarched participant's individual experiences, emerged from the data: Influence of another; Change in perspective; Maintaining an independent self; Mechanisms of engagement and Shared experience. Help-seeking was described as a journey of two stages; 1) initial access and 2) on-going engagement, during which the presence and timing of external influences (parents, teachers) and internal influences (personal beliefs and attitudes) were crucial. A model of help-seeking is presented.

Conclusions

This study is the first of its kind to consider factors that facilitate the help-seeking journey of young men aged 16-18 following self-harm. It highlights the need for provision of information to parents and teachers about how to identify need and ways to facilitate access to services. Information and guidelines for service developers, commissioners and clinicians is also highlighted on how to adapt services to meet the complex developmental needs of young men.

